Modern Trends in Tort Law

Dutch and Japanese Law Compared

Edited by
Ewoud Hondius

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Preface

This volume contains the proceedings of a symposium on 'Modern trends in tort law', which took place at the University of Utrecht in August 1996. The main purpose of the symposium was to study a theme which is central to the development of the law in both Japan and the Netherlands, and thereby to strengthen existing links and establish new contacts between Dutch and Japanese academic lawyers.

The symposium was a sequel to an earlier symposium held in Tokyo in 1992, upon the initiative of Professors R. Hirano (University of Tokyo) and A.A.G. Peters (University of Utrecht). The proceedings of this symposium have been published by the Netherlands-Japan Institute and the University of Tokyo.

The present symposium was held in memory of Professor Peters, who passed away in 1994. The symposium consisted of two parts: one for invitees only and one which was open to the public. The session for invitees was centred on tort law, with discussions on medical liability (including euthanasia), traffic liability, product liability and environmental liability. A list of participants is included.

The open session consisted of public lectures by Professors R. Hirano and Y. Nomi from Japan and Professor E.H. Hondius and Advocate-General – as he then was – T. Koopmans from the Netherlands.

The symposium was made possible by subsidies from the Japan-Netherlands Foundation, the Koninklijke Nederlandse Akademie van Wetenschappen, the Nederlandse Vereniging voor Rechtsvergelijking, the Nederlands Wetenschappelijk Onderzoek foundation, Utrecht University and the Departments of Administrative and Constitutional Law, Criminal Law and Private Law and the Nederlands Instituut voor Sociaal-Economisch Recht of the Utrecht Faculty of Law.

It was organised by Professors P.J.J. van Buuren, E.H. Hondius and C. Kelk, along with Ms F. van Hout, Ms M. Sevenheck, and Ms W. Vreekamp-Douwes. Assistance was given by Mr. G.J.J. Heerma van Voss, Ms E.J. 't Hoenderdaal and Mr. W.A. Visser 't Hooft. Ms M. Peters-Sekino acted as interpreter.

On the Japanese side, Professors R. Hirano, Y. Nomi and T. Tsuchimoto served as the joint organisers. In Japan Dr. W.J. Remmelink of the Netherlands-Japan Institute provided us with his invaluable assistance.

Finally, Ms M. Janssens, Ms M. Steine, Ms C. Groenestein and Mr P. Morris helped to get the papers into good English and into print.

A third symposium in Japan is envisaged in 2000. A committee consisting of Professors R. Hirano, H. Hirose, Y. Nomi, Rokumoto and T. Tsuchimoto from Japan and Professors P.J.J. van Buuren, E.H. Hondius, C. Kelk, T. Koopmans and J.H. Nieuwenhuis has been charged with the preparation.

It is to be hoped that the publication of the proceedings of the symposium will contribute to a better understanding between Europe and Japan.

E.H. Hondius

Table of Contents

Medical Liability in Dutch Law

E.H. Hondius

1 Introduction

In recent years, the number of reported cases of medical liability has increased rapidly in the Netherlands.[1] This has raised fears that soon liability will no longer be insurable[2] and that the costs of health care will grow beyond what society is willing to pay. On the other hand, it has also been pointed out that until recently, the number of reported cases in the Netherlands has consistently been extremely low[3] and that even now many cases are not taken to court because this is too expensive or too cumbersome for the patients concerned. This paper aims at striking a balance between the two conflicting views.

In order to do so, section 2 will first describe the recent Act on Medical Services. Even though this Act, with some exceptions, does not contain provisions on liability, it is very relevant for our subject for two reasons. First, it lays down a number of patients' rights, the infringement of which may lead to medical liability. Secondly, the publicity surrounding its enactment has contributed to making both patients and doctors more claim-conscious.

Most liability questions are still governed by the General Part of the present Civil Code, which entered into force in 1992. These questions will be dealt with in section 3. Once liability has been established, a number of questions concerning the amount of damages remains to be settled, as will be set out in section 4. Many liability cases could have been prevented if patients' grievances had been handled in a better way. More in general, litigation usually is so expensive and unfriendly, that alternatives such

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1 A.T. Bolt, J. Spier, 'De uitdijende reikwijdte van de aansprakelijkheid uit onrechtmatige daad', *Handelingen Nederlandse Juristen-Vereniging* (1996), 19-22.

2 The number of insurance companies willing to insure medical liability in the Netherlands has dropped from 20 to three in twelve years. The companies no longer take on the risk themselves, but rather serve as administrators for insurance mutuals – Bolt/Spier, *op.cit.* See also J. Spier, O.A. Haazen, *Aansprakelijkheidsverzekeringen op claims made-grondslag* 1996.

3 In the first edition of her *Beroepsfouten* (Zwolle 1976), I.P. Michiels van Kessenich-Hoogendam refers to the fact that over the century preceding the publication of her book only 20 medical liability cases have been reported.

E. Hondius (ed.) Modern Trends in Tort Law, 1-25.

as arbitration and an insurance scheme will briefly be considered in section 5. In section 6, some conclusions will be drawn from this survey.

It will be clear that within the ambit of this report, specific problems such as those relating to medical experiments, HIV contamination of blood, minors and incompetents, etc. can unfortunately not be dealt with. Likewise, the number of comparative law and European law[4] references must be limited.

This paper will set out some cases in order to enliven the discussion. Some cases have been reported, others are unreported cases which have been dealt with by a large insurance company.[5] In the latter cases, for privacy reasons all personal details have been replaced.

Although some references will be given in the paper, a fuller account of the rich literature on the subject is given in Appendix 1.

2 The 1994 Act on Medical Services

This Paragraph will set out in some detail the Act on Medical Services. In 1995, the Act introduced articles 7:446–468 into the Civil Code. First, I will try to demonstrate that the Act is of some interest to an international audience (section 2.1). I shall then try to sketch the history of the patients' right in the Netherlands (section 2.2). Finally, I shall set out the scope of the Act (section 2.3), the rules on termination of the contract (section 2.4), on informed consent (section 2.5), on living wills and proxies (section 2.6) and on privacy (section 2.7).

An unofficial English translation of the Act is to be found in Appendix 2. There is also a German translation in existence.[6]

2.1 Interest of the Dutch Act

How should patients' rights be guaranteed? In the Netherlands, this has chiefly been the work of the legislature who has opted for the solution of laying down patients' rights in the Civil Code.[7] This development is different from that in most other

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4 It would be of interest to compare Dutch medical law with the *Draft Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine*, adopted by the Steering Committee on Bioethics of the Council of Europe, June 1996.

5 See my 'Geschillenbeslechting in de gezondheidszorg/De Commissie van Advies Medische Aansprakelijkheid', in: *Een A-typisch geval (Festschrift José M. Berger-Bos)* (1994), 53–59.

6 F. Nieper, A.S. Westerdijk (Eds.), *Niederländisches Bürgerliches Gesetzbuch*, Buch 6 Allgemeiner Teil des Schuldrechts, Bücher 7 und 7A Besondere Verträge (1995), 177–190.

7 E.H. Hondius, A. Hooft, 'The New Dutch Law on Medical Services', 43 *Netherlands International Law Review* 1–17 (1996); L.F. Markenstein, 'The Codification in the Netherlands of the Principal Rights of Patients: A Critical Review', 2 *European Journal of Health Law* (1995), 33–44.

countries, where the courts have had to do the work. The Dutch situation so far is rather unique in Europe; only Finland has a slightly comparable legislation.

The legislative action has been prepared by legal writing, which in medical matters is quite prolific and of high quality. The standards of health law are maintained by a law review,[8] a health law society,[9] an association of personal injury attorneys,[10] and a number of chairs in medical law at the universities.[11]

There is another reason to pay attention to the Dutch Act. This stems from recent European endeavours to realise a EU directive on services, as a corollary to the product liability directive. The draft directive on services in general has been dropped, and instead directives on – among other things – medical services are being considered. Dutch sources have expressed the hope that the Dutch Act may serve as an example for the EU draftsmen.

2.2 A Short History of Patients' Rights

In the Netherlands, the aims of the patients' rights movement were first set out in 1973 by Professor Jaap Rang in his inaugural lecture at Leiden University, entitled 'Patients' rights'. This led the government to ponder the question how to implement such rights. One possibility, to leave it to the medical profession itself, was rejected. Legislation seemed more appropriate. But what kind of legislation: should it be of an administrative nature, by requiring a licence allowing hospitals to practice only under certain conditions? Should it be criminal law, based on the idea that any medical treatment not consented to amounts to battery? Or should civil law prevail?

Once civil law had been opted for, another question arose: should the relation between doctor and patient be based on contract or on negligence? The government opted for a contractual approach. Most authors, although aware of the difficulties involved, agree. Their main argument is that the contract option is based on self-determination, which is considered to be of fundamental importance in the relation between doctor and patient. But it has to be admitted that the contract model does have some disadvantages.[12]

First, contract presupposes a capacity to consent, a capacity that is not necessarily present in *e.g.* psychiatric patients and even absent in comatose patients. Secondly, the contracting party and the patient are not always one and the same person. Children and persons subjected to examination by a medical examiner are two groups where the qualities are usually spread over different persons. Thirdly, a contract usually embodies rights and obligations of both parties. Instead, the medical services contract seems a

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8 *Tijdschrift voor Gezondheidsrecht* 1976– (Editor-in-Chief H.J.J. Leenen).

9 *Vereniging voor Gezondheidsrecht* (President: H.D.C. Roscam Abbing).

10 *Vereniging van Letselschade Advocaten* LSA (President: H.Th. Bouma).

11 Amsterdam (J.K.M. Gevers), Leiden (B. Sluyters), Maastricht (F.C.B. van Wijmen), Nijmegen (J.H. Hubben), Rotterdam (J. Legemaate), Utrecht (H.D.C. Roscam Abbing).

12 See P. Allen, 'Contracts in the National Health Service Internal Market', 58 *Modern Law Review* (1995), 321–342.

very one-sided affair, with only two obligations on the side of the patient, one of which – the obligation to provide the physician with the necessary information and cooperation – can hardly qualify as an obligation, but rather as an '*Obliegenheit*'.

Yet the contract option has the major advantage that a contract is based on party autonomy. This is a natural habitat for such patients' rights as the right to information, to consent and to access to medical records. The disadvantages set out above have partly been met by the Act. Psychiatric patients and minors who cannot formulate their will properly are to be represented under article 7:465. Article 7:464 declares the medical services act of equal applicability for those situations in which the patient is examined by a medical examiner.

2.3 Scope of the Act

The act not only applies to the activities of physicians in relation to their patients, but applies to all contracts whereby a health care provider undertakes to provide medical treatment. The health care provider can either be a natural or a legal person, *e.g.* a hospital. This implies that the patient sometimes has two contracts; one with the hospital for nursing and care and one with the physician for examination and treatment. This is different if the physician is employed by the hospital. The fact that the hospital is seen as a health care provider, however, does not mean that it can interfere with the fiduciary relationship between doctor and patient. Medical treatment includes the treatment of dentists, midwives and so-called related nursing. Activities of pharmacists are excluded.

As the reason for the introduction of the act is to protect the patient, abrogation of the patient's rights to his detriment is not allowed under article 7:478.

2.4 Formation and Termination of the Contract

The formation of a medical services contract does not in itself raise any specific issues. Once a relationship has been entered into, a physician no longer has the right to terminate this relationship. Only when he has 'important reasons' is he entitled to do so, according to article 7:460. Having an affair with the patient and emigration of the patient are two such circumstances which are mentioned in the explanatory report.

Quite a different question is whether or not a patient is entitled to specific costly treatment such as surgery. This is a budgetary question which, like in other countries, has led much political controversy. Unlike the situation elsewhere, Dutch courts occasionally have ordered hospitals to give a plaintiff a specific treatment,[13] although usually this will be denied.[14]

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13 Court of Appeal 's-Hertogenbosch 2 July 1990, *NJ* (1990), 809.

14 For instance Court of Appeal The Hague 7 March 1991, *Tijdschrift voor Gezondheidsrecht* (1991), 394.

2.5 *Informed Consent*

Under Dutch law, physicians are now obliged to inform the patient clearly and, if requested, in writing, about the proposed examination and treatment and about the developments concerning the examination, the treatment and the condition of the patient's health. Dutch law in this regard is now moving in the direction of German law, which had developed the right of informed consent earlier.[15] English law, on the other hand, has been reluctant to accept this American doctrine.[16]

The right to be informed is not unlimited. Paragraph 3 of article 7:448 provides for a therapeutical exception.

It is remarkable that the patient not only has a right to be informed, but, under article 7:449, has a right not to be informed as well. If the dangers of not being informed, for the patient himself or for others, outweigh the benefits, information shall, however, be provided.

The Act does not provide a right to be informed for the patient's proxies.

Under article 7:450 physicians need prior consent for any act emanating from a medical services contract. For patients who are not competent, the Act assigns this authority to others. Minors who are not competent are represented by their parents. Though several authors have expressed their aversion against family members acting as proxies for a patient,[17] article 7:465 paragraph 3 appoints the spouse or the partner as proxy for the incompetent adult. In the absence of such persons, other family members will be appointed. This is only different if the patient has made a living will or appointed a proxy himself.

The proxy will take all decisions concerning the health care of the patient. According to article 7:465 paragraph 4, the health care provider does not have to comply with the proxy's decisions insofar as they are incompatible with the level of care which a conscientious care provider has to provide.

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15 C.C.M. Nadorp-van der Borg, 'Het recht van de patiënt op informatie in het Duitse civiele recht. Een voorbeeld?', *Tijdschrift voor Gezondheidsrecht* (1995), 1–13.

16 *Hills* v. *Potter* [1984] 1 *WLR* 641. See also *Sidaway* v. *Board of Governors of Bethlem Royal Hospital and the Maudsley Hospital* [1985] *AC* 87, [1985] 1 *All ER* 643, [1985] 2 *WLR* 480. S.A.M. McLean, 'Litigating Disputes in Consent to Medical Treatment: The United Kingdom Position', in: S.A.M. McLean (Ed.), *Compensation for Damage/An International Perspective* (1993), 35, at 42 sees some openings in this case for a development towards informed consent.

17 See H.J.J. Leenen, *Handboek Gezondheidsrecht, Rechten van mensen in de gezondheidszorg* (1988), 178–181; J.K.M. Gevers, 'De onbekwame meerderjarige patiënt', *Nederlands tijdschrift voor Geneeskunde* (1987), 2094 (*contra*) and E-B van Veen, 'Plaats voor een onbenoemde wettelijk vertegenwoordiger van onbekwame patiënten?', *Tijdschrift voor Familie en Jeugdrecht* (1993), 6–10 (*pro*). See for the United Kingdom: P.D.G. Skegg, *Law, Ethics and Medicine, Studies in Medical Law* (1984), 72, 73.

2.6 Living Wills and Proxies[18]

Under the Act on Medical Services, a living will containing a refusal is recognised According to article 7:450 paragraph 3 the refusal has to be made in writing while the person is still competent. Furthermore, the living will has to contain the clear wishes of the patient. The health care provider is allowed to deviate from the living will when he has legitimate reasons.

Unlike in the United Kingdom, a patient can legally ask for euthanasia in his living will. The physician, however, wil not be allowed to practise euthanasia if the legal requirements have not been met.[19] He is never obliged to sumbit to the request.

Unlike in some other countries such as England,[20] the patient also has the possibility to appoint a proxy who will take all decisions concerning the health care of the incompetent patient. According to article 7:465 paragraph 3 this appointment has to be made in writing while the person is still competent. The health care provider does not have to comply with the proxy's decisions insofar as they are incompatible with the level of care which a conscientious care provider has to provide. It is generally accepted that the proxy cannot ask for euthanasia unless there is a clear request (for example expressed in writing) from the patient himself.[21]

2.7 Privacy

The Dutch Act lays down several patients' rights relating to their privacy. These rights apply to both physical privacy as well as to confidentiality concerning data.

Before setting out these rights, it should be observed that under article 7:454 a physician is allowed, and even required, to set up a medical record, which he shall preserve for at least ten years. Under article 7:455 the physician shall have to destroy the record at the patient's request, unless keeping the record is in the interest of another patient or required by statute. Unlike English law, the Dutch Act's article 7:456 allows patients an unlimited access to all medical records, unless another person's right to privacy might thereby be infringed. For providing copies, the doctor may claim reasonable costs.

The right of physical privacy implies that the physician carries out his activities outside the perception of others, although other persons whose professional assistance

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18 As to the present state of the law on euthanasia cf. the papers by Kelk and Tsuchimoto elsewhere in this volume.

19 E.Ph.R. Sutorius, D.J. Jansen, 'De juridische status van het levenstestament', *Ars Aequi* (1991), 994.

20 With regard to the problematic aspects of the appointment of a proxy in health care matters under English law, see: Working Party Report, *The Living Will, Consent to Treatment at the End of Life* (1988), 48–49.

21 H.J.J. Leenen, 'Incompetente meerderjarigen, vertegenwoordiging van de patiënt', *Tijdschrift voor Gezondheidsrecht* (1988), 229; J.K.M. Gevers, 'De onbekwame meerderjarige patiënt', *Nederlands Tijdschrift voor Geneeskunde* (1987), 2095.

is required are allowed to be present. Confidentiality concerning data implies that the physician will not supply data to persons other than the patient without his consent. Other professionals directly concerned with the treatment of the patient may receive necessary data as well.

The supply of data, however, may take place without the patient's consent if these data are required by law, *e.g.* in case of certain contagious diseases. Provision without consent may also take place for statistic or scientific research. Article 7:458 paragraph 1 then, however, requires that it is impossible to ask the patient for his consent. The health care provider has to make sure that the data will not lead to recognition of the patient.

3 Liability Questions

This paragraph will set out some questions relating to the physician's liability. It will start with the issue what standard of care may be expected (section 3.1). The paragraph will then turn to some liability issues dealt with in the General Part of the Dutch Law of Obligations: vicarious liability (section 3.2), liability for others (section 3.3), liability in case of non-compliance with the provisions on informed consent (section 3.4), proof (section 3.5), exemption clauses (section 3.6) and central liability (section 3.7).

3.1 Standard of Care

In the 1970s, Dutch authors were at odds with one another as to the standard of care to be applied to physicians. Should they exercise the customary care or good care? The distinction may not at once be clear, but this will become so when one realises that in some regions or hospitals the customary care may be inferior to the care which is considered good by the profession at large. Under article 7:453 of the Dutch Act, the physician shall apply the care of a conscientious physician and he shall act in accordance with the responsibility emanating from the professional standard. Before this test was enacted, it had already been accepted by the Dutch Supreme Court, the *Hoge Raad*, in *Speeckaert* v. *Gradener*.[22]

Article 7:453 does not seem to give physicians and courts much guidance as to what is a conscientious physician. One of the more specific provisions lays down that in principle the physician whom the patient has contracted with shall also perform the treatment. Here the model contract, which in advance of legislation has been drafted by the *Koninklijke Nederlandse Maatschappij voor Geneeskunst* (Royal Netherlands Medical Society, to be compared with organisations such as the British Medical Association) in cooperation with the *Landelijke Patiënten/Consumenten Platform*, a large patients'

22 *HR* 9 November 1990, *NJ* (1991), 26.

organisation, may provide some useful additions.[23] Thus under article 11, the physician shall use fit materials and means; according to article 12, one physician shall be appointed as the contact person in case more of them are concerned with the treatment. Under article 32 the physician shall appoint a capable and competent *locum tenens*. Article 36 entitles the patient to a second opinion and, on a different level, article 38 provides that the physician shall specify his bill.

Various questions may be raised concerning the standard of care.

Case 1 On 12 July 1989, 45-year old Ms Anneke de Vries is taken to the Erasmus Hospital in Utrecht for treatment of a tumor in her breast. It is unclear whether this is a malignant growth or not. Under anaesthesia, Ms De Vries is operated upon by the surgeon Dr Paul van Leeuwen. The growth is removed and the tissue is examined by the pathologist Dr Dorothea Brooke. The pathologist examines the tissue under low temperature (– 20 C) and concludes that the tissue is malignant. Thereupon, Dr Van Leeuwen removes most of the breast. Afterwards, upon closer examination of the tissue, by using a parafine test, it becomes clear that the tissue was not malignant and that the breast has been removed needlessly.

Ms De Vries sues Dr Van Leeuwen for damages. She claims the following:

1. The pathologist has made a mistake in the diagnosis, for which Dr Van Leeuwen is responsible.
2. Since the parafine test gives a clearer picture, this test should have been used instead of the freeze test.
3. Dr Van Leeuwen should have pointed out the risks involved in the freeze test.

Dr Van Leeuwen has the following defence:
a. As of 1989, there were two methods available to test a tissue. One method, chosen in this case, consisted of testing the tissue while the patient was under anaesthesia; in case the pathologist concluded the tissue to be malignant, the breast could be removed instantly under the same anaesthesia. The other method, generally not opted for by Dutch physicians, consisted of removing tissue, then ending the operation, using the parafine test, and then, if the test was negative (as it was in the large majority of cases), operating on the patient again, this time to remove the breast.
b. From American statistics it appears that the freeze test only gives an incorrect diagnosis in 1% of all cases.
c. Although outside the Netherlands it was generally advised to use the parafine test, the Dutch Association of Surgeons in 1989 advised its members to use the freeze test.

Of the various issues raised by this case, the one which is dealt with here involves Dr Van Leeuwen's defence that it is his professional organisation which has set the rules. Although in general this should be a valid defence, I submit that this is not always the case. When professional organisations in other countries have set higher standards, a professional exercising the care of a conscientious physician should follow the foreign example according

23 As to the legal nature of the model contract see C.J.J.M. Stolker, 'De nieuwe Wet geneeskundige behandelingsovereenkomst en het juridisch belang van de Modelregeling arts-patiënt', *Nederlands Tijdschrift voor Burgerlijk Recht* (1994), 115–119.

to article 7:453. Under English law, the application of the Bolam test would lead to a different result: 'in 1986 there was a respectable and responsible body of professional opinion who would not have warned in the circumstances with which this case is concerned'.[24]

3.2 Vicarious Liability

Physicians and hospitals are sometimes held liable for defective materials which are used in medical treatment or are implanted in patients.

Case 1 During an operation a catheter is used. The catheter breaks due to faulty material. As a consequence, a part of the catheter enters the patient's heart with permanent disability as a result.

Under Dutch law, it may be argued that the person who performed the operation is liable, either in contract or in negligence. This point of view has been contested on the basis of the Parliamentary Proceedings. The government indeed contends that if the producer of the defective material may be held liable, the physician should not be held liable. This view in my opinion – which is shared by other writers – is erroneous. It is quite possible to hold both the producer and the physician liable. In most cases the physician will then have recourse against the producer. The physician or the hospital is in a better position to exercise such recourse than the patient.

3.3 Liability for Others

A similar question is whether physicians may be held liable for the acts of other persons, once again either in contract or in tort.

Case 1 The case set out in section 3.1 provides an example of this kind of liability. May Dr Van Leeuwen be held liable for the faulty analysis by the pathologist Dr Brooke? (from the case it is not clear whether or not the pathologist was at fault; for the sake of argument, let us presume she was).

When the patient has not contracted with the pathologist independently, she may indeed hold the physician liable under article 6:76. This view is not shared by all writers and is considered malicious by most physicians, who are probably unaware of the possibility of recourse.

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24 (*Heath* v. *West Berkshire Health Authority* [1992] 3 *Med LR* 57, 59, 8 *BMLJ* 98, 101). This case-law has been criticised by J. Eekelaar, 'Consent to treatment: legal and empirical questions', in: R. Dingwall (Ed.), *Socio-legal Aspects of Medical Practice* (1989), 21, 24.

3.4 Informed Consent

So far, the malpractice cases dealt with had to do with faulty diagnosis or treatment, but what about an infringement of the new article on informed consent. Is there any civil liability?

> *Case 1* The case set out in section 3.1 once again may illustrate this issue. Even if the physician may not be blamed for the analysis, should he not have given his patient the choice between the two methods, or at least have mentioned the availability of the other method, with its drawbacks such as the need for a second anaesthesia in most cases?

Under the new Act, the answer should be in the affirmative, I would submit.

3.5 Proof

The new Act does not lay down any rules as to the burden of proof. The *Hoge Raad*, however, has developed a line which comes close to a reversal of the burden of proof: the health care provider shall give the patient the documents which will enable him to prove the care provider's fault.[25] This reversal of the burden of proof is even applied in the case dealt with in the previous paragraph, where the patient states that the physician has given him sufficient information.[26]

3.6 Exemption Clauses

Under article 7:463 a physician's or a hospital's liability may not be exempted or limited. It has been held that such general prohibition goes too far. If, for example, a famous soccer player is being treated, damages may be extremely high.[27] Under the present Code, only the court's discretionary power to limit damages in certain cases may be of help.[28]

3.7 Central Liability

With Dutch physicians exercising their profession either as independent professionals or as hospital employees, it has always been a major difficulty for patients to find out whom they have contracted with. The difficulty especially becomes apparent when a nurse has acted negligently. Who is the nurse's employer? Article 7:462 tries

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25 *Timmer* v. *Deutman*, *HR* 20 November 1987, *NJ* (1988), 500.

26 *Schepers* v. *De Bruijn*, *HR* 18 February 1994, *NJ* (1994), 368.

27 C.J.J.M. Stolker, *Aansprakelijkheid van de arts/in het bijzonder voor mislukte sterilisaties*, doctoral thesis Leiden (1988), 165–166.

28 B. Sluyters, 'De WGBO, onderdeel van het burgerlijk recht', *Tijdschrift voor Gezondheidsrecht* (1996), 1, 7.