# The Defendant as the Reluctant Player in the Adversarial Setting of Medical Dispute Committees

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**Abstract**

Medical dispute committees in the Netherlands were formalised in 2017. They offer hybrid procedures, combining complaints handling with the processing of a potential claim in cases where a complaint could not be resolved at the health care organisation. Recent scholarship has shown the experiences of complainants (patients and families) with dispute committees, but research regarding the roles and experiences of the defendants (usually representatives of health care organisations) is lacking. This research aims to understand how defendants understand and fulfil their professional roles and how this could impact the dispute committee proceedings. This research features an inductive, thematic analysis of in-depth interviews with defendants at medical dispute committees. Researchers conducted interviews with eighteen defendants at dispute committees. Defendants were generally managers and legal counsel at health care organisations. The main results include defendants who preferred problem-solving and who wanted to avoid conflict. Defendants did not have a strong adversarial mindset, but they did highlight their commitment to defend the health care professional and institution. Some respondents felt forced into a defensive position, which they reluctantly fulfilled. Our main conclusion is that dispute committee proceedings can demand defendants to take on an adversarial role, despite the best intentions of the legislator to create a less legal procedure and a problem-solving mindset among the defendants. The expectations of defendants and patients might connect better to a problem-solving, healing role of defendants and a less formal set-up.

**Keywords:** medical dispute committees, health care incidents, professionals, healing lawyers, comprehensive law movement, complaints.

## 1 Introduction

Internationally, dealing with the aftermath of health care harm has resulted in a multitude of processes ranging from adversarial processes (civil litigation, disciplinary proceedings) to more informal processes (complaints procedures, open disclosure).[1] Adversarial processes have resulted in defensive medicine and do not address some of the primary needs of patients: to be heard and to prevent reoccurrence.[2] More informal processes, such as complaints procedures, could be more suitable to listen to patients and families.[3]

Health care organisations in the Netherlands have a system of internal complaints processes, ideally preceded by an open conversation with the health care professional.[4] Complaints processes are governed by com-



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1 R.I. Dijkstra et al., 'Medical Dispute Committees in the Netherlands: A Qualitative Study of Patient Expectations and Experiences', 22(1) *BMC Health Services Research* 1 (2022); R. Friele et al., 'Complaints Handling in Hospitals: An Empirical Study of Discrepancies between Patients' Expectations and Their Experiences', 8(1) *BMC Health Services Research* 199 (2008); R. Iedema et al., 'Patients' and Family Members' Experiences of Open Disclosure Following Adverse Events', 20(6) *International Journal for the Quality of Health Care* 421 (2008); J. Moore et al., 'Patients' Experiences With Communication-and-Resolution Programs After Medical Injury', 177(11) *JAMA Internal Medicine* 1595 (2017); J. Wailing et al., *Healing After Harm: An Evaluation of a Restorative Approach for Addressing Harm from Surgical Mesh. Kia ora te tangata: He arotakenga i te whakahaumanu. A Report for the Ministry of Health* (2020); A.W. Wu et al., 'Disclosing Adverse Events to Patients: International Norms and Trends', 13(1) *Journal of Patient Safety* 43 (2017).

2 Moore et al., above n. 1, at 1; R. Friele and E. Sluijs, 'Patient Expectations of Fair Complaint Handling in Hospitals: Empirical Data', 6(1) *BMC Health Services Research* 106 (2006); R. Iedema et al., 'Patients' and Family Members' Views On How Clinicians Enact and How They Should Enact Incident Disclosure: The "100 Patient Stories" Qualitative Study', *BMJ* 343 (2011); J. Moore and M. Mello, 'Improving Reconciliation Following Medical Injury: A Qualitative Study of Responses to Patient Safety Incidents in New Zealand', 26(10) *BMJ Quality and Safety* 788 (2017); S.N.P. Wiznitzer, *Defensieve dokters? Een juridisch-empirisch onderzoek naar de invloed van het medisch aansprakelijkheidsrecht op het professionele handelen van zorgverleners* (2021).

3 R. Friele et al., *Evaluatie Wet kwaliteit, klachten en geschillen zorg* (2021).

4 B.S. Laarman, 'Openheid na incidenten en een betere afwikkeling van klachten en claims', 4 *Tijdschrift voor Klachtrecht* 10 (2023);

plaints law, which is primarily aimed at resolving the complaint, learning and empowering patients to claim their rights.[5] Therefore, it focuses less on passing judgment. If a complaint cannot satisfactorily be solved internally, patients are given the option to file their complaint with a medical dispute committee. It is mandatory for health care providers in the Netherlands to be affiliated with such a dispute committee since 2017.[6] Dispute committees serve as independent appeals procedures that provide independent and binding verdicts, without the need for patients to go to court (see also Box 1). Each verdict can potentially be combined with a granted claim up to 25,000 euro.[7] This mandatory yet scarcely researched process is the focus of this article, particularly as regards the role of the defending party.

Box 1

**Medical dispute committees in the Netherlands**

- Currently 41 nationally-based medical dispute committees
- Specific to a health care domain, for example hospital care or dental care
- Governed by the Dutch Quality, Complaints, and Disputes in Health Care Act and dispute committee-specific guidelines
- Complainant files complaint against the defendant
- Committee usually consists of three to five members
- President usually has a legal background, other members have relevant medical backgrounds or are representatives of patient organisations.
- No mandatory representation by a lawyer
- Complainant pays a fee (50-150 euros)
- Process: a written complaint (filed online) → a written statement of defense → a live hearing → a verdict within six months (article 22 Wkkgz)
- A complaint is considered well-founded, partially well-founded, or unfounded (out of 424 finalized complaints in 2019: 23 were well-found, 114 partially well-founded, a little over 100 cases were resolved outside of the proceedings) (see R. Friele et al, *Evaluatie Wet kwaliteit, klachten en geschillen zorg* (2021)).
- Claims can be granted up to 25.000 euro

Dispute committees can formally be characterised as 'proactive, informal and less legal' approaches regarding complaints and claims in the health care domain compared to civil law procedures.[8] Legislative aims include to strengthen the client's position, to reason from their perspective and to address their needs. Dispute committee procedures are also meant to potentially offer restorative value between complainant and defendant, though they do not offer mediation.[9] A dispute committee procedure is therefore seemingly meant to be a hybrid procedure at the crossroads of complaints law and civil litigation.[10] However, when a complaint is filed with a dispute committee in the Netherlands, we believe the original complaint transforms in two important ways. First, the complaint no longer predominantly exists as an issue between the patient and the health care professional but becomes a dispute between the patient and the health care organisation. This means that the importance attached to interpersonal contact between patient and health care professional, in line with complaints law, is no longer a primary concern.[11] The 'defending' party from here on out is the health care organisation, which is represented by a legal counsel or a manager. Second, complaints law with its problem-solving focus no longer singularly governs the process. The Dutch Quality, Complaints and Disputes in Health Care Act (Wet Kwaliteit Klachten en Geschillen Zorg or Wkkgz) introduces elements of liability law because complainants can file a claim. Both changes make the situation at dispute committees of a more adversarial nature than the complaints process at the health care organisation that came before.

The more adversarial nature of dispute committees is reflected in the experiences of patients and their families. Patients and families who filed a complaint at a dispute committee report the predominance of a rather adversarial defendant.[12] Some patients and families experienced an unequal power relationship as regards both the dispute committee and the defendant.[13] The defendant came across as a highly educated and fierce opponent. Patients and families underlined that they experienced seemingly untouchable defendants, lawyers as experts, difficult legal language and different backgrounds in terms of social class.[14] In addition, many patients and families felt discontented: they did not feel



https://openindezorg.nl/.

5 B.S. Laarman and A.J. Akkermans, 'De afwikkeling van medische schade onder de Wkkgz', 3 *Tijdschrift voor Vergoeding Personenschade* 57 (2017).

6 R. Bouwman et al., *Tweede monitor Wkkgz: Stand van zaken patiëntenperspectief en implementatie "Effectieve en laagdrempelige klachten-en geschillenbehandeling"* (2019).

7 Art. 20 Dutch Quality, Complaints, and Disputes in Health Care Act or 'Wkkgz'.

8 A. Akkermans, 'Het geheel is meer dan de som der delen: Een algehele transformatie binnen de conflictoplossende functie van het rechtssysteem', in A. Akkermans et al. (eds.), *Het probleemoplossend vermogen van het rechtssysteem: Inleidingen op de Lustrumconferentie van het Netherlands Institute for Law & Governance* (2020).

9 Dijkstra, above n. 1, at 1; House of Representatives, 'Right of Complaint for Clients Health Care Act ('Wet klachtrecht cliënten zorgsector' or Wkcz)', *Parliamentary Paper 2009-2010*, 32402, 3, 174p; Upper House, 'Rules to Further the Quality of Health Care and the Handling of Complaints and Disputes in Health Care (Dutch Quality, Complaints, and Disputes in Health Care Act) – Letter of the Minister of Public Health, Well-Being and Sport', *Parliamentary Paper 2013-2014*, 32402, I, 59p.

10 Dijkstra, above n. 1, at 1.

11 Laarman, above n. 4, at 4; Art. 19 and 21 Wkkgz; https://openindezorg.nl/.

12 Dijkstra, above n. 1, at 1.

13 *Ibid*., at 1.

14 *Ibid.*



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heard and some felt no tangible improvements had been made as a result of the proceedings.[15]

Given the hybrid aims and proposed reality of dispute committee proceedings, there are several roles the defendant can adopt. By doing so, the defendant influences the way the procedure is experienced by patients and families. Defendants, as representatives of health care organisations, have a similar position to that of lawyers, particularly given the quasi-legal nature of the dispute committee proceedings. Therefore, scholarship regarding how lawyers could or even should act in their profession is relevant here. In this domain, Susan Daicoff has coined a multitude of 'vectors' around the legal profession as the 'comprehensive law movement'.[16] Vectors include, for example, therapeutic jurisprudence, restorative justice and creative problem-solving. They share a focus on the 'emotional, psychological and relational well-being of the individuals and communities' and a broader orientation than just legal responsibility and duty.[17] These vectors are focused more strongly on concepts such as restoration, experienced justice and recognition, among others.[18] Relatedly, lawyers could be characterised as adopting certain roles. These roles can be adversarial (the wolf), harmonising (the healer), morally responsible (the concierge), activist (the activist) or a combination thereof.[19] Questions are posed as to the position and responsibility of lawyers and whether they should be problem-solving, de-escalating and aware of the 'emotional undercurrent of the conflict'.[20] Given the hybrid nature of dispute committee proceedings, the present research aims to understand how defendants understand and fulfil their professional roles and how this could impact the dispute committee proceedings.

# 2 Methods

## 2.1 Aim, Design and Participants

This qualitative research is part of a larger study on the impact of new legislation regarding quality and complaints in health care.[21] Ethical approval was granted by the Tilburg Law School Ethics Review Board. For the study, researchers selected and approached eight dispute committees out of a total of 38, based on the number of cases they handled. Eventually, three dispute committees participated that are responsible for adjudicating the majority of medical disputes in the Netherlands: the Dutch Foundation for Consumer Complaints Board (including dispute committees in seventeen different health care sectors), the Foundation Complaints and Disputes for Primary Care and the Foundation Dispute Committee Oral Care.[22] Each dispute committee distributed information letters, including a topic list, to potential participants, approximately 400 in total (sent to both complainants *and* defendants). Privacy regulations prevented the researchers from making direct contact. Therefore, the selection was based on a convenience sample. Eligibility among complainants was determined based on age (at least 18 years old), a completed dispute settlement before 1 April 2018 and mental health (no cognitive impairment, dementia, psychotic symptoms). At least sixty nine participants registered to participate in the study, of whom fifty patients and family members and nineteen defendants. After researchers reached data saturation and no new themes emerged from the interviews, the data collection was stopped. One defendant withdrew from participation because of an unwillingness to sign informed consent. A separate study has been published regarding the complainants.[23]

## 2.2 Data Collection

The first author, together with two research interns (see Acknowledgements), conducted the interviews in the spring and summer of 2019. Researchers conducted face-to-face, in-depth, semi-structured interviews with eighteen defendants. Respondents had a variety of backgrounds, including law, management and health care. Researchers used the topic list and interview guide that were both informed by chapter III of the Wkkgz-legislation, its underlying goals and known scholarly work on experiences with earlier complaints procedures. The open questions focused on the process leading up to the complaint filed at the dispute committee, the defendant's expectations, the defendant's role and the experiences of the defendant with the proceedings and the verdict. The interviews lasted around 60 minutes each. They were recorded, pseudonymised and transcribed verbatim. Respondents signed informed consent prior to the interviews, and each participant received a resume of the interview for validation. Researchers made sure none of the respondents had a conflict of interest regarding the data collection. In three instances, interviews were conducted with several interviewees together.

## 2.3 Analysis

Following Braun and Clarke's six phases of analysis, one researcher (R.D.) conducted an inductive, data-driven, realist thematic analysis of the data using MaxQDA software.[24]

15 *Ibid.*; Friele et al., above n. 3, at 3.

16 S. Daicoff, 'Law as a Healing Profession: The Comprehensive Law Movement', 6 *Pepperdine Dispute Resolution Law Journal* 1 (2006a); S. Daicoff, 'The Comprehensive Law Movement: An Emerging Approach to Legal Problems', 49 *Scandinavian Studies in Law* 109 (2006b).

17 Daicoff (2006a), above n 16, at 16.

18 *Ibid.*, at 8.

19 D. De Wolff, *Het belang van een goede rechtsbedeling – Oratiereeks* (2018).

20 D. Allewijn, 'Naar een vredestichtendeadvocatuur', in A. Akkermans et al. (eds.), *Het probleemoplossend vermogen van het rechtssysteem: Inleidingen op de Lustrumconferentie van het Netherlands Institute for Law & Governance* (2020).

21 Friele et al., above n. 3, at 3.

22 Translated respectively from 'De Geschillencommissie Zorg', 'Stichting Klachten en Geschillen Eerstelijnszorg' and 'Stichting Geschilleninstantie Mondzorg'.

23 Dijkstra, above n. 1, at 1.

24 V. Braun and V. Clarke, 'Using Thematic Analysis in Psychology', 3 *Qualitative Research in Psychology* 77 (2006); V. Braun and V. Clarke, 'Thematic Analysis', in H. Cooper et al. (eds.), *APA Handbook of Research Methods in*



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*Psychology, Vol. 2. Research Designs: Quantitative, Qualitative, Neuropsychological, and Biological* 55-71 (2012).

*Table 1 Data analysis*

| Data extract → | Initial coding (phase two) → | Searching for themes (phase three) → | Reviewing themes (phase four) → | Final theme (phase five) |
|---|---|---|---|---|
| "But of course, after (the incident, red.) you try to solve it as best you can, and you do everything you can." (#5) | Trying to solve the situation as best you can. | You want the opportunity to restore the situation in a preliminary phase. | Responsibility to prevent proceedings at the dispute committee | Role: proactive dispute resolution and de-escalation |
| "While at the same time, if there is a complaint, I feel responsible to treat that complaint in a manner so that it is not filed at the dispute committee." (#14A) | Making sure a complaint does not need to be filed at the dispute committee. | A feeling of responsibility to prevent dispute committee proceedings. | | |
| | | | | |
| "We sometimes have a conversation […]. You want to prevent that it becomes such a trajectory (at the dispute committee, red.). That is the intention." (#1) | A conversation can sometimes help escalation to a dispute committee. | Attempts to have a conversation | | |
| "[…] you can quickly start a legal process, but that does not help most people. So then we first look whether we can restore the bond of trust." (#2) | A legal process is not beneficiary to most patients. | Attempts to find a solution at the health care facility | Trying to solve the incident internally | |
| | | | | |
| "So that's why you are searching for a solution, not to prevent that you might lose, but to make sure you can stay in the relationship (with the patient, red) […]." (#14A) | Making sure you can stay in the relationship with the patient. | Making sure the situation is stabilized. | Prevent escalation | |

For the first phase, the researcher (R.D.) informed herself of the data and then applied a first round of initial codes through open coding (second phase). Each interview was supplemented by a memo describing the main concepts that arose. During the third phase, the researcher (R.D.) grouped and split themes into overarching themes and sub-themes. Going back and forth between the themes and the data, the researcher (R.D.) reviewed all themes (fourth phase) and finalised them (fifth phase). During these phases, the other named authors (N.E., A.P., R.F.) assessed the themes and code tree and cross-checked them with the data for validation to ensure all relevant themes were flagged and included. The current article depicts the final themes (phase six). An example of the thematic analysis is shown in Table 1, and the article includes quotations to illustrate the analytical process. Some additional themes emerged from the data that were not initially targeted by the interview guide. These themes focused on how respondents viewed the dispute committee proceedings, their own position at the dispute committee proceedings, and their professional attitude. For example, roles that emerged ranged from problem-solving to a middle position to a more adversarial mindset. To report this study, researchers checked the article against Tong's thirty two-item checklist, which includes information on participant selection and data collection.[25]

# 3 Results

## 3.1 Respondents' Characteristics

Of the eighteen respondents for this study, three identified as male and fifteen identified as female. Respondents had different professional backgrounds. Their occupations can be grouped under hospital management (five), legal counsel (six), policy staff (three), support staff (two) and health care professionals (two). The participants were based in a variety of health care institutions, specifically hospitals (four), a nursing or care

25 A. Tong et al., 'Consolidated Criteria for Reporting Qualitative Research (COREQ): A 32-item Checklist for Interviews and Focus Groups', 19(6) *International Journal for the Quality of Health Care* 349 (2007).





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home (three), a mental health care institution (one), a home care organisation (one), a health care consortium (one), independent clinics with a multitude of locations (one), a rehabilitation centre (one) and independent (individual) practices (two). For an overview of the participants and their characteristics, see Table 2. One important finding was the fact that usually no health care professional attended the hearing at the dispute committee. They were rather represented by a non-medical professional from the health care institution, barring two exceptions where the health care professional represented himself/herself. The defendants in the current study were from the internal legal, quality or management departments of the health care institution. Apparently, these defendants were a significant player in dispute committee proceedings. Also, they were sometimes assisted by lawyers from their insurance agency.

*Table 2 Demographics*

| Participant | Occupation | Organization | Gender |
|---|---|---|---|
| 1 | Manager Quality & Safety | Three independent clinics with a multitude of locations | Female |
| 2 | Senior legal counsel medical affairs | Hospital | Female |
| 3 | Legal advisor | Hospital | Female |
| 4 | Independent psychosocial therapist | Independent health care practitioner | Female |
| 5 | Legal counsel | Health care consortium for hospital care, home care, and elderly care | Female |
| 6 | Legal manager | Hospital | Male |
| 7 | Legal counsel | Hospital | Female |
| 8 | Legal advisor | Mental health care organization | Female |
| 9A and B | Executive secretary<br>Director | Home care organization | Female<br>Female |
| 10 | Director | Nursing home | Female |
| 11 | Independent health care professional | Independent health care professional in mental health care | Female |
| 12A, B, C | Policy officer complaints procedure<br>Director<br>Policy officer | Rehabilitation center | Female<br>Male<br>Female |
| 13 | Secretary of the board of directors | Care home | Male |
| 14A and B | Director<br>Counsel to the Executive Board | Care home | Female<br>Female |

## 3.2 Views from Defendants on the Concept of Dispute Committee Proceedings

The respondents reflected on the dispute committee proceedings as a whole. First, they showed a general reluctance to embark on the dispute committee process and an eagerness to resolve the complaint before it escalated and was filed at the dispute committee. Second, respondents valued the potential impact of complaints to inform learning at the health care institution.

### *3.2.1 Preference for Internal Solutions and De-escalation*

When asked about when and how the dispute committee should come into play, respondents revealed that they were reluctant to get involved with a dispute committee procedure. They preferred a complaint to be dealt with and solved internally at the health care institution as early as possible (#1, 2, 3, 4, 5, 6, 7, 9AB, 12ABC, 14AB). Internal processes included complaints officers, personal phone calls to de-escalate or restore trust, small gestures such as flowers, mediating conversations and general attention for what a particular patient wanted or needed (#1, 2, 5, 6, 9AB, 12ABC, 14AB). As a policy officer considered: '*This really is about having a conversation, searching for solutions…*' (#12A). A legal counsel mentioned a similar mindset in the course of dispute committee proceedings. He aspired to always approach situations with a constructive, problem-solving mindset, not a legal mindset (#6). A legal approach could sometimes be effective in shutting a complaint down, but this '*easy road*' would not always be the best (#6). Similarly, one manager aimed to monitor situations that gave her the feeling '*this is not going into the right direction'* and tried to act or contact the patient and families



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before they filed an official complaint (#1). Another respondent, a legal counsel, referred to the hospital's complaints officer as a complaint '*mediator*' (#7). Two respondents considered that it was their responsibility or ambition to let the patient understand why they did or did not do certain things (#7, 12B). Reasons for an internal solution included the restoration of trust (#2) and the strain follow up procedures would put on the health care professional (#3). Furthermore, one manager argued that solving the situation yourself is also cheaper (#1). One legal counsel highlighted that '*it is not in the best interest of the organisation to never offer any compensation'*, but rather to ask the question '*…are you doing justice to what occurred…'* (#5).

One manager considered a dispute committee procedure to be an escalation in itself: '*…we are very active to prevent that we escalate to a dispute committee or our liability insurer…'* (#1). She tried to de-escalate by contacting the patient or family, having a conversation and sometimes offering a small gesture such as flowers. One of the health care professionals (#11) also mentioned that if it came to a dispute committee, '*then it is already too late'* for reconciliation. As one legal counsel summarised the need for an internal solution and improvements: '*That is where it starts, a good first responder. Knowing what the problem is. Involving the physician at the right time. A good conversation. Really hearing people. And making serious changes based on it.'* (#6).

#### *3.2.2 The Importance of Learning*

Several respondents mentioned the importance of learning from the complaints (#4, 6, 9AB, 10, 12ABC, 13). As one director contemplated: '*…each complaint … is a chance to improve your processes'* (#12B). Respondents made overviews of the received complaints (#9AB) or extracted '*points of improvement'* from the dispute committee verdicts (#10) to make them internally known to fuel potential changes. However, one secretary to the board of directors considered that the defendant is not obligated to inform the dispute committee of the ways improvements will be made (#12A). Nevertheless, they had implemented an '*improvement cycle'* based on verdicts that declared the complaints both founded and unfounded (#12A). Similarly, one of the health care professionals considered it vital to reflect on your own acts if something had gone wrong and to ask yourself the question '*What should I have done differently?'* (#4).

### 3.3 Views from Defendants on Their Roles and How They Fulfilled Them

Respondents then reflected on their participation in dispute committee proceedings and on how they viewed and fulfilled their own role. First, some respondents disputed whether the procedure was really helping people. However, they respected that once the complaint was filed by the patient or family, they could do nothing else but abide by their wishes and continue with the dispute committee proceedings. Second, once the procedure had started, respondents reflected on their position as representatives of the health care professional or organisation and considered their role. Several respondents felt pressured into a defensive role and expressed notions of a middle position between patient and health care professional. Finally, respondents observed that professional behaviour was expected from them, which felt unequal at times vis-à-vis the complainant, and some but not all endured emotional impact due to the proceedings. The previous elements are discussed below.

#### *3.3.1 The Procedure as Being Helpful for Participants*

Some respondents wondered whether dispute committee proceedings did most justice to the patients. They argued that, what they felt was taking the emotion out of it, would not be helpful and doubted whether the procedure as a whole would be helpful because it would put a strain on patients (#1, 12A, 14). For example, '*It is founded or unfounded. What good does that really do for the complainant?'* (#12A). Respondents underlined their awareness of the personal drama that the health care incidents signified for the patients and families involved (#3, 6, 7, 9AB, 10, 13). Several respondents considered it important to prevent the impression of conflict and make the patient feel safe or to safeguard the relationship (#2, 14AB). Respondents reported that almost all previous complaints at dispute committees had been declared unfounded (#1, 3) and that they could often already foresee the verdict declaring the complaint unfounded (#1, 3, 5, 8, 12ABC). One manager wondered if, when a verdict is so clear in advance, '*should we put patients through it?'* (#1). Relatedly, several respondents considered that the threshold to file a complaint should be higher (#1, 2, 3, 9AB, 10, 12ABC), for example by adding a financial barrier (#2).

In addition, respondents were sensitive to the formal set-up of the proceedings and their potential to be intimidating (#1, 2, 5, 7, 14AB). As a manager indicated: 'I have gotten used to it, but I can imagine it to be quite intimidating for a patient' (#1). One counsel to the Executive Board reflected that by establishing a dispute committee,

> you are trying to make something less legalistic. But in practice and how it plays out it is an extremely legal instrument' and 'that something that is meant to prevent you from having to go to a judge, eventually itself turns into a judge'. (#14B)

However, one legal counsel emphasised that she experienced the dispute committee hearing as less formal than a disciplinary hearing (#2) and other respondents considered the patient specifically capable of filing the complaint without the need for a lawyer (#3, 9AB).

#### *3.3.2 Supporting the Health Care Organisation and Professional*

Several respondents underlined that they represented the health care organisation (#6, 8, 9AB) or felt they had to take a stand if they felt the hospital did the right thing, out of professional responsibility or principle (#1, 2, 4, 5, 6, 7, 9AB, 10). For example, one legal counsel (#2) considered, '*If I think that we as a hospital have done the*




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*right thing, then that is eventually my stance'*. Another legal counsel also wanted a diligent verdict and proper questions by the dispute committee to offer a fair trial to the health care professionals involved and to prevent the '*undermining'* of the '*legal position of hospitals, in this case my hospital…'* (#6).

Respondents also repeatedly indicated their role as support for the health care professional (#3, 5, 7, 8, 9AB, 10, 12ABC, 14AB). As one director said,

> it is our job to support them. And to show them that you are there for them, and that you are critical and ask the right questions. (#14A)

Respondents mentioned that they took over the process from the health care professional if a complaint was filed at the dispute committee. They prepared for the hearing individually and only consulted the health care professional on what happened (#2, 3, 7). One legal counsel felt like the health care professionals perceived him as their '*leader in the legal procedure'* (#6). In another case, one legal counsel merely assisted health care professionals in drafting the documents (#5).
With regard to attending the hearing, one legal counsel mentioned he did not feel the health care professional should attend. He felt the (evident) verdict did not warrant this, and attending would put a strain on the health care professional's workday (#6). In a similar vein, two other respondents felt hesitant to involve the health care professional *again* at the dispute committee after the internal proceedings because he had finally left it behind him (#9AB).

#### *3.3.3 Resisting the Pressure towards Taking a Defensive Position*

Importantly, some of the – same – respondents felt that it was difficult how they were pushed into a defensive position (#7, 8, 9AB, 10, 13, 14AB). They were pushed into a sort of formal '*polemic'* using sharp insights (#13) or '*pushed into the procedure'* (#6). As illustrated by a director:

> You are, by definition, placed in the defense position. And that is unpleasant. That is unpleasant. Especially if you feel: we did not do anything wrong. In fact, I think we provided high quality health care. (#10)

As two respondents recalled, in light of their initial expectation that there would be room for dialogue: '*You are meant to come up with a strong defense, because that's what the verdict eventually will be based on'* (#9AB). One secretary of the board of directors recalled that they formulated a very formal and clean response to oftentimes a rather emotionally articulated complaint regarding psychiatric health care (#13).
Several respondents, despite their conviction of representing and defending the health care organisation or professional, also considered their position to be in the middle between patient and health care professional (#1, 6). For example, one legal counsel described himself as a '*juncture'* (#6) and a manager considered: '*I try to keep an independent outlook, and function as the link between the patient and the physician.'* (#1) This meant that she, being part of the health care institution, did not feel it was in their best interest if the health care professional was simply exonerated. Instead, each patient and his or her complaint should be supported. One legal counsel also clarified that '*my hospital'* included '*my patients'* and that those patients should be supported after a health care incident (#6). He emphasised the importance of a fair trial instead of support for a legally untouchable or immune health care institution (#6). One director also emphasised that you should not '*crush'* patients or their families just because you, as a professional, '*accidentally had a higher education'* (#12B). In addition, a legal adviser highlighted that they, as a health care organisation, were not against but rather in favour of patients. They knew the personal and medical context of each patient and family, as opposed to the dispute committee, which made things even more relatable (#8). One difficulty regarding the middle position was highlighted by a legal counsel, namely being the confidant for health care professionals as well as patients, while being relied upon to make an internal legal decision (#2). Both patients and health care professionals would reach out to her with their thoughts and doubts.

#### *3.3.4 Professional Role and Emotional Impact*

When reflecting on their position and how they fulfilled it, several respondents mentioned the difficulty of having to maintain their professional role and attitude. They mentioned that to a certain extent patients and their families had the freedom to act in any way they wanted. They could be emotional, inappropriate or unreasonable (#3, 9AB, 14AB). In contrast, the respondents were expected to be professional, they could not communicate as freely, which did not always feel balanced (#3, 9AB, 14AB). As a professional, you would need to be able to '*take a hit'* in terms of unpleasant accusations at the hearing (#7), and the committee would expect that you would rise above the situation (#3, 14AB). As one legal adviser illustrated:

> before a hearing you say hello and shake hands with everyone present. And then the patient refuses to shake hands with the physician. Well, then everyone says 'it's emotional, that can happen'. But only imagine if this were to happen the other way around, that a physician would say: 'I already have three complaints from you and I cannot sleep because of it, and I do not want to shake your hand'. That would be unthinkable because, of course, a physician must be professional. (#3)

Within their professional capacity, several respondents did not feel a negative impact from the dispute committee proceedings, for example, in terms of emotions (#1, 3, 5, 9AB, 12). This lack of impact was because it was not personal (#1) or because the respondents were at a distance from it both professionally and practically, and were not part of the situation causing the complaint (#3,



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5). Even though most respondents were not personally involved, two legal counsels and one policy officer did experience emotional consequences, such as a feeling of failure or not being good at your job (#2, 7, 12A). As one legal counsel pointed out,

> then I can feel like such a failure. I did not do this right. And that makes it difficult. If I was invested in this procedure purely legally, then it would be easier. But it's the reality that I try to find solutions. (#2)

Others, a director and a health care professional, felt anxious during the procedure and relief once they heard the complaints was unfounded (#10, 11). One legal counsel considered it valuable to experience what it felt like to be the accused party (#7). In addition, some respondents felt unprepared and unexperienced at dispute committee proceedings, when they had not involved a lawyer or a health care professional (#7, 9AB, 10).

# 4 Discussion

This research aims to understand how defendants understand and fulfil their professional roles and how this could impact dispute committee proceedings. The respondents in this study showed reluctance to participate in dispute committee proceedings and a preference for early, internal solutions. They also saw the learning potential of complaints for health care organisations, though some questioned how the process of dispute committee proceedings could help its complainants. Once the procedure had started, respondents highlighted their professional position as a representative and supporter of the health care professional and health care organisation. Some felt pressured into this – defensive – position. Respondents also underlined the unwritten expectation that they would behave professionally, even though they sometimes experienced emotional impact.



## 4.1 The Transformation of the Complaint: Understanding the Professional Role

After a complaint is filed with a dispute committee, it transforms from an interpersonal complaint to a dispute between the patient and the health care organisation. This transformation in itself clarifies to a certain extent the distance felt between complainant and defendant and a feeling of not being heard: the original health care professional did not have an active role anymore. In addition, the fact that defendants were predominantly from the legal department or management department could also explain the perceived existence of an 'untouchable' defendant that had legal knowledge and expertise and seemed to come from a different social background. The defendant is the professional who deals with the dispute to the best of his or her professional ability.

However, respondents seemed to be aware of the pitfalls and vulnerabilities of current dispute committee proceedings. They questioned the value of dispute committee proceedings for patients and families. Some respondents questioned whether, by taking the emotion out of it, it would still be advantageous for patients and families to have their cases adjudicated by dispute committees. This was informed especially by their awareness of the personal dramas the health care incidents had caused versus the formal set-up of the dispute committee proceedings. In addition, most respondents in this study did not seem to have strong adversarial mindsets. Respondents did not aim to win at any cost but rather showed a certain drive to avoid conflict, to safeguard the relationship, and to learn from complaints. It is noteworthy that both defendants and patients reported that they missed the opportunity for dialogue.[26]

Apparently, the way many respondents viewed the proceedings at dispute committees is more nuanced than simply defending health care organisations. However, as professionals, respondents highlighted their commitment to defend and represent health care professionals and health care organisations. Respondents respected that once complaints were filed, they had no choice but to participate in the dispute committee proceedings as defendants. Therefore, they would need to simply 'get on with it' despite existing doubts. Some, however, felt they were pushed into a defensive position by how the procedure was structured. Therefore, the way respondents had to act did not always match how they wanted or thought they should act.

## 4.2 Lawyers as Wolves, Healers or Concierges: Impact on Dispute Committee Proceedings

Hence, respondents in this study showed hybrid ideas about their roles. They balanced their professional responsibility in terms of representing and defending health care organisations and health care professionals with a felt preference towards problem-solving and de-escalation. However, the adversarial set-up of dispute committee proceedings did not necessarily allow for such flexibility in role-apprehension. To a certain extent, the dispute committee proceedings pressured the respondents to adopt the most adversarial role. Nevertheless, respondents still managed to apply some nuance to their roles and fit De Wolff's description and ideal-typical traits of a wolf, a concierge, and a healer though they could never be characterised as such in full.[27] The role of activist does not seem applicable to this data.

Some respondents expressed their felt professional responsibilities to support and to defend health care professionals. This aligns with the traits of biased 'wolf' lawyers, who one-sidedly serve the best interests of their clients within the parameters of the law.[28] Being a wolf relates mostly to the adversarial layout of court

26 Dijkstra, above n. 1, at 1.
27 *Ibid.*, at 19.
28 *Ibid.*


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proceedings, or the 'tournament model'.[29] However, respondents oftentimes showed a more nuanced pallet of role-apprehension. Some respondents questioned whether the procedure would really help patients and their families and underlined their awareness of the personal dramas that the health care incidents caused. They may even have felt a certain responsibility towards the well-being of patients and their families, which connects to the trait of a moral compass guiding the concierge.[30] As a concierge, you feel a responsibility for not making things worse (something 'lawful' can also be 'awful') and for safeguarding a well-functioning legal system.[31] Therefore, the focus on learning from the complaints by some respondents is also a trait associated with the concierge.

At the same time, the preference of respondents for internal and swift conflict resolution and a dislike by some respondents of being forced into a defensive position are characteristic for a healer. The healer or connector wants to provide a sustainable solution and to protect relationships.[32] However, a factor that could also be at play here, would be organisational pressure to keep complaints and disputes in house to prevent public apologies and reputational damage. Indeed, respondents in these situations would prefer sustainable solutions, but motives for doing so could be more self-serving or aimed at safeguarding institutional interests. Some respondents also underlined their positions in the middle between patient and health care professional, which shows their position as healers. Some respondents did not enjoy how they had to behave professionally and rise above the situation, and some respondents experienced emotional impact. These experiences do not specifically link to one of the four ideal-typical roles, but seem to fit best with the defendant as a healer, who is himself also human and has limits.

The nuance in the role-apprehension of the respondents shows that at least some of the respondents wanted to be more sensitive and responsive to the situation at hand. Their proclivity towards a more healing or morally just system could inform how they act as participants at dispute committees. Within the health care domain, a more hybrid perception towards a role as a lawyer or defendant could be welcomed, especially given the unique and vulnerable position of patients and families. Particularly for legal professionals, such a broader understanding of the legal profession and the value of an inclusive culture at law schools have been discussed.[33] It is argued in a USA-based study that law schools should combine traditional legal education with a thorough learning and practice of restorative theory and methods.[34] Such enrichment of the curricula would 'produce well-rounded attorneys'.[35] A broader view of a lawyer's skillset and potential also rings true for the defendants at dispute committees, particularly those with a legal background.

However, the adversarial set-up of dispute committee proceedings did not provide much room for respondents to be flexible about their roles. The process required the respondents to act a certain way and to follow certain rules, which complicated a more healing or restorative approach. This gives the impression that dispute committee proceedings, though different from civil litigation, indeed still offer a legal and adversarial arena. This corresponds to an earlier notion that dispute committees could be seen as a 'lighter version' of the tournament model.[36]

There is a willingness on the side of the defendants to learn and respond based on complaints, which should be nurtured. It remains to be seen how professionals at dispute committees would adopt and respond to a different build-up of the proceedings. Nevertheless, currently the hybrid nature of dispute committees causes certain challenges.[37] The adversarial claim-procedure comes from a different school of thought than the resolution of the dispute in line with proactive complaints law.[38] By introducing legal standards specific to claims, the procedure expects its participants to write and argue their case in line with these standards. This limits the potential for defendants to adopt an attitude more open to dialogue, restoration and learning. For patients and families, a responsive approach that meets the need of being heard is paramount. In addition, a collaborative learning approach with regards to the complaint – to make changes – is a key factor for well-functioning dispute committees. At this time, dispute committees do not have specific enforcement mechanisms in place to make sure every verdict is acted upon, apart from constructive recommendations in verdicts and compliance guarantee regulations.[39] Finally, given the importance that patients and families attach to the presence of the health care professional at the hearing, dispute committees might benefit from their mandatory presence as a way to be more responsive to the patients' needs.

### 4.3 Strengths and Limitations

The strengths of this study include a thorough and in-depth exploration of the role of professionals and how this corresponds with the experiences of patients and their families at dispute committees in the Netherlands. In addition, all authors did a validity check of the findings and validity was safeguarded by data saturation. Furthermore, the quasi-legal nature of the proceedings could inform similar processes internationally. For ex-

29 *Ibid.*
30 *Ibid.*
31 *Ibid.*
32 *Ibid.*
33 N. Holvast and W.J. Kortleven, 'De transformatie tot jurist: socialisatie en diversiteit in de rechtenstudie', 1 Ars Aequi 79 (2021); E. Mak, 'Het gezag van de juristen; een normatieve reflectie', in A. Berlee et al. (eds.), *De toekomst van de jurist, de jurist van de toekomst* (2020); N.S. Vedananda, 'Learning to Heal: Integrating Restorative Justice into Legal Education', 64(1) *New York Law School Law Review* 96 (2020).
34 Vedananda, above n. 33, at 33.
35 *Ibid.*, at 33.
36 *Ibid.*, at 20, footnote 30.
37 Dijkstra, above n. 1, at 1.
38 Laarman and Akkermans, above n. 5, at 5.
39 *Ibid.*, at 1.



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ample, it could inform how similar processes after health care incidents could be flexible and leave room for professionals to be responsive to its participants' needs.
A limitation of the study was the recruitment of respondents through convenience sampling because researchers could not directly approach respondents. The convenience sample, together with the varied and small sample of defendants, limits the generalisability of the results. However, the value of this research lies precisely in its in-depth exploration of the variety of defendants and their roles. Lastly, researchers considered there was a risk of socially desirable answers but countered this by asking respondents to make their ideas and motives explicit by giving examples.

## 5 Conclusions

Our main conclusion is that dispute committee proceedings can pressure defendants to reluctantly take up an adversarial, defending role. This is despite the defendants' eagerness to adopt a proactive, problem-solving mindset and the best intentions of the legislator to provide a less legal alternative to civil litigation. Defendants showed traits of lawyers as (reluctant) wolves, concierges and healers.[40] Their proclivity towards a more healing or morally just system could inform their involvement with dispute committees. However, they felt the process required them to take on a defensive role, sometimes forcibly so. The current process is built up to be quite coercive and unfortunately does not seem to foster much potential for restoration.
Offering a more flexible, responsive procedure to its participants by supporting a more problem-solving, healing role of defendants and a less formal set-up might connect better with the expectations of its participants and a sustainable outcome. The presence of health care professionals during hearings could be beneficial in this regard. Also, there is a willingness on the side of the defendants to learn from complaints, which should be nurtured.



40 *Ibid.*, at 19.


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