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Medical Liability in Europe

A Comparison of Selected Jurisdictions

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Medical Liability in the Netherlands

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General Questions

A. The Health Care System Framework

I. General Introduction

1. The health care system in overview

Generally, mainstream physical and/or mental health care in the Netherlands can be divided into health care institutions and independent practitioners. Institutions are mainly hospitals, mental health institutions, psychiatric hospitals, rehabilitation clinics, homes for the elderly etc. The Quality of Health Care Institutions Act (*Kwaliteitswet zorginstellingen*) is a framework Act that serves to maintain the quality of many such institutions and that is mainly enforced by the Health Care Inspectorate. The Individual Health Care Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*; hereafter: *Wet Big*) concerns mainly the quality of health care professionals such as general practitioners, specialists, dentists and obstetricians. For these professions, also subject to public disciplinary law, the *Wet Big* provides for a registration system by means of protection of the professional title. For certain paramedic professions the *Wet Big* sets specific educational standards. It also reserves certain medical practices for regulated (and registered) professions. Several additional national and EC rules regulate various aspects of the professions involved,¹ for example the education and training, certification, competences and free movement of these professionals, their admission to our health care system, but also impose more substantive duties of care on them.

¹ For a more extensive discussion see HJJ Leenen/JCJ Dute/WR Kastelein, *Handboek Gezondheidsrecht*, vol 2 (2008) ch 2, and HJJ Leenen/JKM Gevers, *Handboek Gezondheidsrecht*, vol 1 (2007) ch 9.

- 2 Most important for the duties of care of providers of health care and for patients' rights is the Act on medical services contracts (*Wet geneeskundige behandelingsovereenkomst*, WGBO), which has been incorporated into Book 7 (Specific contracts) of the Dutch Civil Code (CC). Noteworthy for such duties and rights in cases of hospitalisation in psychiatric institutions is the Act on special hospitalisations in psychiatric hospitals (*Wet bijzondere opnemingen in psychiatrische ziekenhuizen*; hereafter: Bopz), which also includes procedural rules, for example regarding a complaints procedure. A more general application scope of the latter type of rules can be found in the so-called Act on the complaints procedure of clients of the health care sector (*Wet klachtrecht cliënten zorgsector*; hereafter: Wkcz). Based on the Wkcz for instance, health care providers must lay down procedural rules for so-called complaints procedures (*klachtenprocedures*); the Bopz and related regulations provide additional rules for the complaints procedure for patients who were hospitalised in a psychiatric institution by a court order or a similar order.² Additionally, there are rules based on the self-regulation of hospitals and other health care providers regarding substantive and/or procedural matters, sometimes based on the aforementioned enactments and/or on prototype regulations drafted by the Royal Dutch Medical Association (KNMG) or other (professional) organisations.
- 3 Patients who are not satisfied with the medical treatment that they were (or were not) given can directly approach or address the practitioner or medical institution. Psychiatric institutions and some other health care providers have an independent confidential adviser for patients (*patiëntenvertrouwenspersoon*) who may inform the patient and may intermediate in the patient's complaint and/or may offer the patient certain other forms of assistance. Patients may also opt for lodging a complaint with the practitioner or with his or her organisation or the complaint commission of the organisation. Whereas institutions such as hospitals generally have their own complaints commissions, independent individual practitioners outside such organisations will most likely work with external, regional complaints commissions.³ Depending on the seriousness of the complaint and the legal needs of the patient, the complaints may also be lodged with the Medical Disciplinary Board (*Medisch Tuchtcollege*) or, in more exceptional cases, directly with the Healthcare Inspectorate (and/or patients may file administrative or criminal law charges against the practitioner or the health care institution).

2 See more in depth on this *J Legemaate, Verantwoordingsplicht en aansprakelijkheid in de gezondheidszorg* (2000) 11 ff and 18 ff.

3 *Ibid* 15.

If the patient, subsequent to the complaint, seeks monetary compensation (or an injunction or similar order), the latter is dealt with by civil law rules; the complaint commission cannot decide on this. Claims for compensation are mostly settled out of court between patients and the liability insurer of the practitioner or the organisation he works for. If the parties cannot reach agreement, civil litigation before a court may be in place. If the complaints commission has already given its decision with regard to the patient's complaint (which is not necessary, but may occur in practice), this will usually, also due to the informal nature of the complaints procedure, not have evidential value as such, although it may be looked at in order to establish the facts of the case.⁴

II. Social Welfare Provision

2. The role of public health care

Patients can only claim compensation for that part of their damage that is not yet covered by salary arrangements, social insurance or private compensatory schemes. Under labour law, the employer (or his private insurance) needs to continue to pay at least 70 % of the victim's time-related income (subject to a maximum amount) throughout the first two years of disability to work. The exact percentage varies, based on the individual's disability to work, but in principle 70 % needs to be paid in cases of full disability (art 7:629 CC). Additionally, labour law prohibits redundancy within that period of time based on the victim's incapacity to work.

After these first two years, income related payments may be made under the long-term disability scheme, the so-called Work and Income Ability Act (*Wet Werk en Inkomen naar Arbeidsvermogen*, WIA). This only offers income replacement pensions to those who are disabled to at least 35 %. It introduces two different schemes for either income related payments for those victims who are disabled permanently and for 80–100 % (*Regeling Inkomensvoorziening Volledig Arbeidsongeschikten*, IVA) or continuation to work for those partially disabled, for 35–80 % (*Regeling Werkhervatting Gedeeltelijk Arbeidsongeschikten*, WGA).

The first scheme makes sure that only those who are fully (ie over 80 %) and permanently incapable of working will receive, and continue to receive, income replacement benefits equivalent to 75 % of their last

⁴ Legemaate (fn 2) 21.

income (subject to a maximum amount). The latter scheme offers 70 % of the last income to those who – out of 39 weeks prior to their disability – had been working for at least 26 weeks (or, for victims who can find a replacement job, 70 % of the difference between their old income and the new income). These payments will, dependent on the victim's period of disability, be continued for six months up to 5 years (at the longest). Thereafter, salary related pensions will only be awarded if the victim works for at least 50 % of his remaining capacity to work; if he does not, he will be left with a certain percentage of the minimum wages. The self-employed have to take out private insurance in order to have their disability risk for lost earnings insured.

- 8 Private insurance may also generally cover the risk of damages which do not fall under labour law arrangements and social security benefits, and therefore would be left uncompensated. The risk of personal damages due to medical malpractice will in most cases be included in individual private sickness or invalidity insurances or in collective insurance arranged by the employer. Most notably for the Dutch health care insurance system is that it introduces a mix of general health care coverage for basic risks of medical expenses and hospitalisation combined with private administration and competition. See further below, at no 11.

3. Differences in treating patient's claims

- 9 Patients' claims for damage caused in the context (at least partially) of publicly funded medical treatment are in principle not handled differently from other personal injury cases. Some specific rules exist in terms of special duties that may give ground for liability and on a more detailed level some specific rules and interpretations of the rules have come up, for example in terms of causation. These will be discussed below.

4. Right of recourse

- 10 Based on special provisions of labour law and social security law, employers who continue salary payments and most social insurance carriers that are under the obligation to make arrangements and payments for the patient's incapacity to work and his medical expenses, have the right to reimbursement (right to recourse). This means that both these employers and social insurance carriers can use civil liability law in order to be reimbursed by the liable person for the insurance sums they had paid to

the insured.⁵ These labour law and social security law provisions determine that, to the extent that the employer and social insurance carriers have reimbursement claims, the victim (the patient) will lose his claim for compensation vis-à-vis the liable party. As will be seen below at no 12, private insurers that compensate damage are, to that extent, subrogated into the insured person's right to compensation.

III. Private Insurance

5. The role of private health insurance

Noteworthy is that the basic risks of medical expenses, such as the costs of 11
medical services, hospital stay and dental care, are covered by private
insurance, which is to that extent mandatory for everyone who lives or
pays income tax in the Netherlands. Health insurance companies are
under the legal obligation to offer this basic health care insurance and
cannot reject individuals on other grounds than those provided for by law.
A less fortunate side-effect is that the new system has left a number of
people uninsured.⁶ Additional insurance can be purchased and offered on
a voluntary basis. All these arrangements are no different for the risk of
suffering medical expenses (and other damage) due to malpractice than
they are for other risks of damage.

Based on the rules of insurance law that are laid down in Book 7 (Specific 12
contracts) of the Civil Code, private first-party insurers, such as the
victim's medical insurer, who have compensated the victim's damage, are
to that same extent subrogated into the victim's right to compensation
under tort and/or contract law (art 7:962 CC). This right to subrogation is
primarily intended for the patient's own private insurers; it does not
protect insurance parties that cover the risk of salary continuation of the
patient's employer in case of work disability as the latter has no right to
compensation, only to reimbursement. But this rigid and rather technical
approach seems to lose support with the increasing financial burdens of
employers in terms of salary continuation: the Amsterdam court of appeal
allowed an employer's insurance carrier to be subrogated into the employ-
er's right to reimbursement for salary continuation payments (art 6:107a

5 For an extensive overview and discussions *EFD Engelhard, Regres* (2003) 73 ff.

6 *EH Hondius* (ed), *The Development of Medical Liability* (2010), mentions in the introduc-
tion to this volume that 240,000 people were left uninsured.

CC), by analogy to art 7:962 CC.⁷ To be clear: these rules are principally no different in cases of medical liability than they are in other cases of contractual or non-contractual liability.

6. Liability insurance

- 13 As in most European countries, the risk of claims for negligence and malpractice is seen as an occupational hazard and practitioners and health care organisations generally chose to limit this risk by taking out liability insurance. It is often said that insurances for medical risks are hardly, if ever, profitable and this is also seen as an explanation for the relatively small number of insurers that offer these insurances, especially where hospital and other health care institutions are concerned.⁸ The medical liability insurance is, however, not mandatory. As in other personal injury claims it seems possible that the amount of compensation to be awarded to the claimant exceeds the amount covered by liability insurance, in which case the mitigation rule of art 6:109 CC may be relevant, see no 76.
- 14 More generally over the last 15 to 20 years there has been a shift from 'occurrence' to 'claims made' systems, which means that the insurance only covers cases that were reported during the duration of the insurance and not just any damage that has occurred in that period (but was only reported later in time). It has been noted that this may make it expensive for practitioners to change liability insurance carriers (as they may then have to take out additional coverage for the risk of damage caused during the running-time of the previous liability insurance).⁹
- 15 Much debated are special clauses in the insurance contract that do not allow the practitioner or the institution to make any statements as to admitting to fault or civil liability and that require them to abstain from any acts that might harm the liability insurer. The main idea behind this is that doctors may admit to having been at fault, when legally there is no wrong and this admission to wrongs may establish liability more easily. The aforementioned clauses have however been heavily criticised by people who claim that it is part and parcel of professional responsibility to prevent the possible deterioration of the patient's state by not telling

7 Hof Amsterdam 10 February 2009, not published but cited and discussed by *M Snel-De Kroon*, PIV-Bulletin 9 (2009).

8 See *inter alia* the (Belgian) thesis of *J ter Heerdt*, *Het experiment beproefd. Een juridische analyse van experimenten met mensen* (2000) 631.

9 *Legemaate* (fn 2) 59.

them what has happened.¹⁰ For this they see support in the information duty of art 7:448 CC, which we will discuss below (see no 70). Since 2006 Dutch insurance law determines that the violation of such prohibition clauses has no effect if the information admitted is actually correct. Also this rule determines that clauses that prohibit acknowledging facts have no legal effect (art 7:453 CC).¹¹ Disciplinary boards have held doctors accountable under (public) disciplinary law for not having reported incidents properly or fast enough.¹²

IV. Professional Standards

7. Applicable professional standards

The prevention of harmful incidents caused by or through medical treatment has become an important goal within the policy to improve patients' safety and the quality of our health care. Over the last few years several special prevention and safety programs were set up.¹³ In February 2009, the Healthcare Inspectorate even proclaimed a prize for the best initiative to promote the prevention of incidents. Also many professional rules, protocols and other regulations were put in force, for the sake of the quality of patient care and for the organisation, administration, registration and sanctioning of incidents. Hereafter we will highlight the most common and basic regimes, some of which – mainly governmental enactments – were mentioned already. 16

Of course one of the drawbacks of enactments by the legislator is its lack of expertise in the medico-professional area.¹⁴ Self-regulated protocols and guidelines as to medical practices, albeit not directly legally enforceable, have therefore an important function in health law.¹⁵ Such 'rules', where applicable, are considered to be important guidelines for determining whether the health care provider incurs civil liability.¹⁶ Vice versa, by taking the violation of such rules as an indication, albeit not necessarily a 17

10 See RWM Giard, *Aansprakelijkheid van artsen: juridische theorie en medische praktijk* (2005) 144 and *Legemaate* (fn 2) 13.

11 Though on drawbacks of this ruling: EFD Engelhard, *Verzekeringsrecht Praktisch Belicht* (2008) 349–375.

12 See *Legemaate* (fn 2) 6.

13 See *Leenen/Dute/Kastelein* (fn 1) ch 2 and para 8.1.

14 *Ibid* para 1.3.

15 I Giesen, *Alternatieve regelgeving in privaatrechtelijke verhoudingen*, in: WJ Witteveen/I Giesen/JL de Wijkerslooth, *Alternatieve regelgeving* (2007) 84.

16 *Ibid* 106.

decisive pointer, that the practitioner has, according to his own professional standards, acted wrongfully, civil liability rules in effect make non-binding protocols 'binding'.¹⁷

8. Quality and/or risk management systems

- 18 Alongside these forms of self-regulation are national enactments that were briefly discussed above, the Quality of Health Care Institutions Act (*Kwaliteitswet zorginstellingen*), which we mentioned in no 1, is a framework law that imposes the obligation on health care institutions to deliver acceptable health care and, *inter alia*, the duty to systematically safeguard, control and improve its quality. The Act on medical services contracts (*Wet Geneeskundige Behandelingsovereenkomst*; WGBO), incorporated in the Civil Code, regulates the legal position of patients (see no 2). The aforementioned Individual Healthcare Professions Act (*Wet op de beroepen in de individuele gezondheidszorg*; Wet Big, at no 1 above) seeks to protect patients against unprofessional practices *inter alia* by means of registration. It also determines which professionals are qualified to practice certain treatments and which requirements must be met in order to use certain professional titles. Also the Wet Big extends disciplinary law to various health care professions.
- 19 The enforcement of all of the aforementioned rules is left to different sanctioning mechanisms that may be called upon by patients or others prior to or as an alternative to the rules on civil liability law. We have mentioned most of these above, viz: complaints commissions of care providers (*Klachtencommissies*), regional disciplinary boards (*Regionale tuchtcolleges*) and the Central disciplinary board (*Centraal tuchtcollege*), the Healthcare Inspectorate (*Inspectie voor de Gezondheidszorg*), which not only handles certain complaints but also promotes the quality of the health care system through working visits, and lastly the dispute settlement board of hospitals (*Geschillencommissie voor ziekenhuizen*). In addition to these sanctioning systems we note that medical liability insurers in their engagements with health care institutions and/or in the insurance contracts as well as patients' boards and quality and certification boards or committees of hospitals and alike may, to some degree, contribute to the quality of the health care system.

¹⁷ Ibid 107.

Civil liability law is also generally seen as a sanctioning system although this system has many drawbacks, such as the burden of proof in terms of fault, relativity and causation and its relatively long procedures and high transaction costs.¹⁸ But as in other European jurisdictions,¹⁹ Dutch lawyers, quite generally,²⁰ seem to agree that liability law aims at more than mere compensation: the threat of an action for damages, and the subsequent law suit, must give health care providers proper incentives to take the appropriate measures to prevent harm.

B. Tort Liability

9. Fundamentals of tort liability

Tort and contract liability rules for medical practice offer patients the right to compensation from the care-provider or its liability insurer in cases of negligence or the use of dangerous equipment (see no 62). In tort law, somewhat differently from contractual liability law (which is *inter alia* dealt with by art 7:453 CC, see below), there are no separate rules whatsoever for medical malpractice. For both, the standard of care and other requirements of liability law are given true meaning in case law. Tort liability can either be based on fault or on risk based (strict) liability. Fault liability (art 6:162 CC) requires wrongful behavior for which the defendant can be held accountable.

In the Dutch Civil Code, title 6.3 deals with tort law. The main provision is article 162 of Book 6 of the Civil Code (hereafter: art 6:162 CC). This is a very general clause and an open rule on tortious liability, which basically reads as follows (paragraph 1) in our own translation: 'A person who commits an unlawful act towards another which can be imputed to him, must rectify the damage which the other person suffers as a consequence thereof'. Note that an act could also be an omission to act. The conditions that need to be fulfilled are, first, that there should be '*een onrechtmatige daad*' (an unlawful act, in a strict sense, wrongfulness), and, second, that

18 EFD Engelhard/GE van Maanen, Aansprakelijkheid voor schade: contractueel en buitencontractueel (2008) 11.

19 See eg H Bocken/I Boone et al, Nieuwe wettelijke regelingen voor vergoeding van gezondheidsschade (2008) 83 f.

20 J Dute/MG Faure/H Koziol (eds), No-fault compensation in the health care sector (2004) 7; RMPP Cascão, Prevention and Compensation of Treatment Injury: A Roadmap for Reform (2005) 121; Giard (fn 10) 85 ff; WH van Boom, Compensatie voor geboorteschade – van aansprakelijkheid naar "no fault"? Aansprakelijkheid, Verzekering & Schade (AV&S) 1 (2006) 8–24, para 4.3.

this act should be accountable to the actor in question ('*toerekening*'). Next to that, damage and causation (*conditio sine qua non* link and legal causation, based on art 6:98 CC, which deals with the issue of remoteness) are required, and the so-called relativity question of art 6:163 CC needs to be resolved.

- 23 The first requirement, wrongfulness, is further elaborated on in art 6:162 para 2 CC: 'Except where there is a ground of justification, the following acts are deemed to be unlawful: the violation of a right, an act or omission violating a statutory duty or a rule of unwritten law pertaining to proper social conduct'. What this comes down to is that there are three categories of unlawful acts: breaching a (subjective) right, violating a statutory rule and violating a norm of good conduct. Each category can lose its unlawful character if there is a ground for justification. The third and last category is the most important one; this is what most case law is built upon and where the tort law system is expanded. This is where one asks whether there was a duty of care (*zorgplicht*) and whether this was breached (negligence). The determination usually depends on certain factors identified in the Dutch Supreme Court's judgment in the so-called Cellar Hatch (*Kelderluik*) case, ie foreseeability, the degree of blame, the likelihood of harm, the nature and seriousness of the harm).²¹ The yardstick (standard of care) as to whether or not the duty was upheld by the defendant is objective: what would a reasonable man in these circumstances have done? What kind of behaviour is appropriate?
- 24 The second condition concerns the accountability of the act to the actor. It deals with the culpability, the subjective element, of the actor but adds something thereto. Again, three possibilities exist: an unlawful act can be imputed to its author if it results from his fault or from a cause for which he is answerable according to the law or common opinion within society. Fault, *culpa*, is the most important of the three; this is the classic case in which one asks whether the actor was culpable, ie was to blame. *De facto* this condition is covered by the concept of '*zorgplicht*' (negligence) explained earlier, which means that the defendant generally has to rebut a presumption as to his blameworthiness once the wrongfulness is given. Unlawfulness is in theory a judgment of the act, and the question as to fault is to be determined by judging the actor, but both elements can be found in the negligence test. Under Dutch law, the actor can be held liable even if personal fault is not present, however. This is the case if he is answerable for the act anyway, because the law or common opinion state

21 Hoge Raad (HR) 5 November 1965, *Nederlandse Jurisprudentie* (NJ) 1966, 136.

so. For instance, handicapped persons may not be at fault with regard to active acts that cause damage to others, but nevertheless they are liable because the law says so (art 6:165(1) in conjunction with art 6:162 para 3 CC). Equally, based on common opinion, the state will be held accountable regardless of personal fault for wrongful administrative decisions made by its organs or state officials. Accountability (*toerekening*) is thus a wider concept than fault. Through this device of accountability, legal persons which could not otherwise be said to have been subjectively at fault can also be held liable for wrongful acts committed by them as such. It should be noted that this is not a form of strict liability in the usual sense as wrongful behaviour is still be required.²²

Once liability has been established, the medical practitioner or hospital may seek to limit the amount of compensation based on the defense of contributory negligence (*eigen schuld*) of the plaintiff. This means that not only fault but also risks for which the plaintiff can be held accountable may cause a reduction of damages. The defendant needs to raise this defense (art 6:101 CC). Contributory negligence also entails the plaintiff's duty to mitigate his losses. 25

In cases of medical negligence either art 6:162 CC as explained above or art 6:74 CC, in conjunction with art 7:453 CC (see below at nos 65–67), will be applied. 26

10. Burden of proof

In principle, the plaintiff will have the burden of proving that his health status had deteriorated (a loss), causation, and someone's fault. However, these rules are not without exception.²³ For claims based on fault liability the asserted wrong may in rare cases (partly) be characterised as the omission to achieve a given result (*obligation de résultat, resultaatsverbintenis*). Some examples are omissions in respect of laboratory research or the refusal to give patients access to their medical status.²⁴ If the poor result in such instances has been shown by the patient it is for the defendant to show that he or she cannot be held accountable for the omission. In general though, practitioners will be bound by the obligation to perform 27

22 Next to this general rule on tort law, there are several specific clauses on specific related topics (mostly cases of strict liability), see art 6:164–191 CC.

23 See also I Giesen, The Burden of Proof and other Procedural Devices in Tort Law, in: H Koziol/BC Steininger (eds), *European Tort Law 2008* (2009) 49 ff, especially no. 6 ff.

24 *Legemaate* (fn 2) 42.

to the best of their abilities (*obligation de moyens, inspanningsverbintenis*),²⁵ and it is then for the patient (the plaintiff) to prove fault as well as causation.

- 28 Another general exception is the use of presumptions (of fact). A presumption, be it in the form of '*res ipsa loquitur*', '*Anscheinsbeweis*' or otherwise, is in essence a mode of reasoning which leads to certain inferences being drawn, ie to the acceptance of certain facts or legal consequences from other proven facts.²⁶ To do so, use is made of rules of thumb and facts that are common knowledge. A presumption thus provides the judge with the opportunity to base the existence of a certain factual element on the presence of another fact which has been proven. So, in essence, the object of proof (the fact that needs to be proven) is changed.
- 29 It is important to note also that accepting such a presumption does not change the burden of proof. It only denotes that for the time being that burden has been discharged. It is then for the opposite side to come forward with evidence to rebut that provisional judgment. In order to do so, the presumption must be countered to such an extent that the judge remains in doubt again as to the existence of the fact in question; going further and actually providing proof to the contrary is not needed. So, in essence, only the 'evidential' burden of proof shifts when a presumption is accepted, but not the 'legal' burden.²⁷ As stated, a presumption does not alter the division of the burden of proof. It just makes it easier to come up with the proof needed because an additional way of 'gathering' evidence is used, alongside the usual modes of providing evidence. The function a presumption thus fulfils is that it might alleviate the evidential needs one may encounter (it is a *Beweiserleichterung*) and it provides for the possibility of using probabilities when deciding a case.²⁸
- 30 As regards the specific element of causation, the possibility of using an exception to the fundamental rule that the burden of proof rests on the plaintiff is an important way of dealing with uncertain causation, which will be dealt with below (at no 36 ff).
- 31 As regards fault, the burden of proof will remain on the plaintiff but the plaintiff is then helped out to some extent by the use of a devise known in the Netherlands as the '*gemotiveerde betwisting*' or '*aanvullende stelplicht*'.

25 See also Rb Alkmaar 11 February 2004, LJN AO3453, r ov 5.5.

26 Cf I. Giesen, *Bewijs en aansprakelijkheid* (2001) 65. See also on presumptions WDH Asser, *Bewijslastverdeling* (2004) 87 ff.

27 Giesen (fn 26) 65 f.

28 Ibid.

This is also known, in Germany, as the '*sekundäre Behauptungslast*', which could also be named (even though it is non-existent in English law) as 'the duty to provide an extra motivated pleading'. This instrument is part of the law of evidence and warrants our attention because of its relevance for tort cases and its potential to solve the evidential needs of (usually) plaintiffs. What we are dealing with here is the obligation of one litigant, usually the defendant, to not only deny the plaintiff's statement of claim and the facts asserted therein, but to go one step further and to underpin and motivate that denial by bringing in factual details and relevant sources. It comes down to this: according to case law, the defendant is charged with a duty to substantiate his defense or claim that he has not acted wrongfully. He has to do so by supplying information on all the factual aspects of the claim. What is thus needed is that the defendant takes an extra step when denying the asserted facts and supplies a certain degree of extra information (which is typically not available to the plaintiff).²⁹ Think of a doctor who is obliged to hand over the medical file, with his notes, to the patient claiming damages.

Since a breach of the medical standard of care is usually hard to prove for a patient, the courts tend to 'lower' the burden of proof a bit and give it a different content when duties of care are supposedly breached. By using this instrument the substantiation of a claim thus rests partly on the defendant. This is done however without reversing the (legal) burden of proof, which is of course important.³⁰ Only the (evidential) burden of producing (pieces of) evidence is shifted.³¹

Even if the defendant complies with this procedural duty to provide information, the plaintiff still needs to prove his or her claim, using the extra information provided by the defendant. If the defendant has not provided the information, the existence of the fact at stake is considered to have been established by law (on the basis of art 149 of the Civil Procedure Code (CPC) in the Netherlands).³² In Germany this legal notion, based on

²⁹ See *Giesen* (fn 23) no 21; *G Baumgärtel*, *Beweislastpraxis im Privatrecht* (1996) nos 307 ff, 347 ff, as well as the references below.

³⁰ See *D Magnus*, *Beweislast und Kausalität bei ärztlichen Behandlungsfehlern*, *Zeitschrift für Zivilprozeß* (ZVP) 120 (2007) 353.

³¹ On these two notions, see *Baumgärtel* (fn 29) nos 9, 14; *P Murphy*, *Murphy on evidence* (2007) 71 ff, *Giesen* (fn 23) no 12 ff.

³² Cf *Saenger*, *ZVP* 121 (2008) 145; *Giesen* (fn 23) nos 41 and 43–47, although the range of possible sanctions is, wrongly as far as we are concerned, considered to be somewhat wider in the Netherlands, see HR 15 December 2006, NJ 2007, 203 (*Noord-Nederlands Effektenkantoor/Mourik*).

the notion of *'Treu und Glauben'*, can be invoked if three conditions have been met. First, the party which carries the burden of invoking and stating facts to support its claim has no further knowledge concerning the determining facts because that party has been outside of the realm in which the facts in question occurred, while second, the opposing litigant knows or is supposed to know these facts, and, thirdly, the obligation can be attributed to that opposing party to introduce those facts into the dispute at hand.³³ In the Netherlands case law has not come up with a specific (similar) list of conditions to be met, but in essence the same principles seem to apply there as well.³⁴

- 34 This *'sekundäre Behauptungslast'* is meant and used as an instrument to alleviate the plaintiff's burden of proof in cases in which it is obvious that such burden cannot be met without some external assistance. The burden of proof is not shifted onto the defendant but lessened in the sense that one is given certain factual information that is needed to build one's claim and which was not available before. An important question is of course why someone would be obliged to help out his opponent this way. Basically, this duty is accepted because without the duty to supply information the burden of proof would become too burdensome. Since it would be an illusion to think that the plaintiff could provide the evidence needed without this duty bestowed on the opponent, the protection that substantive law aims to offer a party would become illusory as well.³⁵ It is thus the desire to safeguard the protection offered by substantive law that ignites this procedural protective measure.
- 35 In principle the use and applicability of the *'sekundäre Behauptungslast'* is not confined to certain cases, although its use has not yet become 'universal'. Of course the conditions that need to be met in order to be able to use the instrument do in fact shape the extent to which it can be invoked in practice. This duty has however already proven to be useful in liability cases, most notably, at least in the Netherlands, in cases of medical negli-

33 See, for example, BGH 18 May 1999, *Neue Juristische Wochenschrift* (NJW) 1999, 2887 ff; *Saenger*, ZfP 121 (2008) 144; *Magnus*, ZfP 120 (2007) 353; *Giesen* (fn 23) no 41. Cf also *Baumgärtel* (fn 29) 307.

34 *Giesen* (fn 23) no 42.

35 See the preliminary advise to the Supreme Court by Asser in the case of HR 10 January 1997, NJ 1999, 286 (*Notary W*) at no 2.9, and *Giesen* (fn 23) no 42.

gence and other forms of professional negligence.³⁶ The information deficit a patient usually encounters when suing a medical practitioner can be balanced by imposing on the doctor the duty to come forward with certain information at his disposal, thus leveling the 'playing field' between the parties to some extent.

11. Uncertain causation

As elsewhere, Dutch law requires the presence of causation to establish liability in tort. This is expressed in art 6:162 s 1 CC, by using the term '*dientengevolge*' (translation: as a consequence thereof) and reinforced by art 6:98 CC. 36

A first test as to the existence of causation concerns the *conditio sine qua non*:³⁷ would the damage have occurred if the act under consideration had not taken place? This requirement is the first (and in principal also a minimal) hurdle that needs to be tackled when dealing with causation.³⁸ An additional test, laid down in art 6:98 CC, then seeks to further delineate the scope of protection. Art 6:98 CC holds that these consequences must also be legally attributed to the defendant given the nature of the liability involved and the type of harm. 37

There is not a lot of case law in the Netherlands that deals explicitly with the question of whether a *conditio sine qua non* link is needed or required to establish liability because this is accepted in general as one of the cornerstones of liability law. It is as such simply not disputed.³⁹ Of course, many unlawful acts are in fact omissions to act, but in the Netherlands, it is generally accepted that such an omission can be the cause of the damage 38

36 *Giesen* (fn 23) no 39 ff. Especially in medical liability cases, this is standing case law since HR 20 November 1987, NJ 1988, 500 (*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 (*anesthesia*); HR 23 November 2001, NJ 2002, 386 (*Ingenhut*) and HR 15 December 2006, NJ 2007, 203 (*Noord-Nederlands Effectenkantoor/Mourik*). To be sure, in the Netherlands such cases are either rooted in contract law or in tort law, without this distinction being relevant for the duty of care.

37 In the Netherlands '*conditio*' is used instead of '*condicio*' (on the use of these terms, see *JH Nicuwenhuis*, Eurocausaliteit, Agenda voor het Europese debat over toerekening van schuld, *Tijdschrift voor Privaatrecht* (TPR) 4 (2002) 1698).

38 *RJB Boonekamp* in: AR Bloembergen (ed), *Schadevergoeding* (losbl) Art 98, note 9.

39 See *Boonekamp* (fn 38) Art 98, note 9.

and thus lead to liability.⁴⁰ There is not a lot of theoretical debate about the question of whether an omission can as such be a cause of anything because in practice both acts and omissions are treated alike.⁴¹

- 39 One way of dealing with uncertain factual causation is by the use of the 'gemotiveerde betwisting' as explained above. A second is the use of presumptions, as explained earlier. A third option is to accept a reversal of the burden of proof. This is particularly relevant where traffic rules or safety regulations or other protective measures have not been followed, for instance in cases of traffic accidents or work related accidents.⁴² Think also of cases of omissions to inform or warn someone else against the potential dangers of a certain act.⁴³ The question arises in such situations also whether the person who should have been given the information or should have been warned, would have acted differently if he had received the information or warning. Would he not have acted differently, the omission to warn that person did not cause the damage.
- 40 This is of course a difficult (factual) question to answer because it inquires about someone's state of mind in the past, which is something that cannot be easily proven. Ever since the famous 1996 judgment in the case of *Dicky Trading II*,⁴⁴ there have been cases in which the rule on the division of the burden of proof, given by the Supreme Court, is contrary to the general rule as laid down in art 150 CPC. This burden of proof does not rest on the claimant as usual, but on the defendant. Therefore, if the facts needed for constituting or denying the claim that causation is present or not, are not clarified (or actually proven), the defendant will lose.
- 41 The precise extent and ambit of this rule (now known as the reversal rule or 'omkeringsregel') are still not exactly settled but it has gained a lot of importance and has triggered a lot of litigation. The Supreme Court has limited the instances in which this burden of proof rule might be applicable. Nowadays, it needs to be made clear, before the rule can be applied,

40 See *A Wolfsbergen*, *Onrechtmatige daad* (1946) 19; *J van Schellen*, *Juridische causaliteit* (1972) 175; *CC van Dam*, *Aansprakelijkheid voor nalaten* (1995) 41; *Boonekamp* (fn 38) Art 98, note 11.

41 See however *Wolfsbergen* (fn 40) 19–21; *GHA Schut*, *Rechterlijke verantwoordelijkheid en wettelijke aansprakelijkheid* (1963) 73–75; *Van Schellen* (fn 40) 167–179.

42 See *Boonekamp* (fn 38) Art 98, note 11, for further case law.

43 There is a vast amount of literature on this, see eg: *I Giesen*, *Bewijslastverdeling bij beroepsaansprakelijkheid* (1999) 66 ff; *Giesen* (fn 26) 116 ff; *AJ Akkermans*, *De omkeringsregel bij het bewijs van causaal verband* (2002); *DT Boks*, *Notariële aansprakelijkheid* (2002) 211 ff.

44 HR 26 January 1996, NJ 1996, 607 (*Dicky Trading II*).

that a certain specific risk of damage was created or enlarged and that this specific risk has in fact materialised.⁴⁵

As for the application of the reversal rule in cases of medical negligence, special attention should be focused on two judgments of the Supreme Court dated 23 November 2001.⁴⁶ The two cases were handed down on the same day and both involved a doctor failing to inform the patient properly about the medical procedure to be undertaken and especially on the risks thereof. The doctor's negligence in not performing their duties was no longer an issue; the debate focused on whether the necessary causal connection was present. The claimants both alleged that the courts of first instance should have applied the reversal rule mentioned above (the 'omkeringsregel').

The Supreme Court, in two identical judgments, first stated the rule known in the Netherlands as the reversal rule. The court then continued: this case concerns a failure by a doctor in fulfilling his duty to inform his patient about the risks of the proposed medical treatment. This duty is meant to enable the patient to make a well-informed decision as to whether or not to agree with the proposed treatment. This duty is rooted in the protection that art 10 of the Constitution grants the right to privacy and that art 11 grants a persons' bodily integrity. It is enshrined in Book 7 of the Civil Code, in art 7:448 and art 7:450 CC. The duty to inform the patient about the risks of a treatment is thus not meant to protect against these risks as such, but is meant to enable the patient to decide well-informed whether or not to consent to the treatment and the risks. Not fulfilling this duty creates the risk of a patient not being able to use his right to self-determination as he wishes; the risk thus of making a choice which would not have been made if the patient had been well informed. The damaging facts in these cases then cannot be seen as a materialisation of the risk that was created by the defendant by not fulfilling his duty to inform. The reversal rule therefore cannot be applied.

With regard to the specific non-application of the reversal rule in these cases, one can say that the cases in this respect fit into the pattern laid down in the last years by the Supreme Court. This pattern is clearly

45 HR 29 November 2002, NJ 2004, 304 (*TFS/NS*) and HR 29 November 2002, NJ 2004, 305 (*Kastelijn/Achterkarspelen*) and on these important cases *GE van Maanen*, *Nederlands Tijdschrift voor Burgerlijk Recht (NTBR)* 2003, 111–116; *C Van Dijk*, *Tijdschrift voor Vergoeding Personenschade (TVP)* 2003, 7–15; *T Hartlief*, *Ars Aequi (AA)* 2003, 298–306; *GR Rutgers*, *AA* 2003, 307–313.

46 HR 23 November 2001, NJ 2002, 386 (*I/Stichting Gezondheidszorg*) and NJ 2002, 387, note *JBM Vranken* (N/P).

designed to limit the application of this rule and its consequences. The Courts' statement that the duty to inform is designed to prevent someone from deciding without the necessary information and that it is not meant to prevent the medical risks as such, has been criticised however.⁴⁷ It has been challenged in lower courts, for example in a case where the claimant had undergone an experimental treatment without being properly informed after which he claimed that the reversal rule should apply in experimental treatments because of their special associated risks (compared to regular treatments);⁴⁸ this argument failed.

- 45 In other medical cases not dealing with the failure to supply the judgment of the Dutch Supreme Court of 2 March 2001 is also important.⁴⁹ A patient, H, went into surgery to undergo an arthroscopy on his left knee. A part of the meniscus was removed. During a check up shortly after the surgery, the surgeon and another doctor diagnosed thrombosis in the left leg. Almost two years later, the same occurred in the patient's right leg. It was undisputed that the protocol of the hospital required the doctor to apply an anti-coagulation or anti-clot treatment after the kind of surgery that the patient had undergone. This treatment was in fact never administered. H then instituted a claim against the doctor and the hospital for damages.
- 46 The Supreme Court first concluded that the appellate courts' judgment on the non-fulfillment of the doctor's duty of care towards the patient (the hospital failed to provide him with an anti-clot treatment) was correct. The court then considered the defendant's claim that the necessary causal connection between not providing the anti-clot treatment and the thrombosis was missing and that the lower court has considered that the reversal-rule should be applied in this instance. This judgment was wrong according to the hospital because the court made the mistake of regarding the violated protocol as a safety rule (which if correct, would have warranted the application of the '*omkeringsregel*'). The Supreme Court upheld the judgment because the court of first instance had already ruled that the connection between the surgery and the thrombosis was likely enough – a judgment that was not contested later on in the proceedings. Given that state of affairs, applying the '*omkeringsregel*' was correct. The '*omkeringsregel*' has also been applied in other instances of failures during operations or treatment.⁵⁰

47 See the case note by *Vranken*, NJ 2002, 387, and *I Giesen* in: WR Kastelein (ed), *Medische aansprakelijkheid* (2003) 21–22, as well as 22–24 for additional critical remarks.

48 Hof Den Haag 19 December 2007, LJN BC1632, paras 12–13.

49 HR 2 March 2001, NJ 2001, 649, note *FCB van Wijmen* and *JBM Vranken* (MCL/H).

50 See eg Hof Den Bosch 10 March 2009, LJN BH5919 (*Spectjens/Jeroen Bosch Ziekenhuis*).

One point should be added to the discussion above. In 2006,⁵¹ proportionate liability (damages awarded in accordance with the degree of possibility or chance, in percentage terms, that the defendant had in fact caused the disease) has been introduced by the Supreme Court. In the case of *Karamus/Nefalit* an employee suffered from lung cancer after having worked with asbestos due to the fault of his employer, while at the same time having been a heavy smoker. The Supreme Court stated that it would be more just to accept proportionate liability in such a case. This new development in the case law⁵² might also be of influence in the future also in medical negligence cases, as an additional fourth mechanism to deal with uncertain causation, but there is still no certainty in that respect.⁵³ 47

In a small number of instances in lower court decisions this proportionality judgment of the Supreme Court has been invoked for other situations. In a medical negligence case it was employed in an attempt to solve the uncertainty as to the causal link between an experimental treatment and damage,⁵⁴ but with no result.⁵⁵ However, if all the above mentioned means of aid have failed and it still remains unclear which staff member of a hospital caused the loss, the so-called central liability of the hospital can be invoked. This will be dealt with more extensively below (see nos 61–62). 48

As was said above, once the *conditio sine qua non* link has been established, an additional ruling, art 6:98 CC, is used, to further delineate the amount of liability. This rule was used in the case *Hospital De Heel/Korver*, which was decided by the Supreme Court and involved a medical malpractice claim. In this case a man underwent jaw-surgery. In the hospital, he accidentally fell out of his bed, since safety-ropes were missing, and lost his eye. Though this was a highly improbable consequence of the negligent act of the hospital, the Supreme Court established liability, since safety instructions were neglected and physical harm was suffered.⁵⁶ 49

51 HR 31 March 2006, Rechtspraak van de Week (RvdW) 2006, 328 (*Karamus/Nefalit*).

52 See also I Giesen in: I Giesen/TFE Tjong Tjin Tai, Proportionele tendensen in het verbintenissenrecht, Preadvies VBR (2008) 57.

53 Articles 7:400–413 CC also apply, since these contain general rules on the service contract as such ('overeenkomst van opdracht'). See for an introduction to the WGBO: B Sluijters/MCIH Biesart, De geneeskundige behandelingsovereenkomst (2005).

54 Hof Den Haag 19 December 2007, LJN BC1632, para 17.

55 Also prior to the Supreme Court's judgement of 31 March 2006, the proportional liability as a way to circumvent causality problems was tried in vain for medical liability cases, see eg Hof Leeuwarden 22 February 2006, LJN AV2474, para 4.1 (concerning the first court's judgment) and Hof Den Haag 26 March 2003, LJN AF6263 (*Baby Kelly*) paras 13 and 15, where the defendants invoked proportionality to be only partially liable (here too in vain).

56 HR 13 January 1995, NJ 1997, 175 (*De Heel/Korver*); third parties who exercise subrogated or recourse rights also benefit from his judgment, see *Engelhard* (fn 5) 273 f.

Based on this (the nature of the harm and the kind of liability), the causal link was extended to cover even an unlikely course of events. There is a long-standing line of decisions in which this extensive interpretation of causation under the scope of art 6:98 CC has been applied with regard to other facts. The defendant's liability is also not limited by the fact that the individual patient may have responded more severely than other persons would have due to pre-existing vulnerabilities or other predispositions.⁵⁷

12. Loss of a chance

- 50 There have been cases where recovery has been allowed despite the fact that the patient had not suffered actual damage (yet), but had lost his chance to recovery. A first important step in the gradual acceptance in the Netherlands of the loss of a chance doctrine, at least in some parts of liability law, was the judgment of the District Court of Amsterdam of 15 December 1993, and the following judgment, on appeal, of the Amsterdam Court of Appeal dated 4 January 1996.⁵⁸
- 51 The plaintiff's one-month-old daughter Ruth was referred to the hospital by the family physician after several small spontaneous bleedings were discovered. The doctor consulted there, defendant De Kraker, examined her but did not find conclusive signs of a brain hemorrhage, as was feared. He decided that Ruth could go home and should come back the next morning for an extensive examination. The same evening, around 20:00, the claimant went back to the hospital again. The doctor on duty concluded there was no need for further examinations at that point in time. The next morning Ruth was examined again. A large brain hemorrhage on the left side was discovered; Ruth was placed on the intensive care ward immediately and underwent brain surgery that same day. Ruth parents' started a civil procedure claiming medical faults were made (they claimed that a more extensive examination should have been undertaken immediately; Ruth should not have been sent home) and these faults caused or at least contributed to the disabilities that Ruth subsequently suffered from. The doctors claimed that Ruth's late admission into the hospital did not cause the damage. Since the bleeding had already been going on for some time,

57 See inter alia HR 9 June 1972, NJ 1972, 360 (*neurotic depression*); HR 21 March 1975, NJ 1975, 372 (*coronary thrombosis*); HR 8 February 1985, NJ 1986, 137 (*Henderson/Gibbs*); HR 4 November 1988, NJ 1989, 751 (*ABP/Van Stuyvenberg*).

58 Hof Amsterdam 4 January 1996, NJ 1997, 213 (*Wever/De Kraker*).

there would have been residual damage in any case, even if there had been an early diagnosis. Experts had concluded this as well.

The District Court concluded that not admitting Ruth when she visited the hospital the second time, at 20:00 in the evening, was a medical error. With regard to the question of whether this fault led to more residual damage for Ruth than would have occurred if she had been admitted sooner, the court concluded the following, based on the report by the medical experts: the fault had led to the loss of a chance for Ruth at a better end result, given adequate medical treatment. That this chance was nil or negligibly small was not decided by the experts, nor raised by defendants. The court did not however agree with the plaintiff's claim that the chance of complete recovery was lost as well. Considering the above, the court found that the damage, being the lost chance of reaching a better result of treatment, was 25 %. For this percentage, the defendants are liable for Ruth's damage. The Court of Appeal had to consider, *inter alia*, objections raised against the decision by the District Court that the chance of complete recovery had not been lost. It decided that although the chance of a complete recovery could not be excluded with 100 % certainty, the chance was extremely large that even with an early diagnosis residual damage would have remained. It also ruled that the District Court was right in holding that the percentage of damage due to the late admittance into the hospital had to be put at 25 %.

The importance of the case sketched above is simple: this was basically the first case, at least in modern times,⁵⁹ in which a Dutch court used the loss of a chance theory to decide a case in which the *conditio sine qua non* link was doubtful.⁶⁰ It involved an issue of medical negligence. Later on, the approach as such was approved by the Dutch Supreme Court in a case against a lawyer (see below). Ever since, the lower courts have increasingly used the loss of a chance approach to decide cases and several of those have been published.⁶¹ One can thus safely say that the loss of a chance approach has been accepted in the Netherlands.

⁵⁹ See however Rb Utrecht, 28 October 1942, NJ 1943, 231, where the chance of winning in court was set at fifty percent.

⁶⁰ See on that theory in general AJ Akkermans, *Proportionele aansprakelijkheid bij onzeker causaal verband* (1997) 107 ff; AJ Akkermans (ed), *Proportionele aansprakelijkheid* (2000), and Nieuwenhuis, TPR 4 (2002) 1710–1717.

⁶¹ See eg Hof Arnhem 14 December 1999 and Rb Den Haag 12 July 2000, TVP 4 (2000) 94 ff (note Giesen) and the cases mentioned by C Van Dijk in C van Dijk, *Toepassing van de theorie van verlies van een kans bij medische aansprakelijkheid*, in: Kastelein (fn 47) 27 ff.

- 54 This does not mean however, that the loss of a chance theory has become predominant or the only approach that might be taken. For instance, the reversal of the burden of proof is also still used. Several approaches are thus at hand to decide a case.⁶² Sometimes these two approaches are even combined, or at least, it is suggested that a combination of the two might work.⁶³
- 55 Another important step was the Dutch Supreme Court's decision of 24 October 1997,⁶⁴ which dealt with the professional liability of a lawyer. A former employee, Baijings, of the Sara Lee/DE company claimed damages for not having been able to cash in on a set of stock options after the termination of his employment contract. Through a fault made by his attorney, his appeal against the negative verdict was never filed. Baijings thus claimed damages from his (by then former) attorney. The main issue in the second case was whether an appeal in the previous proceedings could and would have been successful if the appeal had been filed on time.
- 56 The Court of Appeal decided that given the rules of Dutch labour law the claim of Baijings against Sara Lee/DE would not have succeeded. The claim against the attorney was therefore also dismissed. The Supreme Court first dealt rather extensively with the labour law aspects of the original case and overruled the decision of the Appellate court in this respect. The Court continued as follows: the question in this case is whether, and to what extent, the client of the attorney has suffered damage as a consequence of his failure to file an appeal against the verdict in first instance. To find the answer to this question the court needs to determine how the Court of Appeal would have decided the original case, or alternatively, to estimate the amount of recoverable damage on the basis of the good and bad chances that the party would have had on appeal. In order to enable the judge to do so, it is desirable that the plaintiff and the defendant (the former attorney) provide the judge with all the information that would have been brought to the attention of the judge had the appeal been filed. The client, Baijings, should be given the opportunity to be as well-equipped as he would have been in the appeal. The attorney should have the freedom to take the position that the party who had won the original case in first instance would have taken.
- 57 In cases dealing with damage resulting from the fact that the appeal, contrary to what was intended, had not been filed or had been filed too

62 On the cumulative use of several techniques in this respect, see *Giesen* (fn 43).

63 *Akkermans* (fn 60) (1997) 393 ff; *Giesen* (fn 43) 72 ff and 122 ff and *Giesen* (fn 26) 474 f.

64 HR 24 October 1997, NJ 1998, 257 (*Baijings/mr H*).

late, the relevant *conditio sine qua non* question is whether the original proceedings would have led to success in appeal. If that is not the case, the plaintiff has suffered no damage by the negligent act. The plaintiff's claim should then be struck down. Determining what would have been the outcome of an appeal if it had been filed properly is of course difficult, if only because one of the parties that would have been present at that appeal, the original defendant, is no longer present. Furthermore, a ruling on what someone else 'would have done if', is always difficult.

The Dutch Supreme Court allows the courts to use either one of two 58 methods in determining this issue. Courts can decide what would have been decided in the original case and determine the damages based on that outcome (leading to an 'all or nothing' result), or they can determine by an estimate the chances of success in appeal and base the amount of damages on that estimate. In essence, the Supreme Court decides here that a court is allowed to use the theory of the loss of a chance (the chance lost here is of course the chance at a better result on appeal), leading to a percentage of the claim being awarded. Courts are not obliged to use this method, but they may do so as an alternative to the more classic approach of deciding what (another) court would have decided in the original case (a trial within a trial).⁶⁵ In general, the loss of a chance approach is seen as a subsidiary option.⁶⁶ By now, this is standing case law.⁶⁷

The dogmatic features of this theory and its place within the system of 59 Dutch liability law are not entirely clear yet. The wording by the Supreme Court suggests that this loss of a chance doctrine can be based on art 6:97 CC in conjunction with art 6:105 CC. The former article basically states that if the amount of damage cannot be determined precisely, it will be estimated. This estimate could then of course be the percentage of chance that the claim would have had on appeal. The second article states that the determination of future loss can be postponed or undertaken immediately, after weighing the good and the bad chances.⁶⁸ In the literature the search is not so much focused on finding a suitable place within the system for this loss of a chance theory but more on fitting in the concept of 'proportional liability' in general. In essence, this theory of the loss of a

65 See also the preliminary advice ('*Conclusie*') of the Advocate-General before the decision of the Dutch Supreme Court, under no 3.3 ff, who also deals with the pros and cons of both methods.

66 See *Akkermans* (fn 60) (2000) 108; *C Van Dijk*, *Onzeker causaal verband in de rechtspraak*, in: *Akkermans* (fn 60) (2000) 39.

67 See HR 19 January 2007, NJ 2007, 63 (*Kranendonk Holding BV en De Vries/A*).

68 See *T Hartlief*, *Proportionele aansprakelijkheid: een introductie*, in: *Akkermans* (fn 60) (2000) 15.

chance is then seen as a way of 'implementing' proportional liability,⁶⁹ for which the case of *Karamus/Nefalit* is another example, see no 47.

- 60 Since this approach has been approved by the Supreme Court more and more lower courts have used the loss of a chance approach to decide cases (of professional liability) and several of those have been published.⁷⁰ One can thus safely say that the loss of a chance approach has been accepted in the Netherlands. This does not mean however, that the loss of a chance theory has become predominant or the only approach that might be taken, as was demonstrated earlier.

13. Multiple persons involved

- 61 Due to the so-called central liability approach, if the patient received treatment based on a specific 'contract of medical treatment' as laid down in the arts 7:446–468 CC (see no 65), he can not only sue his professional caregiver in person, but also the hospital (or institution).⁷¹ The relevant ruling is art 7:462 para 1 CC, which states that when a medical services contract is executed in a hospital and the hospital is not a party to this contract, it is nonetheless to the same extent liable in case of non-performance. In addition to this central liability approach the treatment provider remains liable too, jointly and severally (cf art 6:102 CC). Central liability in this context thus 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'.⁷² The idea behind this is not to create liability in a larger number of cases, but to identify the defendant to enable the patient to claim damages.⁷³ As many professional caregivers may not be under a contract of services and/or organisations may be complex, the patient

69 See *Akkermans* (fn 60) (1997) 431 ff and 444–446 on this specific aspect, and *Hartlief* (fn 68) 16–18.

70 See for example Hof Arnhem 14 December 1999 and Rb Den Haag 12 July 2000, TVP 4 (2000) 94 ff (note *Giesen*) and the cases mentioned by *Van Dijk* (fn 61) 27 ff. See also *Akkermans* (fn 43) 102 ff.

71 Ie all hospitals, nursing homes or mental institutions that are acknowledged by the so-called Act on the admission of health care institutions (*Wet toelating zorginstellingen*).

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

73 See the Parliamentary Reports of the Second Chamber of Parliament (TK) 1989/1990, no 21 561, no 3 (Explanatory Memorandum) 23; *CJJM Stolker, WGBO en aansprakelijkheid*, in: *De WGBO: van tekst naar toepassing* (1995) 114.

must be relieved of the burden of finding out who can be held accountable. Miscommunication between persons working at the hospital should thus not result in a situation where the patient has to find out who did something wrong. Also, it is no longer relevant on what legal basis a treatment provider was active at the hospital.

To clarify, central liability refers only 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. But if the patient's doctor violates these rights, the hospital can be held liable for the consequences. If the claimant chooses to address the hospital, the latter will then in some cases have recourse against the physician. **62**

14. Strict liability

Health care institutions can be held liable regardless of fault for the malpractices of their own staff (ie persons they give orders to, such as their doctors and operation room staff; see art 6:170 CC) and independent contractors to whom they assign tasks in the course of the hospital's performance (eg doctors who have their own practice but who work on an independent basis for the hospital or an external lab that analyses blood samples of the hospital's patients, art 6:171 CC).⁷⁴ As for the independent contractors, there needs to be a functional link between the independent contractor's malpractice and the assigned tasks (analysing the blood sample). Also Dutch law has a ground for strict liability for anyone who can be regarded as the keeper of movable objects such as needles, catheters etc, that cause damage, provided that the object was defective. The hospital can then only free itself from liability if, in the hypothetical scenario where the hospital would have had control over the defective object, there would not have been fault liability on the part of the hospital (art 6:173 CC). **63**

Contract law has comparable but slightly less rigid grounds for strict liability. Art 6:76 CC states that if the debtor to an obligation (which may include health care providers that act upon medical services contracts) uses other persons in order to fulfil his obligation, he shall be liable for their acts or omissions in a similar manner as for his own behaviour. It is not clear how far the scope of this article reaches in the medical sphere: does it **64**

⁷⁴ Provided the hospital can be regarded as an enterprise (*bedrijf*), see art 6:171 CC and in the affirmative *RD Lubach*, *Aansprakelijkheid voor zelfstandige hulppersonen* (2005) 310 (and 363).

mean that the physician can be held liable for the faulty analysis of a pathologist?⁷⁵ Art 6:77 CC holds parties to a contract (which may include medical services contracts) liable for damage caused by objects that they use to perform their actions but that are unfit 'unless this is thought to be unreasonable, given the content and purpose of the legal act in question, societal views and other circumstances.' Examples of situations where such an 'unreasonable' result can be assumed are if the defectiveness is extremely rare and/or could not even have been traced by professional experts.⁷⁶ The legislation does not hold the physician (or other contracting parties) liable in cases where the producer of the defective material was liable but that view is generally rejected: the patient may sue each party and they may in turn then have recourse against the other liable person or entity.⁷⁷ At no 65 below, we will discuss whether liability based on each of both contractual grounds may be exonerated.

C. Contractual Liability

15. Basics of contracts in the health care sector

- 65 Next to the general rules of contract law in Book 6 of the Dutch Civil Code which include the general rule for liability based on a breach of contract (art 6:74 CC), there are special rules laid down in Book 7 CC, which deals with several specific contracts such as Sales, Rent, Employment, Insurance *et cetera*. The specific 'contract of medical treatment' (*geneeskundige behandelingsovereenkomst*) is dealt with by articles 7:446–468 CC and is based on the 'Wet op de geneeskundige behandelingsovereenkomst' (WGBO), which is a separate law, in force since 1 April 1995, that has been incorporated in Book 7 CC. The liability of health care providers that conclude such contracts with their patients (as well as the consequential central liability of the hospital, see no 61) may not be contractually limited or excluded (art 7:463 CC). This ruling is based on the unequal position between professional practitioners compared to their patients and the high value of the interests that are involved with their practices such as life and health. Other health care providers however, who fall outside the scope of the aforementioned

75 In the affirmative: EH Hondius, *Medical Liability in Dutch Law*, in: EH Hondius (ed), *Modern Trends in Tort Law, Dutch and Japanese Law Compared* (1999) 9 (though with mention of many contrasting views).

76 *Parlementaire Geschiedenis van het Nieuwe Burgerlijk Wetboek*, Boek 6 (1981) 273 (MvA II).

77 Hondius (fn 75) 9 and *idem* in: Leenen/Dute/Kastelein (fn 1) (2008) 168.

articles of the Civil Code, such as physiotherapists and speech therapists, may still exonerate their (risk of) liability.⁷⁸

The basis of the 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 concretised in several patients' rights. Usually four rights are distinguished: the right to information (art 7:448 CC), the requirement of consent for every/any medical treatment (art 7:450 CC; together they form the requirement of 'informed consent'), the right to inspect the medical records (art 7:454 and art 7:456 CC) and the protection of 'privacy' (arts 7:457–459 CC). There is also a provision dealing with the duty of care that practitioners have to live up to: art 7:453 CC determines that practitioners can be expected to act as 'competent and reasonable' caretakers would have acted when performing the medical services contract.⁷⁹ 66

This standard of care is similar to the standard of care under tort liability (art 6:162 CC).⁸⁰ What the open norm of art 7:453 CC entails in practice will depend on the circumstances of the case as they were at the time (and given the state of the art) that the medical treatment took place, similar to the negligence test that we discussed above. If a (written or judge-made) safety rule has been violated, the standard of care with regard to the liability test will generally be higher: more care is expected.⁸¹ But the mere fact that 'competence and reasonable behaviour' of the practitioner are expected, also indicates that a lack of experience should generally, in terms of legal attribution, not be to the patient's detriment. Lastly, we reiterate that in these cases there may also be central liability of the hospital, see above no 61 f. 67

16. Differences to tort law

Whether a claim is founded on contract law or tort law is hardly of any consequence under Dutch law. As was seen above (no 67), the standard of care remains the same ('competent and reasonable caretaker'), the burden of proof is also the same. The only difference is that the accountability of 68

78 *Sluijters/Biesart* (fn 53) 136.

79 Cf likewise HR 9 November 1990, NJ 1991, 26.

80 *Legemaate* (fn 2) 43.

81 HR 13 January 1995, NJ 1997, 175.

an act is presumed present in a contract case (art 6:75 CC: unless...) and not in a tort case. In practice however, also in tort cases the accountability is presumed.

17. Contractual claims in the absence of direct contracts?

- 69 The question as to whether contractual claims can be possible when there is no direct contract is left to the general rules of contract law under Dutch law: it is a matter of interpretation of the contract. This is confirmed by the Supreme Court in its so-called *Baby Joost* judgment, which deals with a claim for damages of parents for their emotional distress caused by medical malpractice in the treatment of their minor son.⁸² In their appeal before the Supreme Court, the parents argued that the Court of Appeal had no right in holding that the parents were not a contracting party alongside the child in respect of the contract for medical treatment. The Supreme Court however upheld the Court of Appeal's decision in this respect. According to the Supreme Court the Appellate Court had not gone so far as to conclude from the mere fact that the parents had not asked the doctor for any particular performance owed directly to themselves, that the parents were 'thus' just acting as legal representatives. By this the Supreme Court seems to indicate that the mere fact that the contract did not contain any duty directly owed to the parents is not necessarily conclusive; the court must in its assessment of the parties' intentions also look at any statements made and other relevant circumstances to the case. Here however, nothing else was said or done with regard to the parent's capacity in this respect. Therefore, it was fair for the doctor to assume that the parents were only acting as legal representatives. The fact that the parents had a substantive, personal interest in the medical treatment of their son is not sufficient reason to assume that they intended to enter the contract themselves, as contracting parties. This judgment has been rejected in the literature for its highly technical character: parents who are discussing the medical treatment of their son, will generally not be aware of the exact statements that they need to put forward in order to safeguard their own, personal legal position in case there is later malpractice.⁸³ Also the fact that the Supreme Court did not hold the (high) moral

82 HR 8 September 2000, NJ 2000, 734.

83 *CC van Dam*, *De ouders van Joost*, *Verkeersrecht (VR) 2001*, 1-7 and also *Aansprakelijkheidsrecht* http://www.aansprakelijkheidsrecht.com/oudersvanjoost.htm_ftnref1 (with further references).

and material interests of the parents to be sufficient reason to justify them as direct parties to the contract, has been highly criticised.⁸⁴

18. Informed consent

Prior to any medical service based on their contract, the health care provider needs the patient's consent (art 7:450 CC), which must be so-called informed consent. Art 7:448 CC imposes the contractual obligation on health care providers to inform their patients in a clear and reasonable manner, written if requested, about (proposed) medical examinations, the proposed treatment and developments concerning the medical tests, the treatment itself and the patient's health and condition.⁸⁵ The WGBO imposes the obligation on the practitioner to inform his patient in a clear way ('*op duidelijke wijze*'), if requested in writing, about the intended tests and the intended treatment (art 7:448 para 1 CC). In doing so, the practitioner needs to communicate to the patient all that the latter 'reasonably' needs to know with respect to the nature and the purpose of the medical exams or treatment and the medical operations ('*verrichtingen*') that in the practitioner's view need to be undertaken as well as the expected consequences and risks thereof and the alternative methods of examination or treatment that may be used (art 7:448 para 2 CC). Clearly not all the possible risks need mentioning, but the common, foreseeable risks must be explained to the patient. Generally more information needs to be given if the surgery is less urgent.⁸⁶ The fact that 'clarity' is required is generally understood to mean that the information must be sufficiently understandable for the patient. This right does not extend to the patient's relatives. The right to information is of particular relevance to the requirement of the patient's permission, which is dealt with by art 7:450 of the WGBO (in order to give his permission, the patient needs to be sufficiently informed), but the information duty also covers information that is not needed to give permission but that the patient should nevertheless have, such as information concerning possible side-effects of the prescribed medication etc. However, if the information may seriously harm the patient (ie it may have risks in terms of psychological crisis or suicide attempts or similar such effects), it can be withheld from him and, if it is in the patient's best interest, be given to someone other than the patient (art 7:448 para 3 CC). The patient also

84 *Van Dam*, (fn 83) para 3.

85 *J Legemaate*, *Patiëntveiligheid en patiëntenrechten* (2006).

86 *Sluijters/Biesart* (fn 53) 24.

carries an information duty. He needs 'to the best of his knowledge' to inform the practitioner and cooperate with him in as far as is reasonably needed for his treatment (art 7:452 CC).

D. Public Liability

19. Key differences from cases involving private hospitals or doctors

- 71 As both private and public hospitals risk liability on the same grounds, the private-public dichotomy makes hardly any difference in principle. On more specific aspects there may be differences however, such as the fact that art 6:171 of the Dutch Civil Code imposes strict liability for the acts of independent contracts on 'enterprises' but, as was seen above, this term is not interpreted too strictly (and even seems to cover public hospitals).

E. Alternative Compensation Regimes

20. Funds and/or other alternative compensation regimes

- 72 Currently there are no particular funds or alternative compensation schemes for victims of medical malpractices in general. For victims of medical experiments there are special legislative arrangements that require insurance coverage. The so-called Act on medico-scientific research involving humans (*Wet medisch-wetenschappelijk onderzoek met mensen*) determines that such research can only take place if the risk of (liability for the) injury or death of the experimental subjects (the persons whom are used for testing) is covered by insurance. Additional mandatory rules for this insurance coverage are laid down in a special Ministerial Decree of 23 June 2003 (*Besluit verplichte verzekering bij medisch-wetenschappelijk onderzoek met mensen*), which has set the insured sum in principle at € 450,000 per testing person and at € 3,5 million per research, which is further specified in the sense that it gives caps (maximum awards) for the various heads of damage per person, such as income loss (max € 60,000 per year), household costs (max hourly rate of € 7.5), etc. The institution and its staff that conduct the research cannot exonerate their liability risk for the aforementioned damage.⁸⁷

⁸⁷ Art 7 (secs 1, 6 and 8) of the Act. See on this *Ter Heerdt* (fn 8) 343 ff and for Dutch law *EFD Engelhard*, *Schade door medische experimenten*, AV&S (2004), 89–97.

F. Extent of Liability/Remedies

I. Pecuniary Loss

21. Introduction to indemnifying pecuniary loss

Under general tort law, and contract law for that matter, the rules on 73 compensation for damage⁸⁸ are laid down in art 6:95-110 of the Civil Code (CC). These same rules apply to cases of medical negligence as well. Damage that should be compensated (whenever it has been determined according to tort law that there is a right to damages) includes physical and economic loss (loss suffered as well as profits not gained), and other disadvantages, such as immaterial losses.⁸⁹ In principle, all losses suffered should be fully reimbursed, irrespective of the type of injury that occurred. There are thus no specific rules limiting compensation according to the type of injury in certain types of tort cases. This means that not only physical harm (personal injury) and damage to property is recoverable under Dutch law, but also pure economic loss.⁹⁰

All kinds of damages that are recognised under Dutch law are thus 74 theoretically available in any sort of case. A more general limitation is that damages for non-pecuniary loss are only recoverable if the law explicitly so specifies (see art 6:95 CC) as stated in rather general terms in art 6:106 CC. This does however exclude punitive damages since Dutch law does not (yet) recognise this form of damages.⁹¹

Under the Dutch law on damages the principle of full reparation applies 75 (although it has not as such been codified), albeit that contributory negligence (*eigen schuld*) may reduce the amount of compensation (and in

88 See also *I Giesen/MBM Loos*, Liability for Defective Products and Services; The Netherlands, in: EH Hondius/C Joustra (eds), Netherlands Reports to the Sixteenth International Congress of Comparative Law (2002), and in general on that part of the Dutch Civil Code: *SD Lindenbergh*, *Schadevergoeding: algemeen*, vol 1 (2008).

89 See arts 6:95, 96 and 106 CC.

90 Since arts 6:95-110 CC apply to both contractual and tortious claims in similar ways, the same would apply if a claim were to be based on contract law. See on pure economic loss in general *WH van Boom et al* (eds), *Pure Economic Loss* (2004). It is believed, however, that the compensation of loss due to personal injury will be granted more readily than loss due to property damage, see *J Spier*, *De uitdijende reikwijdte van de aansprakelijkheid uit onrechtmatige daad* (1996) 242 f.

91 Although the question whether punitive damages should be accepted under Dutch law is discussed in doctrinal works, the general view has so far been that this should not be the case, although the balance seems to be shifting to some extent. See eg *L Dommering-Van Rongen*, *Productaansprakelijkheid, Een rechtsvergelijkend overzicht* (2000), and *AJ Verheij*, *Onrechtmatige daad* (2005) nos 57 and 58.

serious cases of contributory negligence, eg intentional behaviour, the victim may even lose his/her claim). This principle deserves further attention because of its importance. An important aim of liability law in general is that of doing justice to the individual. In the law of damages this is reflected in the principle that the defendant should compensate the total amount of the loss that was suffered by the individual victim. The plaintiff should be made 'whole'. We will refer to this principle as 'the principle of full (individual total) reparation' (*restitutio in integrum*).⁹²

- 76 However, also important is that many individuals entitled to full reparation of their damage in theory, may have difficulties in obtaining it in practice. The costs of taking legal action may be high. A major problem for most plaintiffs is the stronger negotiation position of liability insurers in situations of factual or legal uncertainty, which results from their ability to spread the risks of the trial over thousands of cases. Furthermore, the principle of individual total reparation is not without exceptions. Calculating damages in an abstract manner, as the Dutch call it, using general measures of damages instead of individual assessments, is not an uncommon phenomenon in the law of damages. This kind of damages calculation is already a deviation from the principle of full reparation, at least in those instances where the victim cannot choose between individual damages assessment and relying on the general, abstract approach prescribed.⁹³ A second exception to the principle lies in the authority given to the judge to mitigate damages. Art 6:109 CC allows the court to mitigate the damages if it decides that awarding the full amount of compensation would be 'unacceptable' given the circumstances of the case, such as 'the nature of the liability, the legal relation between the parties and the financial strength of each of both parties' (art 6:109 para 1 CC), be it no less than the maximum sum for which the defendant has liability insurance coverage (para 2; cf no 13 and no 81). Some authors claim that individual practitioners and health care organisations will have better chances to see the amount of their liability mitigated than commercial businesses such as pharmaceutical companies.⁹⁴
- 77 The plaintiff may seek damages, ie compensation – either in the form of natural restitution (*herstel in natura*), which aims to restore the status quo ante, or in the form of monetary reimbursement, which provides for an equivalent. As stated monetary compensation covers losses (*damnum emer-*

92 See eg *Lindenbergh* (fn 88) nos 10–12; *J Spier/T Hartlief*, *Verbintenissen uit de wet en Schadevergoeding* (2006) no 196.

93 On this, see *Spier/Hartlief* (fn 92) nos 207–208; *Lindenbergh* (fn 88) no 36 ff.

94 *Legemaate* (fn 2) 59.

gens), as well as lost profits and other lost gains (*gederfde winst*). Based on art 6:97 CC the court must calculate damages in the way that is best suited to the nature of the harm and if the amount of damage cannot be calculated in exact numbers, it must be estimated.

22. Loss of earnings vs loss of earning capacity

Both the loss of earnings and the loss of earning capacity are to be 78 compensated under the principle of full reparation explained above. If needed the measure of damages can be assessed by making an estimate (art 6:97 CC).

As regards the loss of non-declared income, this will of course not be fully 79 compensated if the violated interest for which compensation is awarded is (partly) illegal. For the situation in which the income gained from legal activities was not declared, the Supreme Court has ruled that the loss of income can then be awarded but with a deduction of the amount of taxes and social insurance premiums (and similar payments) that would have been deducted if the income had been declared to the tax inspector. Based on decisions by the Supervisory Board of insurers (*Raad van Toezicht van de schadeverzekeringsmaatschappijen*), insurance companies may not report income for which compensation was claimed to the tax authorities. Illegally-earned wages are therefore not to be compensated it seems; the lost earnings can still be recovered however, but only up to the amount that would in fact have been received if the necessary taxes would have been paid.⁹⁵

23. Periodic payments or lump sum?

Based on the Dutch law of damages the claimant has the choice to opt for 80 compensation in the form of periodical payments or to ask for a lump sum. In practice claimants prefer a lump-sum payment.

24. Caps and thresholds

With regard to the amount of damages that may be claimed, things such as 81 generally applied caps or limitations do not as yet exist in the Nether-

95 HR 24 November 2000, NJ 2001, 195 (M/G).

lands.⁹⁶ Art 6:110 CC does recognise the possibility of imposing, by means of a Royal Decree, a limit on the amount of damages that can be recovered, but that possibility has only been used once so far, recently in a case dealing with (a limit on) liability for security companies working at airports.⁹⁷ One should realise, however, that the court does have the discretionary power to limit an award in a specific case on the basis of equity and reasonableness (see art 6:109 CC) if it feels that granting the full amount of damages that would normally be recoverable would lead to unacceptable consequences, given the nature of the liability, the legal relationship between the parties, and their mutual financial capacities. The court can only lower the award to the level at which insurance is or should have been available.⁹⁸ The Dutch Supreme Court has warned the lower courts to be very cautious when using this power,⁹⁹ and it has thus not (yet) gained much popularity.

II. Non-pecuniary Loss

25. Introduction to indemnifying non-pecuniary loss

82 The application of the principle of total individual reparation is difficult in the area of damages for pain and suffering (art 6:106 CC). In general, and also for medical negligence cases, art 6:106 CC provides that if a victim has sustained physical harm he is also entitled to be compensated for non-pecuniary loss (damages for pain and suffering; *smartengeld*).¹⁰⁰ The amount thereof is to be established by the (lower) courts on the basis of equity.¹⁰¹ In determining what amount is to be awarded, all circumstances need to be taken into account.¹⁰² In a case decided in 1992, the Dutch Supreme Court stated that the following are especially relevant

96 Leaving aside the *de minimis* of € 500 in product liability cases based on the European Directive for damage to property used in a private setting. See art 6:190 CC.

97 See *Staatsblad van het Koninkrijk der Nederlanden* (Stb) 2004, 358.

98 See *Dommering-Van Rongen* (fn 91) 146.

99 HR 28 May 1999, NJ 1999, 510 (G/H).

100 For the compensation of other forms of non-pecuniary damages, see *Lindenbergh* (fn 88) 17 ff.

101 The Supreme Court does not touch upon the amount of compensation that is awarded for non-pecuniary losses by the lower courts, see HR 8 July 1992, NJ 1992, 770 (AMC/O) and HR 17 November 2000, NJ 2001, 215 (*Druijff/BCE Bouw*).

102 Cf HR 17 November 2000, NJ 2001, 215 (*Druijff/BCE Bouw*). See also *Lindenbergh* (fn 88) 65 ff.

here: on the one hand, the nature of the liability,¹⁰³ and on the other hand, the nature, duration and intensity of the pain, suffering and loss of amenity sustained by the victim which arose following the act on which the liability is based.¹⁰⁴ Courts must further take note of the amount awarded by other courts in comparable cases, including the highest amounts awarded, taking into account the inflation rate since these cases were decided. Courts may also take into account developments regarding the amounts of compensation in other countries, although such a development may not be decisive for determining the amounts to be awarded in the Netherlands.¹⁰⁵

In practice, courts, lawyers, and insurance companies use the so-called *Smartengeldbundel*¹⁰⁶ as their point of reference. This *Smartengeldbundel* is published every three years and contains a listing of amounts of compensation for non-pecuniary damages awarded by the courts over the years.¹⁰⁷ Generally, the level of compensation for non-pecuniary loss awarded is not all that high,¹⁰⁸ with claims not exceeding (back then) DFL 250,000 (€ 113,445 without inflation) for the more severe cases.¹⁰⁹ The highest amount was awarded in 1992 in a case of (wrongful) contamination with the HIV virus; the amount awarded was (then) DFL 300,000 (€ 136,134).¹¹⁰ There is not a detectable trend towards higher amounts being awarded,¹¹¹ even though claims as such demand higher amounts, at least if one makes allowance for the fact that awards increase to compensate for inflation.¹¹²

Of course for the calculation of these non-pecuniary damages, there is no easily applicable yardstick. If the willingness to pay, to accept the damage or the willingness to pay the costs of avoidance of the damage is taken as the benchmark, the damages awarded by European courts are generally

103 Eg: tortious or contractual liability, fault based or strict liability, or the specific types of liability (employer's liability, traffic liability, product liability or services liability etc).

104 Cf HR 8 July 1992, NJ 1992, 770 (AMC/O.). To that extent also HR 17 November 2000, NJ 2001, 215 (*Druijff/BCE Bouw*), a case in which the liability of a building company towards its injured employee was invoked. See also *SD Lindenbergh*, *De hoogte van het smartengeld in Nederland, Een verkenning van de top*, VR 1999, 129 ff.

105 Cf HR 17 November 2000, NJ 2001, 215 (*Druijff/BCE Bouw*).

106 See the latest (17th) edition, *M Jansen* (ed), *Smartengeldbundel* (2009).

107 Cf *WCT Weterings*, *Vergoeding van letselschade en transactiekosten* (1999) 93.

108 Cf *ibid* 92.

109 Cf *Lindenbergh*, VR 1999, 129 ff.

110 HR 8 July 1992, NJ 1992, 770 (AMC/O.). Cf *Lindenbergh*, VR 1999, 129 and 133.

111 *Lindenbergh* (fn 88) 78.

112 From HR 17 November 2000, NJ 2001, 215 (*Druijff/BCE Bouw*), it becomes clear that the court must take the inflation rate into account when comparing an earlier case with the present claim.

set at levels so low that the principle of full reparation is not observed.¹¹³ However in the Netherlands, as elsewhere in Europe, these damages are generally seen as offering some form of comfort with regard to the grief suffered, especially in cases of severe disabilities, not as full reparation of the damage.¹¹⁴

26. Who can claim compensation for non-pecuniary loss?

- 85 Dutch personal injury law holds the principle that only the primary or the direct victim (ie the person whose physical or mental injury was caused directly by the accident or malpractice itself and not through his confrontation with another person's injury, as is the case with secondary nervous shock victims or similar) can claim compensation for non pecuniary loss.¹¹⁵ Subsequently a claim for bereavement damages is not possible. A legislative proposal to change the law in this respect, by allowing a claim for '*affectieschade*' for the remaining relatives (emotional loss, bereavement damage, *préjudice d'affection*), was rejected by the first Senate of the Dutch Parliament in March of 2010. It was proposed that certain categories of close relatives, such as the spouse or parents of a seriously injured or deceased person would be able to claim a standardised amount of money (€ 10,000). The arguments of the small majority (36 against 30) of Members of Parliament who objected against this legislative proposal felt either that the latter might contribute to the threat of a 'claim culture' and/or that the fixed amounts paid by insurers was not the right way to do justice or to acknowledge the wrong.¹¹⁶
- 86 However, it is possible to claim pecuniary and non pecuniary damages for nervous shock, not only for primary accident victims but also for the so-called secondary victims: those confronted with serious injury or death of others caused by the violation of safety or traffic rule.¹¹⁷ These claims are,

113 Which is generally the case, see *Spier/Hartlief* (fn 92) no 196. With regard to non-pecuniary losses, the principle of full reparation does not apply as such, since no amount will by itself fully compensate the immaterial damage that was suffered.

114 See *CJMM Stolker/FH Poletiek*, *Smartengeld – Wat zijn we eigenlijk aan het doen?* in: *Bewijs en letselschade* (1998) 78–80.

115 *EFD Engelhard*, *Third party losses in a comparative perspective* (triptych with CC van Dam and I Giesen), *Utrecht Law Review* (ULR) 3 (2007) 82 ff.

116 On this enactment, see the Parliamentary Proceedings of the Second Chamber of Parliament (TK) 2004/2005, no 28 781, nos 1–3 ff.

117 HR 22 February 2002, NJ 2002, 240 (*Nervous shock*), recently affirmed HR 9 October 2009, LJN BI8583 (*Reaal Schadeverzekeringen NV*).

as of yet, quite rare though in the field of medical negligence,¹¹⁸ and will accordingly not be further discussed.

G. Procedural Matters

27. Specific rules of jurisdiction or procedure

Until now there are no specific rules of civil procedure for medical negligence cases. Quite recently however, legislation involving the so-called '*deelgeschillen*' has been enacted. This legislation allows future claimants in personal injury claims, and thus also in cases of medical negligence, to put (only) a specific part of his dispute with the wrongdoer before a judge (eg a dispute over the compensation of a certain loss). The judge will rule on that part of the dispute, without touching upon the rest of the possible issues, thereby giving parties legal certainty on that point and thus allowing them to continue negotiating the out of court settlement of the claim between them, thus without further involving a judge. This system is supposed to enhance negotiations because certain insurmountable problems between the parties are taken away, thus clearing the path for a successful settlement.

28. Special institutions handling malpractice claims

The so-called Hospital Dispute Settlement Commission (*Geschillencommissie Ziekenhuizen*) handles claims for damages of patients who have suffered damage caused by an affiliated health care institution, after they have first addressed the institution itself and/or its liability insurer. The Dispute Settlement Commission only allows claims that do not exceed € 5,000 and that are not pending as a civil court procedure. Clearly this alternative dispute settlement system enables the victim or his relatives to claim damages via a means that entails less costs and fewer procedural barriers than public (civil law) court procedures. However, if one or both of the parties do not agree with the decision of the Dispute Settlement Commission, they may still subsequently start legal proceedings before the civil court.

¹¹⁸ The few examples are mainly from prior to the principal nervous shock case of 2002, mentioned in the previous footnote and deal with parents that suffer from mental distress caused by malpractice concerning their child (of which most notably HR 8 September 2000, NJ 2000, 734, *Baby Joost*) and women in labour experiencing severe distress from difficulties at child birth, particularly Rb Maastricht 22 March 2003, LJN AV7273 (omission concerning Caesarean section).

H. Outlook

29. Reform plans

- 89 Although several authors and practitioners have suggested a move away from liability law and a shift towards an alternative insurance plan or something similar, no consensus has ever been reached on this.¹¹⁹ Currently, the Dutch legislature has not presented any plans to reform medical liability.

Cases

Case 1

- 90 Under Dutch medical liability law it is generally assumed that the unborn child can have rights to compensation in case of malpractice, and such a claim has in the so-called *Baby Kelly* case been proven to be successful in a case of wrongful life.¹²⁰ This claim can be either contractual, as Y is to be regarded as a contractual party to the treatment contract (art 7:453 CC; cf the *Kelly* case) or in tort, based on the violation of a duty of care owed by the defendant(s) towards her directly (art 6:162 CC; see no 21 ff). To be clear, in the present case the claim does not seem to include that Y, given the seriousness of her impairments, would not have wished to be born, nor do the facts exhibit that Y's impairments were (partly) caused by a heritable genetic defect within her family for which she was wrongfully not tested (as in the *Kelly* case). Rather, Y's claim seems to be based on the argument that based on the results of the cardiotocograph (CTG) both the midwife D and gynecologist A (acting *ad interim*) omitted to take the medical action that was required, in the absence of a good justification ground. Particularly A, after having seen the results of the CTG, should have carried out further investigations and ordered a caesarean section. If A's contractual and/or non contractual liability based on one of these grounds can be established, the hospital and/or A and B's practice will also be liable (either based on the hospital's central liability in medical

119 See on this *Giard* (fn 10) and further *Cascão* (fn 20) (both with further references).

120 HR 8 March 2005, NJ 2006, 606 (*Baby Kelly*). On that case also EH *Hondius*, *The Kelly Case – Compensation for undue damage for wrongful treatment*, in: JKM Gevers et al (eds), *Health Law, Human Rights and the Biomedicine Convention. Essays in Honour of Henriette Roscam Abbing* (2005) 105 ff; I *Giesen*, *Of Wrongful Birth, Wrongful Life, Comparative Law and the Politics of Tort Law Systems*, *Tydskrift vir Hedendaags Rooms-Hollandsch Recht* (THRHR) 72 (2009) 257 ff.

contract law, which we discussed at no 61 above, or vicariously, see nos 63–64). Given the fault-based foundation of the liability of the practicing physicians themselves, we do not think a claim vis-à-vis B *personally* will succeed given that B was on holiday at the time that X's condition worsened and A stood in for him at the time.

The problem here seems not to be with the question of wrongfulness or breach of contract (which both seem to be given), but rather with causation. It is probable that Y's impairments existed to a certain extent before the delivery and it is also possible that A and D's conduct were the sole cause of the impairments. But from the facts of the case as presented here, it seems also possible that Y already had a pre-existing problem which could 'at least' partially – which means: or fully – have contributed to her present condition. Clearly the defendants cannot be held liable for impairments that would in any case have occurred.¹²¹ If it can be ascertained that Y's pre-existing condition has contributed to her present condition, that fact will not stand in the way of the defendants' liability as defendants in Dutch law must 'take the victim as they find him' (see above, no 49). What is needed, is that Y produces evidence that there is a *conditio sine qua non* connection between A's malpractice and her impairments. This seems uncertain from the facts as presented, even more so because (as in many medical negligence cases) it seems far from clear what Y's condition would have been like if A (and D) would have taken proper action (and thus complied with the professional standards). However, it seems likely that Y's claim can be made successful either through the so-called reversal rule (*omkeringsregel*, see no 40 ff), by awarding damages for the loss of a chance (to be born unharmed, see no 50 ff) or by means of proportional liability (in proportion to the percentage of likelihood that Y's impairments may have been caused or worsened by A's omissions, see no 47). Which one of these options can and/or will be applied will depend on the information that can be discerned from statements of professional experts.

Under Dutch law, the claimant (here Y) is under the duty to mitigate his loss as far as it seems possible, in all reasonableness; if he violates this rule this is usually treated as a form of contributory negligence.¹²² However, it seems most unlikely that this duty would give the hospital a successful defence here as this would mean that civil law would, indirectly, intervene in the decision of Y's (and her parents) right to family life (cf art 8 of the

121 Likewise: HR 2 February 1990, NJ 1991, 292 (*Vermaat/Staat*) and on this *Engelhard* (fn 5) 273.

122 ALM Keirse, Schadebeperkingsplicht, over eigen schuld aan de omvang van de schade (2003).

European Convention of Human Rights). At the utmost, the fact that the associated costs of Y's care (by day in the form of professional care and exclusively by her mother during nights and weekends) are greater than if Y lived in a care home, could be considered to be a reason to mitigate the amount of liability, albeit not below the sum covered by liability insurance (art 6:109 CC; see nos 76 and 81). Y will also be entitled to non-pecuniary damages, of course (again) provided that the *conditio sine qua non* connection between her impairments and the malpractice can be shown based on one of the aforementioned theories.

- 93 As for X's claim for the special care costs that she incurs for Y, a special rule for personal injury cases is applicable which is based on the so-called 'transferred loss theory' (*leer van de verplaatste schade*).¹²³ Based on this ruling, the defendants' liability vis-à-vis Y is extended to any concrete pecuniary damage (eg expenses, lost income and alike) that X incurs for the care that Y needs. Based on relevant jurisprudence on this matter, X may, given the seriousness of Y's condition, even claim damages if she has incurred no concrete loss of income but has had to take leave days (or similar) in order to look after Y.¹²⁴ The time spent on this special care will be calculated on the basis of (no more than) the professional costs that X saved by taking on this care herself, albeit only to the extent that it would have been 'normal and common' (*normaal en gebruikelijk*) to get professional help in the given situation.¹²⁵ As far as X's claim for non pecuniary damages is concerned, she can be seen as the contracting party to the contract for medical services with hospital C, which means that *mutatis mutandis* similar to the arguments discussed for Y's claim above (nos 90–91) X too will have a contractual claim against A and C (cf the aforementioned *Baby Kelly* case) for her mental distress. Affectionate damages (no 85 above) are not recoverable.

123 Engelhard (fn 5) 142 ff.

124 There is currently a preliminary proposal for a special ruling in respect of such costs, see EFD Engelhard, Naar een nieuw criterium voor de vergoeding van derden: het Voorontwerp Inkomensschade en het wetsvoorstel Reïntegratiekosten, VR 2008, 1–9.

125 HR 28 May 1999, NJ 1999, 564 (*Kruithof*) and HR 6 June 2003, NJ 2003, 504 (*Krüter/Wilton*); on these cases Engelhard, ULR 3 (2007) 82 ff. Cf as to fatal injury cases, HR 5 December 2008, RvdW 2009, 1 (*Stichting Ziekenhuis Rijnstate/R*) and on this *R Rijnhout*, Vergoeding voor huishoudelijke hulp door naasten: een overkoepelende analyse van art. 6:107 en 108 BW, AV&S 2009, and SD Lindenberg/I van der Zalm, Vergoeding ter zake van verzorging en huishoudelijke hulp bij letsel en overlijden, Maandblad voor Vermogensrecht (MvV) 2009, 146–151.

Case 2

The mother's claim has a good chance of succeeding under Dutch law, but the father's chances of success are doubtful. Cases like this dealing with a wrongful birth claim of X and Y, the parents of Z, who was born as a result of the failure of the contraceptive implant 'Implanon', are increasingly brought before Dutch courts.¹²⁶ We note that claimants may also opt for a product liability (and/or wrongful advertisement, art 6:194 CC) claim against (most likely) Organon, the type of claim which has also led to many cases in practice.¹²⁷ The case at hand, against the practitioner, will generally be based on art 7:453 in conjunction with art 6:74 CC (breach of contract) and alternatively fault liability. The facts as presented in the case are not completely clear regarding the (alleged) negligence of the gynecologist. First we need to decide if the medical intervention to place the implant can be construed as the practitioner's obligation to achieve a given result, which in Dutch law is a matter of interpretation of the parties' mutual expressions (cf no 27). If this was the case, then it will usually be assumed, with hindsight, that he has violated this obligation if the patient got pregnant quite soon (within a year or so) and if the implant could no longer be traced on an echo.¹²⁸ However, it is often not so much the (apparent) failure in placing the implant, but rather the violation of having informed the patient of the risk that the implant may fail, that will be the breach of contract.¹²⁹ That may then relieve the court of the difficult decision of having to interpret the contractual obligation of placing the implant as an obligation to exercise with due care (trying to properly place the implant) or to guarantee a particular result (proper placement of the implant).¹³⁰ The answer to this question, also for the case at hand, will depend on whether the practitioner had sufficiently warned his patient of the risk of failure, which will be for the claimant to prove (helped in that

126 Inter alia: Rb Arnhem 11 June 2003, LJN AG0130; Rb Alkmaar 11 February 2004, LJN AO3453; Rb Den Bosch 15 June 2005, LJN AT7382; Rb Alkmaar 24 May 2006, LJN AX4831; Hof Den Bosch 28 August 2007, LJN BB2385; Hof Amsterdam 24 January 2008, LJN BC9815 and Rb Den Bosch 26 March 2008, LJN BC7489.

127 See esp the 27 cases of 15 women before Hof Den Bosch 15 June 2005, LJN AT7353 (*Claimants/Organon*) and the joined decision: LJN AT7382 (*X/Organon*). In the prior case (LJN AT7353 at para 4.20) the District Court has shifted, on grounds of reasonableness, the burden of proof with regard to the defectiveness of the Organon implant to the manufacturer.

128 Hof Alkmaar 11 February 2004, LJN AO3453, para 5.14.

129 Rb Arnhem 11 June 2003, LJN AG0130 (*Implanon implant*) at para 14.

130 Cf HR 1 December 2000, LJN AA8724 (*Wrongful birth II*), where the wrongful birth claim of a mother whose pregnancy had resulted from a failing sterilisation procedure by Falope rings, was rejected because she had not shown this was caused through negligence.

respect by the so-called '*aanvullende stelplicht*', dealt with above at no 31 ff, to the detriment of the defendant who will then have to rely on his charts) as the practitioner has agreed to no more than making his best effort, with no results guaranteed (*inspanningsverbintenis*).¹³¹

- 95 If there *has* been malpractice, the practitioner will be held liable for the woman's damage to the extent that it can be attributed to him based on art 6:98 CC (see nos 37 and 49); her choice not to terminate her pregnancy is in any case no causal defense. The woman will however have to convince the court of the fact that if it had not been for the malpractice she would have chosen not to have children. For this, witnesses, particularly loved ones, may be heard.¹³² In a recent decision of the Appellate court The Hague a gynaecologist was held liable for not having properly informed a 37 year old woman, who had consulted him regarding her infrequent menses. The court's decision was based on the fact that he had told her that her blood test results were similar to those of a fifty to sixty year old woman without warning her that using birth control was still needed in order to prevent a pregnancy. He was held liable for the costs of her pregnancy (of twins). The fact that the woman had decided not to have the pregnancy terminated did not break the chain of causation (as was argued by the gynecologist), given the personal nature of that decision.¹³³
- 96 In a wrongful birth case where the gynecologist had *forgotten* to re-insert the woman's intra-uterine device (thus no Organon implant) after she had undergone medical surgery, the Dutch Supreme Court held that for the legal causation (art 6:98 CC) it suffices in principle that a risk was created due to the malpractice, which has materialised. If that can be said then 'in principle' all kinds of pecuniary damage will be attributed to the defendant (the gynecologist), including the costs for maintenance of the child. The court rejected fundamental objections against the compensation of these maintenance costs, namely that making these costs recoverable would suggest that the child is seen as damage or as unwanted. It turned these objections around: compensating the maintenance costs is needed to enable the parents to realise their choice to continue the pregnancy and to raise their child.¹³⁴ However, in an *obiter dictum* the court noted that to the

131 Rb Alkmaar 11 February 2004, LJN AO3453 (*Implanon implant II*) para 5.9.

132 See the extensive witness testimonies in this respect that were taken into account by the Rb Alkmaar 24 May 2006, LJN AX4831 (*Implanon implant III*).

133 Hof Den Haag 10 July 2007, NJ 2007, 656 (*Gynecologist/Claimant*).

134 HR 21 February 1997, NJ 1999, 145 (*Wrongful Birth I*) at para 3.8 of the judgment. Other contra-arguments are given at paras 3.9–3.10. Advocate-General Vranken had, in his advice, elucidated the position of other law systems, particularly German law.

extent that maintenance costs *exceed* the average costs that are calculated objectively (by the so-called National Institute for Budget Consultancy, NIBUD), it is left to the discretion of the court in question to see if that part of the claim must be rejected as it is then based on personal preferences of the parents (and thus their own responsibility). The Supreme Court also pointed to the possibility of mitigating the compensation if the gynecologist has no liability insurance (art 6:109 CC, see no 76).¹³⁵

Another relevant aspect of the Supreme Court's case for present purposes is related to the part of the mother's claim that dealt with her income loss as a result of her pregnancy and the child's birth. She was at the time married to the father and they already had two children but lived on unemployment benefits. According to the Supreme Court her income loss was 'in principle' recoverable, but it was necessary to determine whether the mother's choice to temporarily stop working could be regarded as a 'reasonable' decision in the concrete circumstances of the case.¹³⁶ The claimant would have had to convince the court of this. On the one hand, regard should be had to her right to arrange her life (as well as her child's) in such a way as she thinks fit, while on the other hand she should mitigate her damage in so far as possible and can reasonably be expected of her. The particular circumstances of her family, such as the number and ages of the other children, whether she has a husband and if so, whether he is employed or not and the financial means of the family would have to be considered here.¹³⁷

As for the non pecuniary damage, it is generally left to the discretion of the courts-of-fact, as was explained above (see no 82 ff), to determine whether there are good grounds to award compensation. The court needs to take all the relevant circumstances into account such as, inter alia, the kind of liability in question (eg intent or mere negligence, fault or risk-based).¹³⁸ The Supreme Court even seemed to suggest in its 1997 case that a deduction could be made for the joy that even unplanned children will (also) bring, but in the literature this has met with some criticism.¹³⁹ This

¹³⁵ HR 21 February 1997, NJ 1999, 145 (*Wrongful Birth I*) at para 3.11. In his case note Brunner criticised the court's strong emphasis on an objective calculation of the maintenance costs (based on NIBUD standards).

¹³⁶ HR 21 February 1997, NJ 1999, 145 (*Wrongful Birth I*) para 3.13.2.

¹³⁷ HR 21 February 1997, NJ 1999, 145 (*Wrongful Birth I*) para 3.13.2.

¹³⁸ HR 9 August 2002, LjN AE2117 (*St KUN/Applicant*) para 5.3.

¹³⁹ In these words Advocate-General Spier in his advice preceding HR 9 August 2002, LjN AE2117 (*St KUN/Applicant*) at para 4.25.1–4.26.2 of his advice (with references), but Spier concludes that the non pecuniary advantages outweigh the disadvantages and non pecuniary damages should thus not be awarded here (para 4.41). In this last sense also for an *Implanon* case as the one at hand: Rb Alkmaar 24 May 2006, LjN AX4831 (*Implanon implant III*).

has in some cases actually led to the rejection of the part of the parents' (the woman's) claim related to non pecuniary damages.¹⁴⁰

- 99 It must be noted that so far as cases that have reached Dutch courts are concerned, the father's right to compensation has received much less attention as claims in almost all of these cases came from the mother and are centred around her damage. His position is very different from hers in the sense that generally he will not be regarded as a contracting party, with respect to the contract for medical services concerning her pregnancy.¹⁴¹ Exceptions can be made if there are special indications that the parties were intending to include the father, for example because the mother has told the practitioner that she also acts on the father's behalf (which is of course rare).¹⁴² In most cases so far, however, the father's claim has been rejected for lack of grounds for liability (also in tort).¹⁴³ Some courts, however, will consider the malpractice which constituted a breach of contract towards the mother, almost intrinsically as tortious against the father.¹⁴⁴ In wrongful life claims the Supreme Court has ruled that the violation of the right to self-determination may equally affect the father. He does not have the final say in the decision regarding the possible termination of the pregnancy, but his interests are so closely involved that the contractual malpractice towards the mother constitutes a wrongful act (or rather omission) towards the father. If he can prove that this has resulted in mental injury, then he too is entitled to non pecuniary damages.¹⁴⁵ In our view the latter should also apply to wrongful birth claims, such as the present one.

Case 3

- 100 Under Dutch law X's claim for damages against the defendants seems quite likely to succeed. The case presents several serious omissions by

140 Rb Alkmaar 24 May 2006, LJN AX4831 (*Implanon implant III*).

141 Art 7:446 para 1 CC allows specific thirds ('bepaalde derden') to be included in the contractual scope of protection only if they are the one receiving the treatment. Since the father does not receive any pregnancy treatment, he is by no means party to the contract (ibid Rb Arnhem 11 June 2003, LJN AG0130, at para 5 and Rb Alkmaar 11 February 2004, LJN AO3453, para 5.3).

142 Rb Alkmaar 11 February 2004, LJN AO3453 (*Implanon implant*) para 5.3.

143 Rb Arnhem 11 June 2003, LJN AG0130, at para 9; Rb Alkmaar 11 February 2004, LJN AO3453, para 5.19 (the claim for tort liability against the father needs further proof), Rb Alkmaar 24 May 2006, LJN AX4831.

144 Cf for instance the Court of Appeal's judgment in the wrongful life (!) claim that led to HR 8 March 2005, NJ 2006, 606 (*Baby Kelly*).

145 HR 8 March 2005, NJ 2006, 606 (*Baby Kelly*).

several involved practitioners. Firstly, three omissions by the obstetrician of hospital A: X, a newborn diagnosed with hypoglycaemia (which should have made him a 'high-risk' newborn), was not monitored as was medically indicated, the paediatrician was not consulted and X's mother and the midwife were not informed about the need to monitor his blood sugar level. Secondly the case presents two omissions by the midwife B: she should have recognised the risk posed to X and did not consult the paediatrician. Thirdly the case presents omissions in the organisational sphere by C's paediatric clinic due to which valuable time was wasted. Fourthly, nurse D did not take the proper measures. The crucial question lies of course with the *conditio sine qua non* link between these respective malpractices and the (ultimate) damage: X's severe disability: for X's claim to succeed, it must be established that his severe disability has been or, at least may have been (art 6:99 CC, see no 102 below) caused by any of these failures, and if so, by which one(s). The facts of this case are unclear with regard to the exact *conditio sine qua non* for each of the malpractices seen individually. However, it does seem likely that the sequence of events has caused the damage. This could point to concurrent liability, which means that all defendants are jointly and severally liable for X's damage (art 6:102 CC). There is a high(er) probability that the organic damage was sustained in C's clinic, but that of course tells us nothing about X's serious deterioration process that led to his final state of health (meaning that not just C, but also A and B may be equally, or even more, to blame). It also seems to be unclear at what point in time (and by which of the actions that should have been taken) X's deterioration could have been prevented.

Under Dutch law this issue will probably be treated as one of cumulative **101** causality, meaning that each of the defendants will be held to have contributed to X's deterioration, which ultimately led to his organic damage. The damage may then be attributed to each (art 6:98 CC). The reversal rule as discussed above (no 40 ff) may be used in this regard against any defendant brought to court: the specific risk caused, for instance, by A's omission to monitor X for 24 hours is then taken to have materialised unless the defendant shows that his or her omission did not cause X's deterioration. A similar line of reasoning may be used for the specific risk entailed in not consulting the paediatrician and for the other wrongful acts as well. All defendants can then be held jointly and severally liable and the paying party may seek reimbursement (which will then, in that subsequent procedure amongst the defendants themselves, beg the question as to who caused what). As was said above, in personal injury cases the legal attribution (in terms of causation, art 6:98 CC) of the series of events goes quite far under Dutch law: the defendants liability will

extend also to an unlikely matter of events (eg if the victim of a minor traffic accident suffers from a long-lasting disability because of a cumulative wrong caused after he had been admitted to the hospital).

- 102** Of course it is not apparent that the first series of malpractices already caused X's condition to worsen, although to us this does appear to have been likely. Other options might then be to use the rules on proportional liability or loss of a chance, as explained above (no 47 and no 50 ff), or (more claimant-friendly perhaps) to invoke the rule on alternative liability as laid down in art 6:99 CC and applied in the famous *DES* case.¹⁴⁶ In the 1950s and 60s a pregnancy enhancing drug was marketed by a number of pharmaceutical companies. Later it was discovered that both mothers and daughters suffered considerable physical damage as a result of the use of this drug by the mother. A number of injured daughters claimed compensation from a number of manufacturers, without presenting specific evidence of the identity of the origin of the tablets that their mothers had used. The manufacturers asserted that they could not be held liable in full. The Supreme Court decided that the interests of the injured *DES*-daughters should prevail over the interests of the manufacturers. As a result, an injured daughter could claim in full from any of the manufacturers, even though no specific causation by that manufacturer was proved. Wrongful marketing of the unreasonable unsafe drug was held to be sufficient.
- 103** The *DES* case was decided under the old 1838 Dutch Civil Code, which did not yet have any provision on alternative causation. The Hoge Raad decided that the material rule contained in art 6:99 CC was already substantive law before enactment in 1992. According to the standard of art 6:99 CC, if two or more wrongful acts may have caused the damage, but it is unclear which of these alternative causes did in fact cause the damage, then each responsible actor is liable in full unless he can prove that his act certainly did not cause the damage. In the *DES* case, the wrongful acts were the distribution by several manufacturers of an unreasonable unsafe drug. Any victim of the drug could claim in full from any of the manufacturers, which in effect may cause serious problems in administering and settling mass injuries such as the *DES*-related injuries. In Case 3 as spelled out here, the same reasoning seems to be possible, since all possible wrongful acts have or could have caused the same damage.
- 104** This option seems to be strengthened by a subsequent Supreme Court case.¹⁴⁷ In that case a (believe it or not) 'second group' of arsonists claimed

¹⁴⁶ HR 9 October 1992, NJ 1994, 535 (*DES daughters*).

¹⁴⁷ See HR 31 January 2003, NJ 2003, 346 (*Multiple arsonists*).

that the acts of 'their group' had not caused the entire damage to a certain building. The building they had set fire to must have been already damaged beyond repair by a previous fire by other arsonists, or so they alleged. The Court of Appeal however considered that, based on an evaluation of the facts, the second group's acts in fact could well have caused the entire damage, and concluded therefore that art 6:99 CC should be applied. The Hoge Raad concurred in the sense that the arsonists were held liable in full (art 6:99 CC) unless they could prove that they had not caused the entire damage (which they could not). It seems to us, that this line of reasoning with regard to art 6:99 CC could be followed in the medical case at hand as the facts of that case seem to leave the possibility open that each defendant may have caused the entire damage.

Case 4

This claim may succeed under Dutch law, if X's paralysis has in fact resulted from the surgery and if, this is of course the crucial point, the paralysis would not have occurred in any case (which remains unclear). The case deals with a core issue of 'informed consent', to which we refer in our previous discussion, at no 70. The information duty (as was discussed there) that the Act on medical services contracts (*Wet geneeskundige behandelingsovereenkomst*, WGBO) imposes on practitioners clearly includes the surgery suggested for X in the case at hand, all the more since this particular surgery had such serious risks was attached and was, according to the facts presented, not absolutely necessary. As was explained above, the WGBO imposes the obligation on the practitioner to inform his patient in a clear way ('*op duidelijke wijze*') about the intended tests and treatment and that this means the information must be sufficiently understandable for the latter. In the explanatory memorandum the legislature indicates that if the patient has language difficulties, the practitioner needs to bring the information across by using somebody who may assist him, if needed through a centre for translators.¹⁴⁸ In the Netherlands medical practitioners can turn to the Centre for Translators to request the services of a translator on relatively short notice (within days) or even immediately (in case of an emergency or if telephone services will suffice). The Dutch Ministries of National Health, Welfare and Sports and of Justice subsidise the costs of professional translators in the sectors of health care and social affairs.

¹⁴⁸ See the Parliamentary Reports of the Second Chamber of Parliament (TK) 1989/1990, no 21 561, no 3 (Explanatory Memorandum), 11.

- 106** The burden of proof with regard to the violation of the duty to inform the patient is on the latter. As was explained in no 35, practitioners are expected to come forward with factual information to motivate their defences, at the risks that the burden of proof of the plaintiff will be changed or alleviated to the disadvantage of the defendant.¹⁴⁹ Much can be said for that in the present case. The kinds of damage claimed by X are all recoverable under Dutch law, possibly with a deduction for social benefits that already cover part of X's expenses for the adjustments made in his house and/or his car if X did not deduct these already.

Case 5

- 107** There may be a chance that this claim will succeed under Dutch law, despite the high level of uncertainty as to what has happened. The facts of this case state that it is certain that the damage to the patient can only have been caused by the positioning of the patient's arm at the beginning of the surgery (for which the surgeon was responsible) combined with the compression during the operation (which was foremost the anaesthetist's responsibility). This could result in joint liability, but for the fact that it cannot be proven that the way that the patient's arm was positioned was in any way incorrect or that the anaesthetist, who was an intern at the time, acted negligently. The court may assist the plaintiff in proving this (using the '*aanvullende stelplicht*', no 31 ff) if it is certain that his complaints can be related to the operation (the fact that his complaints started directly following the surgery may be indicative of this). This may be particularly so, as the fact that both matters cannot be proven is due to the lack of documentation with regard to the operations during surgery (which might perhaps even give rise to a substantive claim, based on art 7:454 CC, in which case the lost chance theory could be invoked, see no 50 ff above, although for the case at hand this seems somewhat farfetched).
- 108** Dutch courts use an objective standard of care for professionals, which means that generally a lack of experience (as for C) and lack of time (as for D) will not relieve them from their duty to act as 'good' practitioners (in terms of art 7:453 CC, see nos 67 and 23 above). If several persons can be held liable for the same damage, they will each be jointly and severally liable (art 6:102 CC) and after having paid the plaintiff they are entitled to reimbursement from one another (art 6:6ff CC). Using the article on central liability of the institution is also an option of course (see no 61).

¹⁴⁹ HR 20 November 1988, NJ 1988, 500 and HR 18 February 1994, NJ 1994, 368.

As for the rules for compensation, provided that there is sufficient ground for compensation, X will, subsequent to his physical disability, be entitled to non-pecuniary damages (art 6:106 section b CC) and compensation for his loss of earnings. If his weekend job was not declared, the loss of income can be awarded but with a deduction of the amount of taxes and social insurance premiums (and alike) that would have been deducted if declared to the tax inspector (see no 79). The fact that he refuses retraining may give problems under social security law, but will probably have no effect under the law of damages (notwithstanding the fact that X is under a duty to mitigate his damage, but only within the boundaries of what can be 'reasonably' expected of him). As for the assessment costs, these are recoverable under Dutch law (art 6:96 CC), but there is a so-called double test for reasonableness: was it, given his duty to mitigate his damage, reasonable to incur these costs in the first place (in our view it may well be), but secondly: was it in all reasonableness necessary to incur high costs or could it also have been done for less costs or even free of charge. Given that the free of charge method was available to the defendants it will be for X to convince the court that it was reasonable by explaining, for example, the (possible) differences as to the quality of each of both alternatives (was the one assessment more extensive than the other and was this necessary for his claim, etc).

Case 6

It is doubtful whether this claim will succeed. Household costs are recoverable under Dutch law, even if they are made by people other than professionals (cf no 93) and can be calculated objectively, but the problem in the present case rests with the grounds for liability. There was a contract between the patient and C and/or D (as the legal representatives of the orthopaedic practice). The patient can file a claim vis-à-vis the practice as such and against C and/or D in person. There are at least two major questions that may cause difficulties in succeeding with the claim: firstly the question of whether the practitioners' duty was breached and secondly the causal link issue. As regards the duty of care, the Health Authorities' Report seems to indicate that (unwritten) standards of hygiene were not respected; whether this gives rise to sufficient arguments to establish liability depends in part on the hygiene rules that are common in this area. It seems to us that the practice was not sufficiently hygienic.

Variation 1

- 111 If the carrier of the bacteria cannot be identified, the claim will generally fail as it is, in principle, for the victim to prove the causal link between the defendant's lack of hygiene and the infection. If she can prove that the infection was caused by someone from the staff, but cannot prove which one, she may be helped by the ruling for alternative causation (art 6:99 CC), which may shift the burden of proof. Here however, it could have been anyone, and for this (general) causation problem there is no special ruling in the Civil Code. She can probably not be helped by the court on the ground that 'the facts speak for themselves' either, as this seems not to be the case here, nor may the reversal rule (*omkeringsregel*) work; given the Supreme Court's restrictive approach it seems very doubtful that the creation of a specific risk which relates to the infection may be derived from the Health Authority's report (in terms of the violated rules of hygiene). See no 41 ff. The solution of proportionate liability, which was introduced in an asbestos case, will not easily be extended to what we suspect to be more common cases like the one at hand. Although in HR 24 December 2010, LJN B01799 the Supreme Court has accepted the possibility (under strict conditions) of using proportionate liability outside asbestos cases. Accordingly, the claim will probably not be awarded.

Variation 2

- 112 From what we have discussed above, it will come as no surprise that in the absence of fault, there will be no liability under Dutch law, as the rules for strict liability (see nos 63–64) are not applicable here and the mere fact that the patient acquired the infection will not in itself constitute fault.