The Dutch disciplinary system for health care:
an empirical study

Erik Hout
The study presented in this thesis was performed at the Institute for Research in Extramural Medicine (EMGO institute) at the department of Public and Occupational Health, of the VU University Medical Center (VUMC), Amsterdam, the Netherlands. The EMGO institute participates in the Netherlands School of Primary Care Research (CaRe), which was re-acknowledged in 2000 by the Royal Netherlands Academy of Arts and Sciences (KNAW).

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   *Risk and Safety in Medicine; in press (double publication)*

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Part I

General introduction
1.1 BACKGROUND

1.1.1 The disciplinary system: origin and essentials
In the Netherlands there has been a statutory disciplinary system for physicians, dentists and midwives since 1928, and for pharmacists since 1951. The aim of this system is to foster and monitor the quality of professional practice and to protect the general public against incompetence and carelessness. Any person who is directly involved can lodge a complaint; usually this is a patient or a member of the patient’s family. Moreover, the inspector for health care has the authority to make a complaint. In first instance the disciplinary proceedings are dealt with by five regional disciplinary boards. In deciding on their verdicts, the disciplinary boards take into account, among other things, the legal requirements, jurisprudence, professional codes and rules of conduct, professional-technical regulations, standards, guidelines and protocols, also collectively referred to as the professional standard. The members of the boards include not only legally qualified members, but also health professionals, generally from the same speciality as the accused.

The disciplinary boards can decide, for reasons relating to the public interest, to entirely or partially publish an anonymous verdict in the Netherlands Government Gazette (in Dutch: de Nederlandse Staatscourant) and offer for publication to journals or newspapers indicated by the disciplinary board. Unlike the Government Gazette, the journals and newspapers are not obliged to publish verdicts.

1.1.2 Changes in the disciplinary proceedings with the introduction of the IHCP Act
The disciplinary proceedings have been incorporated in the Individual Health Care Professions Act (IHCP Act; in Dutch: Wet BIG) since it was introduced at the end of 1997, before which it fell under the Medical Disciplinary Act (MD Act; in Dutch: Medische Tuchtwet). Over the years various complaints had been made about the MD Act, and among other things these focussed on the weak position of the complainant in the procedure, and the basically closed nature of the disciplinary proceedings. With the introduction of the IHCP Act the disciplinary proceedings have been amended in various ways in an attempt to alleviate these complaints.

By increasing the number of legally qualified members in the disciplinary boards, the intention was to strengthen the position of the complainant. Some people were of the opinion that the former composition of the boards, one legal qualified member and four health professionals, resulted in professionals protecting each other.

Since the introduction of the IHCP Act the disciplinary board meetings are, in principle, open to the public. The former closed situation made it impossible for the public to obtain adequate insight into the disciplinary procedures. The scope of the disciplinary proceedings have been extended to include four more professional groups, namely nurses, physiotherapists and health care psychologists and psychotherapists. Since the Netherlands is one of the few countries that differentiates between health care psychologists and psychotherapists and most articles are published in international bio-medical or scientific law journals, these professions will generally be combined in this thesis and referred to as health care psychologists. Moreover, there has also been a change in the disciplinary norms and appeal procedures, and the IHCP Act includes a regulation that makes it possible to
summon and question witnesses and experts. The arsenal of sanctions has also been increased and made more specific (Table 1).

1.1.3 Reasons for introducing a disciplinary system for four other professional groups

**Nurses**

There was a number of reasons for introducing a disciplinary system for nurses in the Netherlands. With regard to the care that is provided, the patient is extremely dependent on the nurse, who mainly has an autonomous function in the relationship with the patient. In the collaboration between nurses and physicians it was experienced as unfair that, when disciplinary offences that occurred within a team were assessed, certain members of the team were not subject to the disciplinary proceedings. The criminal law and the labour law offer little opportunity for monitoring the quality of care or protecting the patient. The introduction of a disciplinary system for members of the professional organizations only would not meet the requirements, because of the relatively limited professional organization of nurses. Finally, serious pleas from the nursing profession itself also contributed to the introduction of the disciplinary system.

**Physiotherapists and health care psychologists**

Just like nurses, one reason for the introduction of a disciplinary system for physiotherapists and health care psychologists was the high degree of dependence of the patient or client on the professional. Moreover, the patient or client is unable to assess the expertise of a physiotherapist or a health care psychologist. For health care psychologists another reason was the fact that there was no other effective corrective measure that could be applied to professionals who were not employed in mental health care institutions. In addition to the statutory disciplinary system, the Dutch Professional Association of Psychologists (DPAP; in Dutch: NIP) and the Royal Dutch Society for Physiotherapy (RDSP; in Dutch: KNGF) also have their own internal disciplinary system. Evaluation of the internal disciplinary system for the physiotherapy profession showed that almost half of the complaints could not be dealt with because the physiotherapists in question were not members of the RDSP. Moreover, the possible sanctions had insufficient impact, because expulsion as a member is the most severe disciplinary measure. The internal disciplinary system for psychologists does not only apply to health care psychologists, but also to other psychologists (such as occupational and organizational psychologists, vocational and career psychologists and child and youth psychologists) who are also members of this organization.

1.1.4 Evaluation of the IHCP Act

The evaluation of the IHCP Act enabled the research underlying this thesis. The IHCP Act stipulates that the Dutch Ministry of Health, Welfare and Sport presents both Houses of the States General with a report on the way in which the IHCP Act has been applied within five years after its introduction (1st December 2002). The Institute for Research in Extramural Medicine, Department of Public and Occupational Health of the VU University Medical Center in Amsterdam was commissioned to carry out this evaluation, in cooperation with the Health Law sections of the VU University, the University of Utrecht and the University
### Table 1
Differences between the Medical Disciplinary Act (MD Act) and the disciplinary proceedings of the Individual Health Care Professions Act (IHCP Act)

<table>
<thead>
<tr>
<th>Professions subject to the disciplinary system</th>
<th>MD Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>physicians, dentists, pharmacists and midwives</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authorized complainants</th>
<th>MD Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>a person who has a direct interest</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>the person for whom or the board of an institution for which the person about whom the complaint is being made works or with whom or with which he is registered for the provision of individual health care</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>the inspector for health care</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disciplinary norms</th>
<th>MD Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>undermining confidence in the position of fellow professionals</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>negligence resulting in serious damages</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>evidence of serious professional incompetence</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position of the complainant and the accused during the preliminary hearing and the trial</th>
<th>MD Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>during the preliminary hearing only the accused can be heard if an unfounded or non-eligible complaint is not concerned</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>during the preliminary hearing and the trial the accused can be represented by a counsel</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>the regional disciplinary boards are obliged to hold a preliminary hearing during which complainant and accused are given the opportunity to be heard; during this preliminary hearing an attempt may be made to reach an amicable settlement which implies that the complainant withdraws the complaint</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Composition of the disciplinary boards</th>
<th>MD Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>the medical disciplinary board consists of one legally qualified member and four health professional members</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>the regional disciplinary board consists of two legally qualified members and three health professional members</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Witnesses and experts</th>
<th>MD Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>the Chairman can summon and question witnesses and experts but their attendance is not always obligatory</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>the regional disciplinary boards can summon and question witnesses and experts and their attendance is obligatory. The complainant and the accused can also invite or summon witnesses and experts but their attendance is only obligatory when summoned</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public access to meetings and verdicts</th>
<th>MD Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>in principle no public access</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
<tr>
<td>in principle public access</td>
<td>doctors, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
<td></td>
</tr>
</tbody>
</table>
Table 1
Differences between the Medical Disciplinary Act (MD Act) and the disciplinary proceedings of the Individual Health Care Professions Act (IHCP Act)

<table>
<thead>
<tr>
<th></th>
<th><strong>MD Act</strong></th>
<th><strong>IHCP Act</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgency procedure</td>
<td>no possibility of an urgency procedure</td>
<td>the inspector can ask the disciplinary board to arrange an urgent hearing</td>
</tr>
<tr>
<td>Sanctions</td>
<td>warning, reprimand, fine, suspension of the right to practise the profession concerned, withdrawal of the right to practise the profession concerned</td>
<td>warning, reprimand, fine, suspension of the entry in the IHCP register, striking off the entry in the IHCP register, partial withdrawal of the right of the person entered in the IHCP register to practise the profession concerned, conditional suspension of the entry in the IHCP register, combination of suspension of the entry in the IHCP register and fine, a suspension of the entry by way of a provisional measure</td>
</tr>
<tr>
<td>Possibilities for appeal</td>
<td>- Court of Justice (for the sanctions of fine, suspension and withdrawal), followed by appeal to the Supreme Court</td>
<td>- the central disciplinary board (three legally qualified members and two health professional members) - appeal to the Supreme Court only in the interest of the law</td>
</tr>
<tr>
<td></td>
<td>- all other appeals are made to the central medical disciplinary board (one legally qualified member and four health professional members)</td>
<td></td>
</tr>
<tr>
<td>Sanctions for incompetence</td>
<td>assessment of competence for professional practice is the responsibility of the disciplinary boards</td>
<td>the Medical Supervision Board assesses professionals who, due to a physical or psychological illness or as the result of an addiction, are not competent to practice in the profession; only the Health Care Inspectorate can submit a written report to the Medical Supervision Board</td>
</tr>
</tbody>
</table>

of Amsterdam. The aim of the evaluation was to gain insight into the extent to which the IHCP Act serves its purposes - to protect the general public against incompetence and carelessness and to foster and monitor the quality of professional practice – and functions in practice. The disciplinary system was one of the aspects on which the study focussed.7

1.2. OBJECTIVE, RESEARCH QUESTIONS AND METHODS

The system of disciplinary proceedings for health care differs from country to country.8-15 There are important differences between the EU countries with regard to the role and function of the medical disciplinary system among other things with regard to the role of medical professional organisations, the standards, and the sanctions that can be enforced. To our knowledge almost all western countries have some type of disciplinary system for physicians but this does not apply to the four other professions which have been included
since the introduction of the IHCP Act (henceforth labelled as ‘new’ professions). A statutory disciplinary system for nurses exists in some western countries, such as the UK, in the USA, Canada and the Netherlands. A disciplinary system for physiotherapists also exists in those countries and in Australia. To our knowledge there is no statutory disciplinary system for health care psychologists in other western societies. We found no information in a Pubmed/Medline search or in any other searches. Very little literature or empirical research has focused on the issue of the disciplinary system in general.\textsuperscript{15-17}

Quantitive data concerning the disciplinary proceedings in the Netherlands are scarce and mainly concern the professions that were subject to the disciplinary system before the introduction of the IHCP Act (henceforth labelled as ‘old’ professions).\textsuperscript{16-22}

1.2.1 Objective
The objective of this thesis is to provide empirically based insight into certain aspects of the functioning of the Dutch statutory disciplinary system for health care, in particular since the introduction of the IHCP Act.

1.2.2 Research questions
The following research questions were studied:
1. What is the practical application of the Dutch statutory disciplinary system for health care for the different ‘old’ and ‘new’ professions with regard to the characteristics of the complaints dealt with, including the complainants, the accused and the verdicts, and how has this developed over time (for the ‘old’ professions) in particular since the introduction of the IHCP Act?

2. What is the practice and policy concerning the publication of disciplinary proceedings in the Netherlands?

3. What are the perspectives of those directly involved (professionals, board members, practicing lawyers) in the Dutch statutory disciplinary system for health care, in particular with regard to the changes in the disciplinary proceedings with the introduction of the IHCP Act?

1.2.3 Methods
To answer the research questions we collected data on the practical application of the disciplinary proceedings on the one hand, and data on knowledge, opinions and considerations on the other hand. The different types of data which we gathered necessiated the use of different methods. To investigate the practical application, use was made of the collection of verdicts in the archives and the computerized database of the Health Care Inspectorate and the issues containing disciplinary verdicts published in the Dutch Government Gazette. To investigate the perspectives and policy, questionnaires were sent to different groups of health care professionals, disciplinary board members and practicing lawyers, and the editorial boards of three journals. The methods are described below in more detail.
Study of the complaints dealt with
A. Retrospective study of the Health Care Inspectorate collection of verdicts
Studied were all 13,228 verdicts, concerning physicians, dentists, pharmacists and midwives (‘old’ professions), pronounced by the regional disciplinary boards during the period 1983-2002. Verdicts concerning 187 nurses, 33 physiotherapists and 68 health care psychologists (‘new’ professions) were studied for a period of 4 or 5 years after the introduction of the IHCP Act. The year of the verdict was noted, the number and nature of the complaints, the types of complainants, the categories of professionals accused, the gender and field of work of the accused professionals (only for the ‘new’ professions), the nature of the verdicts, the number of appeals and amended verdicts (except for physiotherapists), and the nature of the amendments. Furthermore, data were obtained on the number of professionals who were practicing (for health care psychologists the number of registered professionals) during the study period and, for the ‘new’ professions, data on their field of work (except for health care psychologists) and gender distribution.

B. Retrospective study of verdicts that were published in the Netherlands Government Gazette
Studied were all 323 verdicts that were published in the Netherlands Government Gazette from 1995 to 2002 by the disciplinary boards and Courts of Justice. The following characteristics were noted: the year of publication in the Government Gazette, the year of the verdict, the disciplinary board involved, the accused professional, the type of complainant, the nature of the complaint and verdict, and the journal that was offered the verdict for publication.

Study of the questionnaires
A. Questionnaires for individual respondents
Questionnaires were sent to 1300 physicians (400 general practitioners, 350 internists, 250 gynaecologists and 300 psychiatrists; response 69%, 65%, 60% and 60%, respectively), 3200 nurses (response 71%), 300 physiotherapists (response 76%), all 388 disciplinary board members (response 89%) and 43 practicing lawyers (response 65%). The questionnaire contained, among other things, questions concerning their knowledge about the disciplinary proceedings (nurses), opinions about the standards set by the disciplinary boards, the sanctions imposed, the public nature of the disciplinary proceedings (physicians, disciplinary board members and practicing lawyers), the change in composition of the disciplinary boards, the involvement of experts, the criteria for terminating membership of the disciplinary boards (disciplinary board members and practicing lawyers) and the disciplinary system for the ‘new’ professions or for their own profession (nurses, physiotherapists, disciplinary board members and practicing lawyers).

B. Questionnaires for organizations
A written questionnaire was used to investigate the considerations of the 5 regional disciplinary boards and the central disciplinary board with regard to their publication policy. Another questionnaire was sent to the editorial boards of the three journals that were offered the most verdicts for publication, to investigate their considerations with regard to
whether or not to publish (offered) verdicts. These journals were ‘Medisch Contact’, ‘Tijdschrift voor Gezondheidsrecht’ and ‘Nederlands Tijdschrift voor Geneeskunde’. Four of the five regional disciplinary boards, the central disciplinary board, and all three journals responded.

The methodology of this research is justified in the separate articles (the chapters in parts II, III and IV). Discussed, among other things, are the sources, size and selection criteria of the samples, and the reliability, validity, representativeness and response.

1.3. OUTLINE OF THE THESIS

This thesis consists of five parts.

**Part I. General introduction (Chapter 1)**

This part of the thesis describes the background, the objective, the research questions, the methods and the outline of the thesis.

**Part II. Practice of the disciplinary proceedings for the ‘old’ professions (Chapters 2 and 3)**

This part of the thesis describes the practical application of the disciplinary proceedings for the four professional groups that were subject to the disciplinary system both before and after the introduction of the IHCP Act, i.e. physicians, dentists, midwives and pharmacists, based on a study of the verdicts concerning these professions.

Chapter 2 (‘Statutory disciplinary proceedings for health care in the Netherlands: a 20-year overview’) provides insight into the nature and number of the complaints, the complainants and the accused, and the sanctions imposed during the period 1983-2002.

In chapter 3 (‘No improvement of disciplinary proceedings since the implementation of the Individual Health Care Professions Act [IHCP Act]’) we made a comparison of the complaints that were dealt with by the disciplinary boards before the IHCP Act (1995-1997) and those that were dealt with after the introduction of the IHCP Act (1999-2001). Investigated were differences in the number and the nature of the complaints, the complainants and the accused, and the verdicts.

**Part III. Disciplinary system for the ‘new’ professions: practice and views (Chapters 4-6)**

This part of the thesis concerns the disciplinary system for the professional groups that became subject to this system after the introduction of the IHCP Act, i.e. nurses, physiotherapists and health care psychologists. A study of the verdicts concerning these professions provides insight into the practical application of the disciplinary proceedings for these professions. By sending questionnaires to health professionals, disciplinary board members and practicing lawyers we investigated, among other things, their opinions about the disciplinary system for the ‘new’ professions.

Chapter 4 (‘The disciplinary system for nurses and its contribution to the quality of nursing care in the Netherlands’) provides insight into the practical application of and views
on the disciplinary system for nurses in the Netherlands. During a period of 4 years (1998-2001) a survey was made of all the complaints about nurses that were dealt with by the disciplinary boards. This study from the perspective of the nurses included investigating their knowledge about the disciplinary proceedings and their opinions about the normative and preventive effects of the system. Finally, the opinions of members of the disciplinary boards and practicing lawyers with regard to the disciplinary system for nurses were also investigated.

Chapter 5 (‘The Dutch disciplinary system for physiotherapists: practice and views’) describes a survey that was made of all the complaints about physiotherapists that were dealt with by the disciplinary boards during a period of 5 years (1998-2002). The views of physiotherapists with regard to this system were also studied.

Chapter 6 (‘Practice of the statutory disciplinary system for health care psychologists in the Netherlands’) describes a survey that was made of all the complaints about health care psychologists that were dealt with by the disciplinary boards during a period of 4 years (1999-2002). The opinions of members of the disciplinary boards and practicing lawyers with regard to the disciplinary system for health care psychologists were also investigated.

Part IV. Specific aspects of the disciplinary proceedings and the disciplinary system (Chapters 7 and 8)

This part of the thesis deals with some specific aspects of the disciplinary proceedings and the disciplinary system. It provides insight into the practice and policy regarding the publication of disciplinary verdicts by means of a study of verdicts that were published in the Netherlands Government Gazette and a study of the questionnaires that were sent to the disciplinary boards and journals that were offered the majority of verdicts for publication. By sending questionnaires to physicians, disciplinary board members and practicing lawyers we investigated their opinions about the disciplinary system, in particular since the IHCP Act came into effect.

Chapter 7 (‘Publication of disciplinary proceedings in the Netherlands: practice and policy’) gives a description of the number and the nature of the verdicts which the disciplinary boards published in the Netherlands Government Gazette during the period 1995-2002, and the verdicts that were offered to and published in journals. Also studied were the considerations underlying the decisions made by the disciplinary boards to offer verdicts for publication, and the reasons why the journals that were offered the majority of verdicts for publication decided to publish these verdicts.

In chapter 8 (‘Views of physicians, disciplinary board members and practicing lawyers on the new statutory disciplinary system for health care in the Netherlands’) we investigated the opinions of physicians, disciplinary board members and practicing lawyers with regard to (changes in) the statutory disciplinary proceedings.

Part V. General discussion (Chapter 9)

This final part of the thesis determines, on the basis of the findings, the extent to which the research questions can be answered. The findings are also discussed in more detail and, finally, some recommendations are made for practice, policy and scientific research.
The chapters in parts II, III and IV concern articles which can be read separately. These articles, which overlap somewhat with parts I and V, have been submitted to national and international bio-medical or scientific law journals. Information about whether the article is accepted, in press, or published can be found on the title page of the chapter in question and in the table of contents.

References

1. Dutch Lower House 1985/86, 19 522, nr. 3, p. 64.


Part II

Practice of the disciplinary proceedings for the ‘old’ professions
Chapter 2

Statutory disciplinary proceedings for health care in the Netherlands: a 20-year overview

Summary
Background. Very little empirical literature has been published on the subject of the disciplinary system, whereas this might contribute to monitoring the quality of health care.

Methods. We examined all verdicts, concerning physicians, dentists, pharmacists and midwives, pronounced by the regional disciplinary boards during the period 1983-2002. The following were noted: the year of the verdict, the number and nature of the complaints, the types of complainants, the categories of professionals accused, the nature of the verdicts, and the number of appeal cases and their consequences.

Findings. During the study period, 13,228 complaints were dealt with by the disciplinary boards: an average of 662 per year. The number of complaints increased more rapidly than the number of professionals. Most of the complaints concerned physicians (92%). The complaint density was also highest for physicians; for general practitioners it was higher than for hospital specialists, and for surgical specialists it was higher than for non-surgical specialists. Half of the complaints concerned ‘lack of care or inadequate care’ or ‘incorrect treatment’. The sanctions/complaints ratio decreased during the study period (average 18%). The sanction density remained constant during the study period: 0.25 sanctions per 100 practitioners. The sanction density was highest for physicians, and it was higher for general practitioners than for specialists. There was a total of 45 entries permanently struck off the register/withdrawals of the right to practice.

Interpretation. There has been a slight increase in the number of disciplinary complaints over the past 20 years. The corrective effects of the disciplinary system are obvious. Increasing the effects on the quality of care should be sought in prevention and education. Disciplinary jurisprudence deserves to receive more attention in further education courses and through publication of the verdicts.

INTRODUCTION

The disciplinary system for health care differs from country to country. Moreover, very little literature or empirical research has focused on this issue. This limits the opportunity to learn from each other’s experiences. Since 1928 there has been a statutory disciplinary system for physicians, dentists and midwives in the Netherlands, and since 1951 also for pharmacists. The aim of this disciplinary system is to foster and monitor high standards of professional practice, and to protect the general public against incompetence and carelessness, including harm and abuse. Every directly interested party can make a complaint; in practice this is mainly a patient or a patient’s family. The inspector for health care is also authorized to lodge a complaint. The disciplinary proceedings are dealt with by 5 regional disciplinary boards. In deciding on their verdicts, the disciplinary boards take into account, among other things, the legal requirements, jurisprudence, professional codes and rules of conduct, professional-technical regulations, standards, guidelines, and protocols, also collectively referred to as the professional standard. The members of the boards include not only lawyers, but also health professional members from the same profession as the accused. Since the end of 1997 the disciplinary proceedings have been incorporated in the Individual Health Care Professions Act (IHCP Act; in Dutch Wet BIG). With the introduction of the IHCP Act the scope of the disciplinary proceedings has been
increased to include four more professional groups, i.e. physiotherapists, health care psychologists, psychotherapists and nurses.

Only a limited amount of quantitative data concerning disciplinary proceedings in the Netherlands is available.\textsuperscript{11-13} The Health Care Inspectorate is the only authority in the Netherlands which receives all verdicts and registers certain data. With the approval of the Health Care Inspectorate a study was carried out to investigate the nature and number of the complaints, the complainants and the accused, and the sanctions imposed during the period 1983-2002. The focus was on the four professional groups that were subject to the disciplinary system both before and after the introduction of the IHCP Act.

METHODS

A retrospective study was made of all the complaints about physicians, dentists, pharmacists and midwives that were dealt with by the regional disciplinary boards between 1\textsuperscript{st} January 1983 and 1\textsuperscript{st} January 2003. The study period for the appeal cases ended on 1\textsuperscript{st} May 2004. Use was made of the collection of verdicts in the archives and the computerized database of the Health Care Inspectorate. Data on the number of registered professionals during the study period were obtained from the various registers for the professions involved. Aspects that were studied were: year of the verdict, number and nature of the complaints, type of complainants, categories of professionals accused, nature of the verdicts (sanctions imposed), number of appeals and amended verdicts, and nature of the amendments. The nature of the complaints was described according to the classification of the Health Care Inspectorate. Differences in the percentage of sanctions per professional were analysed with the Chi-square test.

20-year overview. It was not possible to perform a trend analysis, because for the period 1983-1992 only the 10-year figures were available. Outcomes between 1983-1992 and 1993-2002 are compared whenever possible. Differences in the number of complaints were calculated with Poisson’s test. The distributions of sanctions per complaint, complaints per type of complainant and nature of the verdict were analysed with the Chi-square test.

The complaint density and the sanction density were defined as the number of complaints and the number of sanctions, respectively, per 100 professionals per year.

RESULTS

Number of complaints. During the period 1983-2002 a total of 13,228 complaints were dealt with by the 5 regional disciplinary boards: an average of 662 per year. By far the most complaints concerned physicians (12,180/13,228; 92\%). The complaint density was also the highest for physicians (1.6). Almost half of the complaints concerned hospital specialists, and almost one third concerned general practitioners. The complaint density was higher for general practitioners than for hospital specialists (2.8 versus 2.2) (Table 1). Table 2 shows that considerable differences were found between the various hospital specialties. Psychiatrists and surgeons were most often involved in disciplinary proceedings. The
complaint density was highest for plastic surgeons (5.2), neurosurgeons (4.8), general surgeons (4.3) and orthopedic surgeons (4.2), and much lower, for instance, for internists (1.7) and pediatricians (0.9).

Table 1
Average annual number of complaints about health professionals dealt with by the five regional disciplinary boards during the period 1983-2002; absolute numbers (%)

<table>
<thead>
<tr>
<th>Health professional</th>
<th>Number (%)</th>
<th>Number of complaints per 100 practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital specialist</td>
<td>286 (43)</td>
<td>13,057 (27)</td>
</tr>
<tr>
<td>General practitioner</td>
<td>199 (30)</td>
<td>7,015 (14)</td>
</tr>
<tr>
<td>Public health physician</td>
<td>26 (4)</td>
<td>3,564 (7)</td>
</tr>
<tr>
<td>Other physicians*</td>
<td>99 (15)</td>
<td>13,631 (28)</td>
</tr>
<tr>
<td><strong>Total physicians</strong></td>
<td><strong>610 (92)</strong></td>
<td><strong>37,267 (77)</strong></td>
</tr>
<tr>
<td>Dentist†</td>
<td>41 (6)</td>
<td>7,496 (15)</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>3.4 (0.5)</td>
<td>2,398 (5)</td>
</tr>
<tr>
<td>Midwife</td>
<td>7.7 (1)</td>
<td>1,254 (3)</td>
</tr>
<tr>
<td><strong>Total/average</strong></td>
<td><strong>662 (100)</strong></td>
<td><strong>48,415 (100)</strong></td>
</tr>
</tbody>
</table>

* this category included MDs, interns, retired physicians, prison physicians, nursing-home physicians, confidential physicians and physicians whose specialism was not defined
† including oral surgeons and orthodontists

Nature of the complaints. Table 3 provides insight into the nature of the complaints. Many of the complaints concerned ‘lack of care or inadequate care’ (3639/13,228; 28%) or ‘incorrect treatment’ (2840/13,228; 21%). The latter applied more to hospital specialists (1439/5701; 25%) than to general practitioners (676/3981; 17%). ‘Not, or belated visiting when requested’ was a complaint that almost only concerned general practitioners (531/591; 90%), and in particular locums (343/531; 65%, data not shown). The category ‘other complaints’ included multiple complaints with no clear main complaint, ‘nonsensical’ complaints, complaints that did not directly concern care, complaints in which the plaint or the verdict contained little information about the complaint, and complaints that were difficult to classify. That is the reason why there were so many complaints in this category.

Number of sanctions. Table 3 also indicates the number of sanctions that were imposed; 18% of all complaints resulted in a sanction. Complaints about pharmacists, midwives and dentists resulted relatively often in a sanction, namely in 32% (22/68), 29% (45/154) and 26% (216/826) of the cases, respectively. Complaints about public health physicians and ‘other physicians’ resulted less often in a sanction (63/511; 12% and 187/1987; 9%, respectively) than other complaints (p=0.0003 and p<0.0001, respectively). Complaints about general practitioners more often resulted in a sanction than complaints about hospital specialists (894/3981; 22% versus 998/5701; 18%, p<0.0001).
difference could mainly be attributed to the high percentage of complaints about locums that resulted in a sanction (257/873; 29%, data not shown); in almost two fifths of these cases the complaint concerned ‘not, or belated visiting when requested’ (343/873; 39%). The percentage of sanctions for plastic surgeons was 20% of the complaints (28/143), for general surgeons 19% (178/930), for neurosurgeons 14% (11/80), for internists 20% (113/570), for pediatricians 17% (27/160), for psychiatrists 15% (161/1049), and for neurologists 14% (49/357). ‘Professional misconduct’, ‘violation of professional secrecy’ and ‘not, or belated visiting when requested’ resulted most often in a sanction, namely in 52% (12/23), 39% (125/324) and 34% (201/591) of the cases, respectively.

Table 2
Average annual number of complaints about hospital specialists dealt with by the five regional disciplinary boards during the period 1983-2002; absolute numbers (%)

<table>
<thead>
<tr>
<th>Hospital specialist</th>
<th>Number (%)</th>
<th>Number of complaints per 100 specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td>52 (18)</td>
<td>1 476 (11) 3.5</td>
</tr>
<tr>
<td>Surgeon*</td>
<td>47 (16)</td>
<td>1 097 (8) 4.3</td>
</tr>
<tr>
<td>Internist†</td>
<td>29 (10)</td>
<td>1 666 (13) 1.7</td>
</tr>
<tr>
<td>Gynaecologist</td>
<td>27 (9)</td>
<td>767 (6) 3.5</td>
</tr>
<tr>
<td>Neurologist</td>
<td>18 (6)</td>
<td>507 (4) 3.6</td>
</tr>
<tr>
<td>Orthopaedic surgeon</td>
<td>17 (6)</td>
<td>402 (3) 4.2</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>11 (4)</td>
<td>550 (4) 2.0</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>11 (4)</td>
<td>548 (4) 2.0</td>
</tr>
<tr>
<td>Ear nose and throat specialist</td>
<td>9 (3)</td>
<td>450 (3) 2.0</td>
</tr>
<tr>
<td>Urologist</td>
<td>9 (3)</td>
<td>262 (2) 3.4</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>8 (3)</td>
<td>884 (7) 0.9</td>
</tr>
<tr>
<td>Anaesthetist</td>
<td>8 (3)</td>
<td>963 (7) 0.8</td>
</tr>
<tr>
<td>Plastic surgeon</td>
<td>7 (2)</td>
<td>137 (1) 5.2</td>
</tr>
<tr>
<td>Neurosurgeon</td>
<td>4 (1)</td>
<td>85 (0.7) 4.8</td>
</tr>
<tr>
<td>Others‡</td>
<td>29 (10)</td>
<td>3 267 (25) 0.9</td>
</tr>
</tbody>
</table>

Total/average        | 286 (100)  | 13 067 (100) 2.2                       |

* including cardiopulmonary surgeon
† including haematologist and oncologist
‡ radiotherapist, nuclear physician, gastro-enterologist, allergologist, dermatologist, pathologist-anatomist, pneumonologist, radiologist (specialism abolished in 1995), radiodiagnost, reumatologist, rehabilitation specialist, clinical chemist, clinical geneticist, clinical geriatrist, microbiologist (formerly bacteriologist)
Table 3
Number of complaints and sanctions (between round brackets) imposed on the basis of the nature of the complaint per health professional during the period 1983-2002; absolute numbers

<table>
<thead>
<tr>
<th>Nature of the complaint</th>
<th>Hospital specialists</th>
<th>General practitioners</th>
<th>Public health physicians</th>
<th>Other physicians</th>
<th>Dentists</th>
<th>Pharmacists</th>
<th>Midwives</th>
<th>Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Not or belated visiting when requested</td>
<td>19 (5)</td>
<td>531 (185)</td>
<td>-</td>
<td>32 (6)</td>
<td>1 (-)</td>
<td>-</td>
<td>8 (5)</td>
<td>591 (201) [34]</td>
</tr>
<tr>
<td>• Incorrect treatment</td>
<td>1 439 (274)</td>
<td>676 (195)</td>
<td>51 (3)</td>
<td>337 (39)</td>
<td>295 (103)</td>
<td>2 (-)</td>
<td>40 (14)</td>
<td>2 840 (628) [22]</td>
</tr>
<tr>
<td>• Lack of care or inadequate care</td>
<td>1 677 (398)</td>
<td>1 098 (244)</td>
<td>89 (11)</td>
<td>512 (64)</td>
<td>188 (59)</td>
<td>15 (8)</td>
<td>60 (19)</td>
<td>3 639 (803) [22]</td>
</tr>
<tr>
<td>• Insufficient information</td>
<td>290 (45)</td>
<td>31 (3)</td>
<td>5 (2)</td>
<td>34 (5)</td>
<td>17 (2)</td>
<td>-</td>
<td>-</td>
<td>377 (57) [15]</td>
</tr>
<tr>
<td>• Impolite behaviour</td>
<td>150 (22)</td>
<td>166 (31)</td>
<td>21 (-)</td>
<td>47 (6)</td>
<td>33 (7)</td>
<td>-</td>
<td>3 (2)</td>
<td>420 (68) [16]</td>
</tr>
<tr>
<td>• Non-referral or referred too late</td>
<td>34 (3)</td>
<td>141 (22)</td>
<td>2 (-)</td>
<td>25 (2)</td>
<td>9 (4)</td>
<td>-</td>
<td>3 (1)</td>
<td>214 (32) [15]</td>
</tr>
<tr>
<td>• Incorrect statement or reporting</td>
<td>175 (30)</td>
<td>44 (16)</td>
<td>66 (10)</td>
<td>45 (7)</td>
<td>2 (-)</td>
<td>-</td>
<td>2 (-)</td>
<td>334 (63) [19]</td>
</tr>
<tr>
<td>• Incorrect fees</td>
<td>9 (-)</td>
<td>10 (5)</td>
<td>-</td>
<td>6 (-)</td>
<td>25 (-)</td>
<td>-</td>
<td>-</td>
<td>50 (8) [16]</td>
</tr>
<tr>
<td>• Violation of professional secrecy</td>
<td>118 (40)</td>
<td>105 (52)</td>
<td>57 (17)</td>
<td>31 (8)</td>
<td>10 (6)</td>
<td>-</td>
<td>3 (2)</td>
<td>324 (125) [39]</td>
</tr>
<tr>
<td>• Professional misconduct†</td>
<td>11 (3)</td>
<td>6 (6)</td>
<td>1 (1)</td>
<td>4 (2)</td>
<td>1 (-)</td>
<td>-</td>
<td>-</td>
<td>23 (12) [52]</td>
</tr>
<tr>
<td>• Other complaints</td>
<td>1 779 (178)</td>
<td>1 173 (135)</td>
<td>219 (19)</td>
<td>914 (48)</td>
<td>245 (32)</td>
<td>51 (14)</td>
<td>35 (2)</td>
<td>4 416 (428) [10]</td>
</tr>
<tr>
<td>Total*</td>
<td>5 701 (998)</td>
<td>3 981 (894)</td>
<td>511 (63)</td>
<td>1 987 (187)</td>
<td>826 (216)</td>
<td>68 (22)</td>
<td>154 (45)</td>
<td>13 228 (2 425) [18]</td>
</tr>
</tbody>
</table>

* the percentage of complaints that resulted in a sanction [between square brackets]
† the category of professional misconduct was first included in 1997
Table 4 provides insight into the sanction density. Per 100 professionals, 0.25 sanctions were imposed each year. With regard to the sanction density per professional group, the pattern was similar to that of the complaint density. The sanction density was higher for physicians than for pharmacists, midwives and dentists, and it was higher for general practitioners than for hospital specialists.

Table 4
Average annual number of sanctions imposed by the five regional disciplinary boards per health professional during the period 1983-2002; absolute numbers (%)

<table>
<thead>
<tr>
<th>Health professional</th>
<th>Number (%) sanctions</th>
<th>Number (%) practitioners</th>
<th>Number of sanctions per 100 practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital specialist</td>
<td>50 (41)</td>
<td>13 057 (27)</td>
<td>0.38</td>
</tr>
<tr>
<td>General practitioner</td>
<td>45 (37)</td>
<td>7 015 (14)</td>
<td>0.64</td>
</tr>
<tr>
<td>Public health physician</td>
<td>3.1 (3)</td>
<td>3 564 (7)</td>
<td>0.09</td>
</tr>
<tr>
<td>Other physicians</td>
<td>9.4 (8)</td>
<td>13 631 (28)</td>
<td>0.07</td>
</tr>
<tr>
<td><strong>Total physicians</strong></td>
<td><strong>107 (88)</strong></td>
<td><strong>37 267 (77)</strong></td>
<td><strong>0.29</strong></td>
</tr>
<tr>
<td>Dentist</td>
<td>11 (9)</td>
<td>7 496 (15)</td>
<td>0.14</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1.1 (0.9)</td>
<td>2 398 (5)</td>
<td>0.05</td>
</tr>
<tr>
<td>Midwife</td>
<td>2.3 (2)</td>
<td>1 254 (3)</td>
<td>0.18</td>
</tr>
<tr>
<td><strong>Total/average</strong></td>
<td><strong>121 (100)</strong></td>
<td><strong>48 415 (100)</strong></td>
<td><strong>0.25</strong></td>
</tr>
</tbody>
</table>

Type of complainants. Table 5 shows that over two thirds of all complaints were made by the patient (8984/13,228; 68%) and almost one third by someone else, in most cases a member of the patient’s family (3991/13,228; 30%). In comparison, the inspector for health care lodged only a small number of complaints (253/13,228; 2%).

Nature of the verdicts. The majority of the complaints was considered unfounded (8462/13228; 64%). In a considerable number of cases investigation was not continued or the complaint was withdrawn, especially by the patients themselves (1643/13,228; 12%). The most frequently imposed sanctions were a warning (1650/2425; 68%) and a reprimand (481/2425; 20%). Many of the complaints lodged by the inspector resulted in a sanction (193/253; 76%). Especially the most severe sanction before and after the introduction of the IHCP Act, withdrawal of the right to practice and entry struck off the IHCP register respectively, were imposed for complaints that were lodged by the inspector (38/57; 67%).

Number of appeals. An appeal was made against almost one third of the verdicts pronounced by the 5 regional disciplinary boards (4086/13,228; 31%). Per 1st May 2004 there were still a few cases pending. The verdict was amended in 13% (551/4086) of all the appeals that were made. In almost two fifths of the verdicts (213/551; 39%) a warning was changed into an unfounded complaint, and in one fifth of the verdicts it was the reverse (111/551; 22%). Eventually the verdict was amended in 4% (551/13,228) of the total number of cases.
Number of entries struck off the register/withdrawals of the right to practice. During the study period the sanction of entry struck off the register/withdrawal of the right to practice was imposed 50 times by the regional disciplinary boards. Appeals were made in 26 cases, 11 of which resulted in a less severe sanction or an unfounded complaint. In 6 cases the appeal still resulted in a withdrawal of the right to practice or entry struck off the register. The 45 cases in which the entry was permanently struck off the register or the right to practice was withdrawn concerned 12 general practitioners, 11 physicians whose specialism was not defined, 9 psychiatrists, 6 dentists, 4 pharmacists, 1 ophthalmologist, 1 pathologist and 1 midwife.

Comparison 1983-1992 with 1993-2002. The number of complaints increased from 5333 in the period 1983-1992 to 7895 in the period 1993-2002 (p< 0.001). The number of professionals increased less than the number of complaints; the complaint density was 1.2 in the period 1983-1992 and 1.5 in the period 1993-2002. With regard to general practitioners, the complaint density increased from 2.4 to 3.2. The sanctions/complaints ratio decreased from 20% (1068/5333) to 17% (1357/7895) (p<0.001). The sanction density remained the same; 0.25 sanctions per 100 professionals. There were differences between the various professional groups. The sanction density increased from 0.57 to 0.69 for general practitioners and from 0.07 to 0.12 for public health physicians, but for midwives it decreased from 0.23 to 0.15.

Although the percentage of unfounded complaints remained roughly the same (3443/5333; 65% in 1983-1992 and 5019/7895; 64% in 1993-2002), the number of verdicts of ‘unfounded without further investigation’ increased from 20% (1061/5333) to 34% (2707/7895), and the number of verdicts of ‘unfounded after a hearing’ decreased from 45% (2382/5333) to 29% (2312/7895) (in both cases p<0.001). The number of ineligible complainants more than doubled in these two periods, from 3% (172/5333) to 7% (526/7895) (p<0.0001). The percentage of complaints lodged by the inspector decreased from 2.4% to 1.6% (p=0.0003); the absolute number of complaints remained roughly the same (130 and 123, respectively).
Table 5  
Nature and number of the verdicts pronounced by the five regional disciplinary boards divided over the persons lodging the complaint during the period 1983-2002

<table>
<thead>
<tr>
<th>Verdict</th>
<th>Inspector</th>
<th>Patient</th>
<th>Other person*</th>
<th>Total(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Entry struck off the IHCP register†§</td>
<td>38</td>
<td>13</td>
<td>6</td>
<td>57‡ (0.4)</td>
</tr>
<tr>
<td>• Partial withdrawal of the right to practise the profession concerned§</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>- (-)</td>
</tr>
<tr>
<td>• Combination of (conditional) suspension of the entry in the IHCP register and fine§</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>5 (0.0)</td>
</tr>
<tr>
<td>• Suspension of the entry in the IHCP register†§</td>
<td>51</td>
<td>76</td>
<td>25</td>
<td>152 (1)</td>
</tr>
<tr>
<td>• Conditional suspension of the entry in the IHCP register§</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>16 (0.1)</td>
</tr>
<tr>
<td>• Fine</td>
<td>18</td>
<td>33</td>
<td>13</td>
<td>64 (0.5)</td>
</tr>
<tr>
<td>• Reprimand</td>
<td>39</td>
<td>229</td>
<td>213</td>
<td>481 (4)</td>
</tr>
<tr>
<td>• Warning</td>
<td>43</td>
<td>896</td>
<td>111</td>
<td>1650 (12)</td>
</tr>
<tr>
<td><strong>Total sanctions</strong></td>
<td>193</td>
<td>1 257</td>
<td>975</td>
<td>2 425 (18)</td>
</tr>
<tr>
<td>• Unfounded after a hearing</td>
<td>53</td>
<td>2 860</td>
<td>1 781</td>
<td>4 694 (35)</td>
</tr>
<tr>
<td>• Unfounded before a hearing</td>
<td>1</td>
<td>2 877</td>
<td>890</td>
<td>3 768 (28)</td>
</tr>
<tr>
<td>• Not eligible</td>
<td>2</td>
<td>531</td>
<td>165</td>
<td>698 (5)</td>
</tr>
<tr>
<td>• Investigation discontinued or complaint withdrawn</td>
<td>4</td>
<td>1 459</td>
<td>180</td>
<td>1 643 (12)</td>
</tr>
<tr>
<td><strong>Total no sanctions</strong></td>
<td>60</td>
<td>7 727</td>
<td>3 016</td>
<td>10 803 (82)</td>
</tr>
<tr>
<td>Total (%)</td>
<td>253 (2)</td>
<td>8 984 (68)</td>
<td>3 991 (30)</td>
<td>13 228 (100)</td>
</tr>
</tbody>
</table>

* mostly a member of the patient’s family  
† before the introduction of the IHCP Act, the sanctions ‘entry struck off the IHCP register’ and ‘suspension of the entry in the IHCP register’ should be read as ‘withdrawal of the right to practise’ and ‘suspension of the right to practise the profession concerned’  
§ this sanction exists since the Individual Health Care Profession Act came into effect. The IHCP Act has a constitutive register. The right to use a professional title only becomes effective after entry in the IHCP register.  
‡ this concerned 50 professionals

**DISCUSSION**

In the Dutch health care system the disciplinary proceedings are one aspect of the regulation of professional practice. This study presents a predominantly quantitative overview of the disciplinary proceedings that the four professional groups have already been subjected to for decades. Data on the complainants, the accused, the complaints and the verdicts over a period of 20 years give an indication of the contribution of the disciplinary proceedings to monitoring the quality of health care in the Netherlands, and provide an opportunity for other countries, with similar or different regulations for professional practice, to learn from the Dutch experience.
During the study period the regional disciplinary boards dealt with an average of 662 complaints per year, the great majority of which concerned physicians. The number of complaints increased more rapidly than the number of professionals.

The risk of being brought before a disciplinary board is different for the various professions. The complaint density was highest for physicians, higher for general practitioners than for hospital specialists, and higher for surgical specialists than for non-surgical specialists. It is possible that these differences are related to differences for the patient with regard to the severity and verification of the medical treatment. The fact that verification seems to play an important role is clear, for instance, from the considerable number of complaints that are made about general practitioners with regard to not, or belated visiting when requested. It was also found that in the period 1993-2001 the number of claims for medical damages per 100 specialists was higher for surgical specialists than for non-surgical specialists. In the Netherlands there has been no great increase in the number of claims for medical damages and the number of disciplinary complaints over the past 20 years. During this period there has even been a relative decrease in the number of claims for damages which were dealt with by the civil courts or the disciplinary boards. There has also been a decrease in the number of disciplinary complaints since 2001, but whether or not these developments are structural, only the future can tell. The increase in the number of tasks per professional (more surgical work, prescription of medication, etc.) and the increasing autonomy of the patient can lead to an increase in complaints and claims. However, this development is also influenced by the possibility of formal proceedings (via a complaint committee) and informal proceedings (i.e. a complaints officer or the Health Care Information and Complaint Service). The relatively low number of claims for damages can, to a certain extent, be explained by the fact that the Netherlands has a relatively good social security system, which functions as a financial safety net in the event of physical damages. This makes claims for damages less necessary to compensate for the consequences of loss of income.

Half of the complaints concerned ‘lack of care or inadequate care’ or ‘incorrect treatment’, and a warning or a reprimand were the most frequently imposed sanctions. The sanctions/complaints ratio, average 18%, decreased during the study period. In the years immediately following the introduction of the IHCP Act the number of justified complaints was even as low as 15%. While the percentage of sanctions decreased and the number of complaints per professional increased during the study period, the total sanction density remained the same: 0.25 sanctions per 100 professionals. However, the sanction density for general practitioners was much higher, and even increased during the study period.

The majority of complaints was made by the patient or by some other person, in most cases a member of the patient’s family. In comparison, the inspector lodged only a limited number of complaints, but these mainly concerned serious cases, and often resulted in a (severe) sanction.

It should be noted that the disciplinary system in the Netherlands is highly dependent on complaints made by the general public, whereas many people are not aware of the purpose or content of the disciplinary system, and they do not know which complaints they can bring before a disciplinary board. Complaints are often made to the wrong authorities, and many complaints are made during an emotional period of mourning, or with little or no
expert legal support. The great majority of complaints were unfounded, and a considerable number of complaints was withdrawn or a decision was made not to continue with the investigation. The number of ineligible complaints – which gives an indication of public knowledge of the disciplinary proceedings – increased during the study period to an average of 5%. This increase seems to be continuing; in 2002, 11% of the complaints were declared not eligible. Informing the public about the disciplinary proceedings and other ways in which complaints can be made can contribute to an increase in the number of eligible complainants, and therefore more justified complaints or sanctions.

In most of the cases in which an appeal was made the verdict remained the same. In principle, this indicates good quality jurisprudence in the first instance, despite the fact that in quite a number of cases (13%) the verdict was amended after the appeal (more often less severe than more severe).

The aim of the disciplinary system is to foster and monitor the quality of professional practice. It is intended to have a preventive, educative and corrective effect on the quality of care. In general, prevention should be sought in the publication of verdicts. Half to four fifths of the professionals indicate that the publication of a verdict concerning a colleague in the same profession would influence their own professional practice. However, only a small percentage of the verdicts are published. If the disciplinary proceedings are to achieve the intended effect on professional practice, then the publication policy must receive more attention. Educative effects can be achieved by further development of the professional standards based on the considerations of the disciplinary boards in their verdicts. Paying attention to these aspects of the professional standard in the basic curriculum, during specialization and in further training courses will be both educative and preventive. The corrective effects are apparent from the number of sanctions imposed. Even the warning, which is the least severe sanction, is considered by the disciplinary boards and the professionals to be serious. In the past 20 years, 45 professionals have had their right to practice withdrawn or their entry struck off the register, and this has probably made a considerable contribution to the safety of patients. Finally, because the European law provides equal opportunities for professionals to settle and practice in other countries of the European Union, this makes it very important that there is more collaboration between the various disciplinary boards and governments in the member states, to ensure that the ‘bad apples’ do not continue to practice irresponsibly in another country.

References

Chapter 3

No improvement in disciplinary proceedings since the implementation of the Individual Health Care Professions Act (IHCP Act)

Published as: Hout FAG, Cuperus-Bosma JM, Peuter OR de, Hubben JH, Wal G van der. No improvement in disciplinary proceedings since the implementation of the Individual Health Care Professions Act (IHCP Act) [in Dutch: Tuchtrechtsspraak niet verbeterd sinds de invoering van de Wet op de Beroepen in de Individuele Gezondheidszorg]. Nederlands Tijdschrift voor Geneeskunde 2004;148:135-9
Abstract
Objective. To compare the number and nature of the complaints, the complainants, the accused health professionals and the sanctions imposed by the disciplinary boards before and after the Individual Health Care Professions Act (IHCP Act; in Dutch: Wet BIG) came into effect at the end of 1997.

Method. The authors examined all 4980 verdicts pronounced by the disciplinary boards in the first instance during the period 1995-1997 (before the IHCP Act) and then during the period 1999-2001 (after the IHCP Act) together with the resulting appeal procedures involving physicians, dentists, pharmacists and midwives. The following were noted: the year of the verdict, the number and nature of the complaints, the types of complainants, the categories of professionals accused, the nature of the verdicts, and the number of appeal procedures.

Results. During the first period, 2453 complaints were brought before the disciplinary board, compared to 2527 during the second period. Most of the complaints were made against physicians (92% in both periods). The number of complaints that were declared to be justified fell from 19% to 15% (p<0.001). In both periods, approximately half of the complaints concerned 'lack of care or inadequate care' or 'incorrect treatment', the most frequent sanction was a warning (67% and 72%, respectively), and appeals were lodged against almost one-third of the verdicts. The number of complaints submitted by the inspector for health care decreased from 47 to 19.

Conclusion. In any important aspects, the IHCP Act did not lead to improvement of the disciplinary proceedings. The decrease in the number of complaints that were declared to be justified could be explained by the change in composition of the disciplinary boards prescribed by the IHCP Act (more legally qualified members and less health professional members). Informing citizens about disciplinary proceedings and other procedures for lodging complaints may increase the number of justified complaints and hence the number of 'justified' verdicts. There is a need for further clarification of the tasks and responsibility of the Health Care Inspectorate in case of complaints to the disciplinary boards.

INTRODUCTION

In the Netherlands there has been a statutory disciplinary system for physicians, dentists and midwives since 1928, and for pharmacists since 1951. The aim of this system is to foster and monitor the quality of professional practice and to protect the general public against incompetence and carelessness. Every person who is directly involved can lodge a complaint; in practice, however, this is usually a patient or a member of the patient’s family. Moreover, among other things, the inspector for health care has the authority to make a complaint. The disciplinary proceedings have been incorporated in the Individual Health Care Professions Act (IHCP Act) since it was introduced at the end of 1997, before which it fell under the Medical Disciplinary Act (MD Act; in Dutch: Medische Tuchtwet).

Over the years various complaints had been made about the MD Act, and among other things these focussed on the weak position of the complainant in the procedure, and the basically closed nature of the disciplinary proceedings. With the introduction of the IHCP Act, the disciplinary proceedings has been amended in various ways in an attempt to alleviate these complaints (Table 1).
Table 1
Differences between the Medical Disciplinary Act and the disciplinary proceedings of the IHCP Act

<table>
<thead>
<tr>
<th>Professions subject to the disciplinary system</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>physicians, dentists, pharmacists and midwives</td>
<td>physicians, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disciplinary norms</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- undermining confidence in the position of fellow professionals</td>
<td>- inadequate care for the patient or the patient’s relatives</td>
</tr>
<tr>
<td></td>
<td>- negligence resulting in serious damages</td>
<td>- any other act or omission that is in conflict with good individual health care practice</td>
</tr>
<tr>
<td></td>
<td>- evidence of serious professional incompetence</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position of the complainant and the accused during the preliminary hearing and the trial</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- during the preliminary hearing only the accused can be heard if an unfounded or non-eligible complaint is not concerned</td>
<td>- the regional disciplinary boards are obliged to hold a preliminary hearing during which complainant and accused are given the opportunity to be heard; during this preliminary hearing an attempt may be made to reach an amicable settlement which implies that the complainant withdraws the complaint</td>
</tr>
<tr>
<td></td>
<td>- during the preliminary hearing and the trial the accused can be represented by a counsel</td>
<td>- during the preliminary hearing and the trial the complainant and the accused can be represented by a counsel</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basic composition of the disciplinary boards</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the medical disciplinary board consists of one legally qualified member and four health professional members</td>
<td>the regional disciplinary board consists of two legally qualified members and three health professional members</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public access to meetings and verdicts</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>in principle no public access</td>
<td>in principle public access</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgency procedure</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no possibility of an urgency procedure</td>
<td>the inspector can ask the disciplinary board to arrange an urgent hearing</td>
</tr>
</tbody>
</table>
Chapter 3 Disciplinary proceedings since the IHCP Act

Table 1
Differences between the Medical Disciplinary Act and the disciplinary proceedings of the IHCP Act

<table>
<thead>
<tr>
<th>Sanctions</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>warning, reprimand, fine, suspension of the right to practise the profession concerned, withdrawal of the right to practise the profession concerned</td>
<td>warning, reprimand, fine, suspension of the entry in the IHCP register, striking off the entry in the IHCP register, partial withdrawal of the right of the person entered in the IHCP register to practise the profession concerned, conditional suspension of the entry in the IHCP register, combination of suspension of the entry in the IHCP register and fine, a suspension of the entry by way of a provisional measure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Possibilities for (cassation) appeal</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Court of Justice (for the sanctions of fine, suspension and withdrawal), followed by appeal to the Supreme Court - all other appeals are made to the central medical disciplinary board (one legally qualified member and four health professional members)</td>
<td>- the central disciplinary board (three legally qualified members and two health professional members) - appeal to the Supreme Court only in the interest of the law</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sanctions for incompetence</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>assessment of competence for professional practice is the responsibility of the disciplinary boards</td>
<td>the Medical Supervision Board assesses professionals who, due to a physical or psychological illness or as the result of an addiction, are not competent to practice in the profession; only the Health Care Inspectorate can submit a written report to the Medical Supervision Board</td>
</tr>
</tbody>
</table>

By increasing the legal element in the disciplinary boards, the intention is to strengthen the position of the complainant. Some people were of the opinion that the former composition of the boards resulted in professionals protecting each other. Since the introduction of the IHCP Act the disciplinary board meetings are, in principle, open to the public. The former closed situation made it impossible to obtain adequate insight into the disciplinary procedures. Moreover, the scope of the disciplinary proceedings has been extended to include four more professions, and there has been a change in the disciplinary norms and appeal procedures. The arsenal of sanctions has been increased and made more specific.

Only a limited amount of quantitative data relating to disciplinary proceedings in the Netherlands is available. The Health Care Inspectorate is the only authority in the
Netherlands that receives all verdicts and registers certain data. With the approval of the Health Care Inspectorate, and within the framework of the evaluation of the IHCP Act\textsuperscript{1}, a comparison was made of the complaints that were dealt with by the disciplinary boards before the IHCP Act and those that were dealt with after the introduction of the IHCP Act. The purpose of the study was to investigate whether there were differences in the number and the nature of the complaints, the complainants and the accused, and the verdicts after the IHCP Act came into effect.

**METHOD**

Within the framework of the evaluation of the IHCP Act, a retrospective study was made of all the verdicts pronounced by the five disciplinary boards in the first instance during the period from 1\textsuperscript{st} January 1995 to 31\textsuperscript{st} December 1997 (before the IHCP Act) and from 1\textsuperscript{st} January 1999 to 31\textsuperscript{st} December 2001 (after the IHCP Act). The study period for the appeal cases ended on 31\textsuperscript{st} December 2002. For this purpose the study concentrated on the four professional groups which were subject to the disciplinary system both before and after the IHCP Act, namely: physicians, dentists, pharmacists and midwives. Use was made of the collection of verdicts in the archives and the computerized database of the Health Care Inspectorate. Data on the number of physicians who were practicing during the study period were obtained from the registers of Statistics Netherlands (in Dutch: CBS), the Netherlands Institute for Health Services Research (in Dutch: Nivel), the specialist registration committees; Medical Specialists Registration Committee (in Dutch: MSRC), General Practitioner and Nursing Home Physician Registration Committee (in Dutch: HVRC) and Public Health Physicians Registration Committee (in Dutch: SGRC) and the IHCP register. The following was noted: the year of the verdict, the number and nature of the complaints, the types of complainants, the categories of professionals accused, the nature of the verdicts (sanctions imposed) and the number of appeal cases. The nature of the complaints was described according to the classification used in the Annual Reports of the Health Care Inspectorate.

The year 1998 was not investigated because in that year the regional disciplinary boards assessed some complaints according to the MD Act and others according to the IHCP Act. In 1999, 40 complaints were still assessed according to the MD Act. Because these were only a very small percentage of the total number of complaints in 1999 (4.5%), they have been included in the period after the IHCP Act came into effect.

Differences in outcome percentages between 1995-1997 and 1999-2001 were analysed with the $\chi^2$-test. Moreover, in a number of cases a 95% confidence interval was calculated for the outcome percentages in the period 1999-2001. The complaint density was defined as the number of complaints per 100 professionals.
RESULTS

Number of complaints. In the period 1995-1997 the disciplinary boards dealt with 2453 complaints (1995: 793, 1996: 809 and 1997: 851); in 1999-2001 there were 74 more complaints, namely 2527 (1999: 872, 2000: 874 and 2001: 781). By far the majority of complaints, 92% in both periods (2267 and 2313, respectively), were made against physicians. The complaint density in both periods was also highest for physicians, namely 2.2 and 2.1 complaints per year per 100 physicians, respectively and it was lowest for pharmacists, namely 0.2 and 0.1, respectively. Almost half of the complaints made against physicians in both periods concerned medical specialists (1066 (47%) and 1038 (45%), respectively) and approximately one third concerned general practitioners (760 (34%) and 746 (32%), respectively).

Nature of the complaints. In both periods a large majority of the complaints concerned ‘lack of care or inadequate care’ (600 (24%) and 764 (30%), respectively) or ‘incorrect treatment’ (587 (24%) and 513 (21%), respectively). Complaints about ‘not or belated visiting when requested’, ‘insufficient information’, ‘impolite behaviour’, ‘non-referral or referred too late’, ‘incorrect statement or reporting’, ‘incorrect fees’, ‘violation of professional secrecy’ and ‘professional misconduct’ together accounted for 15% and 16% of all the complaints in 1995-1997 and 1999-2001, respectively. In 1999-2001 there were more complaints about professional misconduct and incorrect fees than in 1995-1997 (18 vs. 1 and 15 vs. 3 complaints, respectively). There was a large category of ‘other complaints’ in both periods (887 (36%) and 818 (32%), respectively), because the Health Care Inspectorate includes in this category multiple complaints with no clear main complaint, ‘nonsensical’ complaints, complaints that do not directly concern care, complaints in which the plaint or the verdict contains little information about the complaint, and complaints that are difficult to classify.

Number of sanctions imposed. The number of complaints that led to a sanction decreased (p<0.001) from 462 (19%) in 1995-1997 to 376 (15%; 95% CI: 13.6-16.4) in 1999-2001 (1995 and 1996: 145 (18%) and 149 (18%), 1997: 168 (20%), 1999: 137 (16%), 2000: 122 (14%), 2001: 119 (15%)). In both periods ‘professional misconduct’, ‘violation of professional secrecy’ and ‘not or belated visiting when requested’ most frequently resulted in a sanction. The category of ‘other complaints’ seemed to contain a relatively large number of less serious complaints, in more of these cases (p<0.001) investigation was discontinued or the complaint was withdrawn. Moreover, in comparison with the other complaints, these complaints were more often (p<0.001) declared not eligible and less often (p<0.001) resulted in a sanction.

Complainants. Table 2 shows that two thirds of all the complaints were submitted by a patient (69% and 67%, respectively) and almost one third by someone else, usually a member of the patient’s family (29% and 32%, respectively). The number of complaints submitted by the Inspectorate in 1995-1997 was small (47/2453; 2%), and in 1999-2001 there were less than half as many (p<0.001) (19/2527; 0.8%) (95% CI: 0.4-1.2).

Nature of the verdicts. In both periods it appeared that almost two thirds of the complaints were unfounded (1561/2453; 64% and 1633/2527; 65%, respectively), and in both periods in almost the same number of cases the investigation was discontinued or the
Table 2
Nature and number of verdicts pronounced by the regional disciplinary boards as a result of complaints made by the inspector, a patient or another person during the periods 1995-1997 and 1999-2001*

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Entry struck off the IHCP register‡</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>11 (0.4)</td>
<td>7 (0.3)</td>
</tr>
<tr>
<td>• Partial withdrawal of the right to</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>practise the profession concerned‡</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Suspension of the entry in the IHCP</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>4 (0.2)</td>
<td></td>
</tr>
<tr>
<td>register and fine¶</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Suspension of the entry in the IHCP</td>
<td>13</td>
<td>2</td>
<td>10</td>
<td>10</td>
<td>1</td>
<td>5</td>
<td>24 (1)</td>
<td>17 (0.7)</td>
</tr>
<tr>
<td>register‡</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>6</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>15** (0.6)</td>
</tr>
<tr>
<td>• Conditional suspension of the entry in</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the IHCP register¶</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fine</td>
<td>3</td>
<td>1</td>
<td>11</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>16 (0.7)††</td>
<td>1 (0.0)</td>
</tr>
<tr>
<td>• Reprimand</td>
<td>9</td>
<td>2</td>
<td>47</td>
<td>29</td>
<td>44</td>
<td>32</td>
<td>100 (4)</td>
<td>63 (2)</td>
</tr>
<tr>
<td>• Warning</td>
<td>3</td>
<td>2</td>
<td>160</td>
<td>153</td>
<td>148</td>
<td>114</td>
<td>311 (13)</td>
<td>269 (11)</td>
</tr>
<tr>
<td>• Unfounded after a hearing</td>
<td>10</td>
<td>2</td>
<td>452</td>
<td>344</td>
<td>289</td>
<td>261</td>
<td>751 (31)</td>
<td>607 (24)</td>
</tr>
<tr>
<td>• Unfounded before a hearing</td>
<td>-</td>
<td>1</td>
<td>642</td>
<td>722</td>
<td>168</td>
<td>303</td>
<td>810 (33)</td>
<td>1 026 (41)‡‡</td>
</tr>
<tr>
<td>• Not eligible</td>
<td>-</td>
<td>-</td>
<td>80</td>
<td>175</td>
<td>28</td>
<td>38</td>
<td>108 (4)</td>
<td>213 (8)</td>
</tr>
<tr>
<td>• Investigation discontinued or</td>
<td>-</td>
<td>1</td>
<td>299</td>
<td>250</td>
<td>23</td>
<td>54</td>
<td>322 (13)</td>
<td>305 (12)</td>
</tr>
<tr>
<td>complaint withdrawn</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total (%)</td>
<td>47 (2)</td>
<td>19 (0.8)</td>
<td>1 702 (69)</td>
<td>1 693 (67)</td>
<td>704 (29)</td>
<td>815 (32)</td>
<td>2 453 (100)</td>
<td>2 527 (100)</td>
</tr>
</tbody>
</table>

* excluding ‘new’ professional groups. In 1999 only 40 complaints were dealt with under the Medical Disciplinary Act. These have been included in the Table.
† mostly members of the patient’s family
‡ the sanctions ‘entry struck off the IHCP register’ and ‘suspension of the entry in the IHCP register’ during the period 1995-1997 should be read as ‘withdrawal of the right to practise the profession concerned’ and ‘suspension of the right to practise the profession concerned’
§ this concerned 6 professionals. Against 1 dentist a complaint was made by both the Health Care Inspectorate and a patient.
¶ this sanction exists since the IHCP Act came into effect
† this concerned 11 professionals. Against 1 general practitioner 7 complaints were made (4 times by a patient and 3 times by another person).
‡‡ this concerned 13 professionals. Against 1 dentist 4 complaints were made by a patient.
†† in 1999, 33 complaints were made against the same prison physician. These complaints were unfounded before a hearing.
The complaint was withdrawn, mainly by the patients themselves. In the period 1999-2001, there were more ineligible complainants (p<0.001) than in 1995-1997 (8% (95% CI: 6.9-9.1) vs. 4%). The sanctions in both periods mainly concerned a warning or a reprimand, but in the second period both sanctions were less often imposed (p<0.05 and p<0.01, respectively). The number of warnings decreased from 13% to 11% (95% CI: 9.8-12.2), and the number of reprimands decreased from 4% to 2% (95% CI: 1.4-2.6). The other, more serious sanctions, together formed a relatively small, but constant percentage of the verdicts (51/2453; 2% and 44/2527; 2%, respectively). In 1999-2001, the new sanctions ‘conditional suspension of the entry in the IHCP register’ and ‘suspension of the entry in the IHCP register and a fine’ were imposed on 14 and 4 professionals, respectively. In principle, ‘partial withdrawal of the right to practise the profession concerned’ was not imposed upon physicians, dentists, pharmacists or midwives in the period 1999-2001 in first instance, but was imposed twice in appeal cases (not shown in the Table).

Many of the complaints made by the inspector in both periods resulted in a sanction (37/47; 79% and 15/19; 79%, respectively). In particular, the most serious sanction, entry struck off the IHCP register (in 1995-1997 withdrawal of the right to practise) was imposed for complaints that were submitted by the inspector (9/11; 82% and 4/7; 57%, respectively). In one case the board imposed a suspension of the entry by way of a provisional measure (not shown in the Table).

**Appeal cases.** In the period 1995-1997 an appeal was made to the central medical disciplinary board and the Courts of Justice against 31% (766/2453) of the verdicts pronounced by the disciplinary boards. In 1999-2001 appeals were made against approximately 29% of the verdicts pronounced by the regional disciplinary boards.

**DISCUSSION**

The above information provides a mainly quantitative description of the disciplinary proceedings before and after the IHCP Act. Many similarities and some differences were found. Some of the differences can be attributed to the IHCP Act, and others have another origin.

One similarity is that in both periods approximately the same number of complaints were dealt with. In the period 1983-1992 the number of complaints was still rising, but after 1992 various different developments appear to balance the situation. The increase in the number of tasks per professional (more surgical work, prescription of medication, etc.) and the increasing autonomy of the patient could have led to an increase in complaints, but quality policy development and growing self-regulation could have led to a decrease. One reason for the decrease in complaints is probably the Act governing the right of clients of the care sector to complain, that was introduced in 1995, which has given rise to the wide-scale establishment of complaint committees in the health care system. It is also possible that physicians deal with the complaints more appropriately, or that, because of the public nature of the disciplinary proceedings, the general public is less inclined to lodge a complaint concerning a private matter.
One notable difference is that the number of justified cases decreased from 19% to 15%. The increase in the number of legally qualified members in the disciplinary boards has apparently resulted in raising the already high threshold for justification, which should, after all, always result in a sanction. In this respect, the change in composition of the disciplinary boards has resulted more in weakening than in strengthening the position of the complainant. Moreover, a considerable percentage of the general public is not adequately aware of the aim and the content of the disciplinary system, and does not know what type of complaints can be brought before a disciplinary board.

In principle, the addition of another legally qualified member to the disciplinary board has no added value, according to the widely accepted opinion of the members of the disciplinary boards. On the other hand, the decrease in the professional input is considered to be a limitation in the basis of the decision-making, certainly now that there is quite regular criticism that the disciplinary boards show too little affinity with professional practice.

Another difference concerns the reduction, by more than half, in the already limited number of complaints made by the inspector. However, in both periods a sanction was imposed in more than three quarters of the cases, and this was relatively often one of the more serious sanctions. The decrease in the number of complaints does not appear to be dependent on the changes in disciplinary proceedings. According to the Health Care Inspectorate this is primarily the result of prioritization. Moreover, since the end of 1996 the Health Care Inspectorate is no longer involved in dealing with complaints, and is therefore less well informed about the incidents that occur. A bill has recently been introduced to propose changes in the Health Care Institutions Quality Act and the act governing the right of clients of the care sector to complain, in order to ensure that through notification the Health Care Inspectorate is better informed about health care incidents.

The new sanction of conditional suspension of the entry in the IHCP register that has been included in the IHCP Act, seems to meet the needs. This sanction was imposed in various situations. The other new sanctions were rarely imposed during the study period.

In general, the IHCP Act does not appear to have led to improvement in any important aspects of the disciplinary proceedings. In particular, the position of the complainant does not seem to be strengthened. The following indications can be made for further improvement. Informing citizens about disciplinary proceedings and other procedures for lodging complaints may increase the number of justified complaints and hence the number of ‘justified’ verdicts. A higher percentage of justified complaints and thus a more accurate standard-setting will be achieved if there is a possibility to declare a complaint justified without imposing a sanction. In order to increase professional support for the disciplinary verdicts, the number of health professional members in the regional disciplinary boards should be increased, and the boards should return to their former composition according to the regulations of the MD Act (in agreement with the viewpoint of the Royal Dutch Medical Association). The decrease in the number of complaints made by the Health Care Inspectorate calls for further clarification of the task and responsibility of the Health Care Inspectorate in case of complaints to the disciplinary boards.
References

12. Lower House 2001/02, 28 489, nrs 1-2. (proposal of law) [in Dutch: voorstel van wet]
Part III

Disciplinary system for the ‘new’ professions: practice and views
Chapter 4

The disciplinary system for nurses and its contribution to the quality of nursing care in the Netherlands

Abstract

Aim. To obtain insight into the contribution of the disciplinary system for nurses to monitoring the quality of nursing care in the Netherlands.

Methods. Complaints dealt with in the period 1998-2001 were studied. Questionnaires were sent to 3200 nurses (71%), all 388 members of the disciplinary boards (89%) and 43 practicing lawyers (65%).

Results. There was an increase in the number of nurses who were accused (20 in 1998, 12 in 1999, 54 in 2000, and 56 in 2001) and also in the annual percentages of sanctions imposed (0% in 1998, 8% in 1999, 13% in 2000 and 16% in 2001). The disciplinary system appears to be an important corrective instrument for serious professional misconduct.

INTRODUCTION

A disciplinary system for nurses already exists in various western countries, such as in the United Kingdom (UK), in the United States of America, in Canada and the Netherlands. Such a disciplinary system was introduced in the Netherlands at the end of 1997 when the Individual Health Care Professions Act (IHCP Act; in Dutch: Wet BIG) came into effect. Until that time there had only been a disciplinary system for physicians, dentists, midwives and pharmacists, and the disciplinary system was governed by the Medical Disciplinary Act (1928).

The aim of the disciplinary system is to foster and monitor high standards of professional practice, and to protect the general public against incompetence and carelessness, including harm and abuse. The disciplinary system for nurses is a definite step towards further professionalization of nursing practice. The IHCP Act also contributes by accentuating the individual responsibility of nurses.

There was a number of reasons for the introduction of a disciplinary system for nurses in the Netherlands. With regard to the care that is provided, the patient is extremely dependent on the nurse, who mainly functions autonomously in the relationship with the patient. In the collaboration between nurses and physicians it was experienced as unfair that when disciplinary offences that occurred within a team were assessed, certain members of the team were not subjected to the disciplinary proceedings. The criminal law and the labour law offer little opportunity for monitoring quality or protecting the patient. The introduction of a disciplinary system for members of the professional organizations only would not meet the requirements because of the relatively limited organization of nurses. Finally, serious pleas from the nursing profession itself also contributed to the introduction of the disciplinary system.

The disciplinary proceedings are dispensed by 5 regional disciplinary boards, and appeals are made to the central disciplinary board. The two disciplinary norms against which the disciplinary board assesses a case are: are the acts or omissions in conflict with the care that a professional should provide for the patient or close relatives of the patient, or have the acts or omissions in any other way been in conflict with the interests of good practice in individual health care. In deciding on its verdicts, the disciplinary board takes into account, among other things, the legal requirements, jurisprudence, professional codes...
**Box 1**
Definitions concerning disciplinary jurisprudence in the IHCP Act

| Complainants | - a person who has a direct interest (in practice, mostly a patient or close relative of the patient)  
| - the inspector for health care  
| - the institution in which the nurse is employed  
| - a physician who gave an order to the accused nurse |
| Disciplinary norms* | - inadequate care for the patient or the patient’s relatives  
| - any other act or omission that is in conflict with good practice of individual health care |
| Composition of the disciplinary boards | - the five regional disciplinary boards consist of two legally qualified members and three health professional members (i.e. nurses)  
| - the central disciplinary board consists of three legally qualified members and two health professional members (i.e. nurses) |
| Public access | in principle there is public access to meetings and verdicts of the disciplinary boards |
| Disciplinary actions | - warning  
| - reprimand  
| - fine  
| - conditional suspension of the entry in the IHCP register†  
| - suspension of the entry in the IHCP register†  
| - combination of suspension of the entry in the IHCP register† and fine  
| - partial withdrawal of the right of the person entered in the IHCP register† to practise the profession concerned  
| - striking off the entry in the IHCP register† |
| Possibilities for appeals against verdicts | - the complainant, but only if declared not eligible or the complaint was rejected  
| - the accused professional and the inspector for health care are entitled to appeal against all verdicts |
| Sanctions for incompetence | the Medical Supervision Board assesses professionals who, due to a physical or psychological illness or as the result of an addiction, are not competent to practice in the profession; only the Health Care Inspectorate can submit a written report to the Medical Supervision Board‡ |

* complaints must concern actions of the nurse that took place after 1st December 1997 (the date on which the IHCP Act came into effect)  
† the right to use a professional title only becomes effective after entry in the IHCP register  
‡ in the period 1998-2001 one written report concerning a nurse was submitted by the Health Care Inspectorate because of the use of substances under the Opium Act. Specific conditions were imposed on professional practice. No appeal was made.

and rules of conduct, professional-technical regulations, standards, guidelines and protocols, also collectively referred to as the professional standard. The sanctions that can be imposed range from mild to severe: warning, reprimand, fine, (conditional) suspension.
of the entry in the Individual Health Care Professionals register (IHCP register; in Dutch: BIG-register), partial withdrawal to practise the profession concerned, and striking off the entry in the register. Every directly involved party can make a complaint; in practice this is mainly a patient or a patient’s family. The inspector for health care is also authorized to lodge a complaint (Box 1).

Protecting the general public is achieved by imposing sanctions on nurses who have acted against the disciplinary norms. It is also anticipated that the disciplinary system has a preventive effect, and that it contributes to the further development and accentuation of the professional standard. To our knowledge, no empirical data concerning a disciplinary system for nurses has yet been published in scientific journals. We found no information in a Pubmed/Medline search. The aim of this article is to obtain insight into the contribution of the disciplinary system for nurses, which has now been in force for several years in the Netherlands, to monitoring the quality of nursing care in the Netherlands. For this purpose, during a period of 4 years a survey was made of all the complaints against nurses that were dealt with by the disciplinary boards. The perspective of the nurses themselves has also been studied, and this included investigating their knowledge about the disciplinary proceedings and their opinions about the normative and preventive effect of the disciplinary system. Finally, the opinions of other involved parties, members of the disciplinary boards, and practicing lawyers were investigated.

METHODS

Study of the complaints dealt with
Within the framework of the evaluation of the IHCP Act, a retrospective study was made of all the complaints about nurses dealt with by the regional disciplinary boards between 1st January 1998 and 31st December 2001. The study period for the appeal cases ended on 31st July 2003. Use was made of the collection of verdicts in the archives and the computerized database of the Health Care Inspectorate. Aspects that were studied were: year of the verdict, number and nature of the complaints, gender and field of work of the accused nurses, type of complainants, nature of the verdicts, number of appeals and amended verdicts, and nature of the amendments. For the description of various complaints and the associated verdicts, and the considerations of the disciplinary board, the Annual Reports of the regional disciplinary board in Amsterdam were used. Data on the number of nurses in employment and their distribution over the various sectors during the study period were obtained from Prismant (Research and Advice Office on Health Care in the Netherlands), and the gender distribution was obtained from the IHCP register. The 95% confidence intervals were calculated for the number of accused (Poisson distribution) and the percentage of sanctions imposed in 2001, and for the gender distribution and the distribution of the accused over the various sectors for the entire study period (binomial distribution).

Study of the questionnaires
Half way through 2001 a questionnaire was sent to a representative sample of 3200 nurses,
taken from the IHCP register. Included in the sample were nurses who had been registered before January 2001 and had no restrictions or clauses concerning their registration, were born after 1-1-1942, and were living in the Netherlands. These inclusion criteria were chosen in order to select nurses who were subjected to the disciplinary system and had at least some experience with the IHCP Act. In general, due to the arduous nature of the profession, nurses over the age of 60 are probably no longer working, so they are therefore not included in the sample. Prior to sampling, no information was available on their current employment status or place of work. The questionnaire contained, among other things, questions concerning background characteristics of the respondent, knowledge about the disciplinary proceedings, and opinions about the normative and preventive effects of the disciplinary system.

All 388 members of the disciplinary boards (regional and central) and 43 practicing lawyers with experience of disciplinary proceedings were sent a questionnaire at the end of 2001. Their names were on a central disciplinary board list of practicing lawyers who were fairly regularly involved in the central disciplinary board proceedings. The questionnaire contained, among other things, questions about background characteristics of the respondent, a statement about abolishment of the disciplinary system for nurses, and two statements about the (as yet) relatively small number of complaints about professionals who have been subject to the disciplinary system since the introduction of the IHCP Act. These two statements therefore did not only apply to nurses, but also to physiotherapists and health care psychologists.

In order to achieve maximum participation, measures were also taken to ensure the privacy of the respondents. In the covering letter it was stated that the questionnaire could be returned anonymously, and that the information contained in the questionnaire would only be used to answer the research questions addressed in the study. Moreover, a letter of recommendation from a number of nursing organizations was included, and the nurses were offered a modest incentive (a travelling alarm). In order to increase the validity of the results, considerable attention was paid not only to anonymity, but also to the content of the questionnaires, which were designed specifically for this study. Various experts; practicing lawyers, nurses and nursing organizations, were involved in the development of these questionnaires, which were tested in a small pilot study. There was no need to obtain informed consent or ethical approval, because patient-related research was not involved.

RESULTS

Study of the complaints dealt with

Number of complaints, accused, verdicts and sanctions imposed

During the period 1998-2001 the regional disciplinary boards dealt with 187 complaints about nurses, excluding 15 complaints that concerned actions that had taken place before the IHCP Act came into effect. In the first year (1998) 34 identical complaints about the same nurse were dealt with, which implies that there were 154 different complaints over the entire period. The 187 complaints were made about 142 different nurses, they were made by 147 different complainants, and resulted in 143 verdicts (more than one complaint about
the same nurse resulted in only one verdict). The number of accused increased during the study period (20 in 1998, 12 in 1999, 54 in 2000, and 56 in 2001; 95%-CI 2001: 41.0-71.0). A sanction was imposed on 17 nurses (12% of the verdicts). The percentage increased during the study period from 0% in 1998, 8% in 1999, 13% in 2000 to 16% in 2001 (95%-CI 2001: 7.6-28.3) (Table 1).

Table 1
Number of (different) complaints, accused, verdicts and sanctions imposed during the period 1998-2001

<table>
<thead>
<tr>
<th>Number during the period 1998-2001</th>
<th>Background and details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints (in fact plaints)</td>
<td>187</td>
</tr>
<tr>
<td>Different complaints</td>
<td>154</td>
</tr>
</tbody>
</table>
| Accused                            | 142                    | Some nurses were accused more than once:  
|                                   |                        | • 1 nurse 35x, 34 identical complaints  
|                                   |                        | • 1 nurse 10x                           
|                                   |                        | • 2 nurses 2x                           |
| Different complainants*            | 147†                   | Some complainants submitted complaints about different nurses considered together in one hearing:  
|                                   |                        | • 2 complainants each with 6 complaints  
|                                   |                        | • 1 complainant with 5 complaints       
|                                   |                        | • 3 complainants with 4 complaints      
|                                   |                        | • 4 complainants with 3 complaints      
|                                   |                        | • 9 complainants with 2 complaints      |
| Verdicts (including investigation discontinued, withdrawal of the complaint) | 143                    | Several complaints about the same nurse led 3 times to only 1 verdict:  
|                                   |                        | • 35 complaints about 1 nurse, 1 verdict  
|                                   |                        | • 10 complaints about 1 nurse, 1 verdict  
|                                   |                        | • 2 complaints about 1 nurse, 1 verdict  |
| Sanctions (% of verdicts)          | 17 (12)                | For the separate years:  
|                                   |                        | 1998: 0 (0)  
|                                   |                        | 1999: 1 (8)  
|                                   |                        | 2000: 7 (13)  
|                                   |                        | 2001: 9 (16)  |

* complaints made by the Health Care Inspectorate are classified as different  
† possibly less. Complaints made by the same complainant which were not considered together in the same hearing are classified as made by separate complainants.

**Gender and field of work of the accused**
Because the disciplinary system had only been in existence for a short time, the complaint density, defined as the number of accused per 100 working professionals, was calculated only over the last 2 years of the study period. In these 2 years an average of 55 different
nurses out of almost 135,000 working nurses were accused, which is equal to a complaint density of 0.04 (55/135,000). This is approximately 1 complaint per 2500 working nurses per year. The gender of 15 nurses was unknown, as was the field of work of 18 nurses. Almost half of the accused (45%, 95%-CI: 36.2-53.8) were male; during the study period 16% of all the nurses were male. Over two fifths of the accused nurses (43%, 95%-CI: 34.1-51.9) were employed in a hospital. During the study period almost half of all the working nurses were employed in this sector (47%). One third of the accused were working in care for the mentally ill and handicapped (33%, 95%-CI: 24.6-41.4), which was in agreement with the percentage of nurses working in this sector. In care for the elderly were 11% (95%-CI: 5.4-16.6) of the accused working, and 9% of all the working nurses were employed in this sector. There were 9% (95%-CI: 3.9-14.1) of the accused working in a penitentiary institution, a sector in which less than 1% of all working nurses were employed. Home care accounted for 2% (95%-CI: 0.2-5.7) of the accused, and 10% of all nurses. The remaining 3% of the nurses who were accused were working in other sectors, 2% of whom in the Municipal Health Services, in which sectors less than 1% of all nurses were employed.

Type of complainants
Two fifths of the complainants were patients (40%) and over a quarter were members of a patient’s family (28%). The inspector for health care lodged 4 complaints, and 1 complainant was the employer of the accused. There was a large category of ‘other complainants’ (40/138; 29%) because 34 prisoners made an identical complaint against the same nurse (Table 2).

Table 2
Complainants during the period 1998-2001; absolute numbers (%)

<table>
<thead>
<tr>
<th>Complainant</th>
<th>Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>55</td>
<td>(40)</td>
</tr>
<tr>
<td>Member of a patient’s family</td>
<td>38</td>
<td>(28)</td>
</tr>
<tr>
<td>Inspector for health care</td>
<td>4</td>
<td>(3)</td>
</tr>
<tr>
<td>Employer of the accused</td>
<td>1</td>
<td>(1)</td>
</tr>
<tr>
<td>Other complainants*</td>
<td>40</td>
<td>(29)</td>
</tr>
<tr>
<td>Total</td>
<td>138+</td>
<td>(100)</td>
</tr>
</tbody>
</table>

* it concerned 34 times a prisoner with an identical complaint against the same nurse
† it was unknown from 9 complainants. It concerned in all complaints/complainants but one complainants that were considered not eligible or the complaints were withdrawn or the hearing was abandoned.

Nature of the complaints and verdicts
Table 3 provides insight into the nature of the complaints and the number of sanctions imposed. The complaints mainly concerned ‘lack of care or inadequate care’ (29%). The category of ‘other complaints’ was large, because included in this category were complaints consisting of several components without a clear main complaint, ‘nonsensical’
complaints, complaints that did not directly concern care, complaints in which the plaint or the verdict contained little information about the complaint, and complaints that were difficult to classify. For sexual intimacies and sexual/physical abuse, a sanction was always imposed.

Table 3
Number of complaints, verdicts and sanctions imposed on the basis of the nature of the complaint during the period 1998-2001; absolute numbers (%)

<table>
<thead>
<tr>
<th>Nature of the complaint</th>
<th>Number of different complaints</th>
<th>Number of verdicts</th>
<th>Number of sanctions (% of verdicts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of care or inadequate care</td>
<td>44 (29)</td>
<td>43*</td>
<td>7 (17)</td>
</tr>
<tr>
<td>Sexual intimacies and abuse</td>
<td>16 (10)</td>
<td>7*</td>
<td>7 (100)</td>
</tr>
<tr>
<td>Incorrect treatment</td>
<td>12 (8)</td>
<td>12</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Impolite behaviour</td>
<td>9 (6)</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Violation of professional secrecy</td>
<td>5 (3)</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Incorrect statement or reporting</td>
<td>3 (2)</td>
<td>3</td>
<td>1 (33)</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>2 (1)</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Other complaints</td>
<td>63 (41)</td>
<td>62*</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>154 (100)</td>
<td>143</td>
<td>17 (12)</td>
</tr>
</tbody>
</table>

* a number of times several different complaints about the same nurse resulted in 1 verdict

Almost one in seven decisions (22/143; 15%) concerned a non-eligible statement from the complainant. In the same number of cases (22/143; 15%), either the complaint was withdrawn or the hearing was abandoned. In over half of the verdicts (82/143; 57%) the disciplinary board was of the opinion that the complaint was unfounded, usually before a hearing (63/82). Seventeen verdicts concerned a justified complaint, for which a sanction was imposed (17/143; 12%), which was usually a warning (7/143; 5%) or a reprimand (4/143; 3%). Two nurses had their entry struck off the IHCP register and three nurses had a conditional suspension of their entry in the IHCP register with a probation period of 2 years (Table 4). These conditions consisted in one case of withdrawal from direct patient care during the probation period, in one case of no repetition of disciplinary culpable actions or omissions, and in one case of not committing similar disciplinary actions and convincing the inspector that the treatment from a psychologist included specific focus on prevention of a repetition. All the complaints made by the inspector resulted in a sanction.

**Background of the verdicts**
Reasons for non-eligible complaints were: the plaint contained insufficient information, so it was not clear who was accused (complainants sometimes only know a nurse’s christian name) or what exactly the complaint was (6x), the complaint did not directly concern care (6x), the accused was not a nurse (2x), or the complainant was not directly involved (1x) (Box 2). In 7 cases the reason for non-eligibility was unknown. Examples of unfounded
complaints are given in Box 3. With regard to the 26 complaints (10 of which against the same nurse) that the regional disciplinary boards considered to be justified, Table 5 and Boxes 4 and 5 provide insight into the nature of the complaint, the gender and the field of work of the nurse, and the sanctions imposed. With regard to the complaints, eight concerned lack of care or inadequate care, seven concerned sexual intimacies and abuse, one concerned incorrect treatment and one was for an incorrect statement or report. In all cases the sexual acts took place in the mental health care sector, and most of the complaints concerning lack of care or inadequate care came from a hospital (5/8). The complaints about sexual intimacies and sexual/physical abuse were all made against male nurses, and in all but one of the cases the more severe sanctions were imposed. The other 10 complaints, made against four male and six female nurses, resulted in seven warnings and three reprimands. Of the nine complaints about lack of care or inadequate care or inadequate treatment, two cases concerned suicide of a patient, in one case a stillborn baby and in three cases the patient died (two of these complaints concerned the same patient).

Table 4
Nature and number of the verdicts pronounced by the regional disciplinary boards during the period 1998-2001

<table>
<thead>
<tr>
<th>Verdict</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry struck off the IHCP register</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Partial withdrawal of the right to practise the profession concerned</td>
<td>1 (0.7)</td>
</tr>
<tr>
<td>Combination of (conditional) suspension of the entry in the IHCP register and fine</td>
<td>1 (0.7)</td>
</tr>
<tr>
<td>Suspension of the entry in the IHCP register</td>
<td>-</td>
</tr>
<tr>
<td>Conditional suspension of the entry in the IHCP register</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Fine</td>
<td>-</td>
</tr>
<tr>
<td>Reprimand</td>
<td>4 (3)</td>
</tr>
<tr>
<td>Warning</td>
<td>7 (5)</td>
</tr>
<tr>
<td>Unfoundend after a hearing</td>
<td>19 (13)</td>
</tr>
<tr>
<td>Unfounded before a hearing</td>
<td>63 (44)</td>
</tr>
<tr>
<td>Not eligible</td>
<td>22 (15)</td>
</tr>
<tr>
<td>Investigation discontinued or complaint withdrawn</td>
<td>22 (15)</td>
</tr>
<tr>
<td>Total (%)</td>
<td>143 (100)</td>
</tr>
</tbody>
</table>

Box 2
Complainant not eligible

It was considered that the complainant was not eligible because the accused nurse carried out no nursing activities at all within the institution in which she was working and she was also not involved in the treatment of the complainant’s mother. The nurse, in her function as head of the unit, was only involved in allocating the accommodation supervisors to the various accommodation departments and advising and co-ordinating the accommodation within the institution.
Box 3
Unfounded before a further hearing

- A four-fold complaint was made by the son of a patient who was admitted to a nursing home in which the four accused nurses worked. The regional disciplinary board found that no disciplinary action could be taken against the nurses with regard to the care provided and supervision of the patient, but that the communication between the complainant and the nurses had apparently not been optimal. The board could find no grounds for the accusation that the patient was deliberately admitted to a psychiatric institution. The board further added that from the statements it was more likely that discussions were held with the various parties involved with the intention of offering the patient a optimal accommodation. All these decisions were upheld by the central disciplinary board.

- A complaint against a socio-psychiatric nurse who was working in the psychiatric department of a hospital inferred that for no reason at all he had secluded the complainant during admission and had also maltreated her. The regional disciplinary board considered it acceptable that the seclusion of the complainant was necessary and occurred according to the treatment plan, and that it did not appear that the nurse, although he admitted that he had eventually pulled her along by her arm, had performed any incorrect actions in the given situation.

- A socio-psychiatric nurse, working in a regional institution for ambulatory mental health care, was accused of refusing to co-operate in having the complainant admitted to a ‘normal’ home for the elderly and that he did not want to give her any medicine. The first aspect of the complaint was rejected because it was apparent from the reports that the nurse had done everything possible to find the most suitable type of accommodation for the complainant. The second aspect was rejected because of lack of evidence.

- Two complaints from the same complainant were connected with complaints about the actions of four physicians and a health care psychologist who were all involved in his treatment in a hospital. All the complaints concerned participation in a complot to force the complainant to be admitted to a psychiatric hospital, with the intention to prevent the complainant from taking disciplinary action for medical errors. The regional disciplinary board found no evidence at all that such a complot had existed. The complaints were also rejected by the central disciplinary board.

Box 4
Warning

The complaint, submitted by the inspector for health care, was that the intensive care nurse had made a grave mistake by going off to drink coffee somewhere else and leaving his patient alone, without checking to see if his patient could speak after he had taken him off the breathing apparatus and connected him to a ‘speech tube’. The nurse had forgotten to uncuff the tracheal tube, with the result that the patient received a continuous flow of four litres of oxygen per minute when his exhalation was blocked. The patient died as a result of a tension pneumothorax. The conclusion of the regional disciplinary board was that the nurse failed in the most elementary skills and responsibilities that are required from a nurse, namely observation, supervision, nursing and care. In its decision with regard to the sanction to be imposed, the board took into consideration the fact that the nurse admitted to the seriousness of his mistakes and the fact that at the time of the calamity the hospital had no protocol for the connection of a ‘speech tube’.

Appeal

An appeal was made to the central disciplinary board in 38 cases, which is 20% of all complaints (187) and 28% of the cases in which an appeal could be made (134). On 31st July 2003 there was an appeal pending in at least one case. One reprimand was changed to a warning, and one warning was changed to an unfounded complaint. Apart from these cases, the appeal verdicts remained unchanged.
Table 5  
Nature of the complaint, gender and field of work of the accused and sanctions imposed by the disciplinary boards for justified complaints during the period 1998-2001

<table>
<thead>
<tr>
<th>Nature of the complaint</th>
<th>Specific nature of the (main) complaint</th>
<th>Gender of the accused</th>
<th>Field of work of accused</th>
<th>Sanction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of care or inadequate care * n= 8</td>
<td>Incompetent and careless treatment, inadequate file</td>
<td>Man</td>
<td>Ambulatory mental health care</td>
<td>Warning, appeal unfounded</td>
</tr>
<tr>
<td></td>
<td>Insufficient tests</td>
<td>Man</td>
<td>Ambulatory mental health care</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Inadequate care for patient and inadequate checking of apparatus (‘speech-tube’) (see also Box 4)</td>
<td>Man</td>
<td>Hospital</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Neglect, incorrect (and omissions in) nursing care (pulmonary embolism)</td>
<td>Wife</td>
<td>Hospital</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Primary check too late (pulmonary embolism)</td>
<td>Wife</td>
<td>Hospital</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Inadequate monitoring and interpretation of cardiotocography</td>
<td>Wife</td>
<td>Hospital</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Insufficient action</td>
<td>Wife</td>
<td>Ambulatory mental health care</td>
<td>Reprimand, appeal still pending</td>
</tr>
<tr>
<td></td>
<td>Flushing the infusion with incorrect liquid</td>
<td>Wife</td>
<td>Hospital</td>
<td>Reprimand</td>
</tr>
<tr>
<td>Sexual intimacies and abuse n= 7</td>
<td>Sexual relationship</td>
<td>Man</td>
<td>Ambulatory mental health care</td>
<td>Reprimand†</td>
</tr>
<tr>
<td></td>
<td>Sexual relationship</td>
<td>Man</td>
<td>Hospital mental health care</td>
<td>Conditional suspension of the entry in the register for 1 year‡</td>
</tr>
<tr>
<td></td>
<td>Sexual relationship</td>
<td>Man</td>
<td>Hospital mental health care</td>
<td>Conditional suspension of the entry in the register for 1 year and fine‡</td>
</tr>
<tr>
<td>Nature of the complaint</td>
<td>Specific nature of the (main) complaint</td>
<td>Gender of the accused</td>
<td>Field of work of accused</td>
<td>Sanction</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------</td>
<td>--------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Sexual intimacies and abuse</td>
<td>Sexual intimacies</td>
<td>Man</td>
<td>Hospital mental health care</td>
<td>Suspension of the entry in the register for 4 months, 2 conditional‡</td>
</tr>
<tr>
<td></td>
<td>Sexual intimacies (see also Box 5)</td>
<td>Man</td>
<td>Residential care for handicapped</td>
<td>Partial withdrawal from practising the profession</td>
</tr>
<tr>
<td></td>
<td>Sexual relationship</td>
<td>Man</td>
<td>Hospital mental health care</td>
<td>Entry struck off the register</td>
</tr>
<tr>
<td></td>
<td>Maltreatment of patients¶</td>
<td>Man</td>
<td>Nursing home</td>
<td>Entry struck off the register§</td>
</tr>
</tbody>
</table>

Incorrect treatment
N= 1

| Incorrect statement or reporting | Statement about a relationship between the decompensation of patient and the sexual intimidation of complainant unwise or incorrect | Wife | Ambulatory mental health care | Warning |

* the 4th and 5th complaints were made by the same complainant
† because this nurse had already arranged to have his entry struck off the IHCP register himself and had indicated that he no longer wanted to be registered, the only sanction that the regional disciplinary board imposed was a reprimand
‡ the conditions consisted in one case of not being involved in direct patient care during a probation period of two years, in one case it was not repeating any disciplinary culpable actions or omissions, and in one case it was not committing similar disciplinary actions and convincing the inspector that the psychotherapy included specific focus on the prevention of a repetition
§ also dismissal and criminal proceedings. In other cases it is not known whether dismissal or criminal proceedings took place
¶ this involved 10 complaints from different complainants
Box 5
Partial withdrawal from professional practice

The Board of Directors of an organization providing services for people with a mental handicap made a complaint against a nurse, after the father of a resident reported that at night his son, who was a minor, had several times been the victim of indecent behaviour from the nurse. The nurse was immediately dismissed and a report was made to the police. Later it appeared that the nurse had also been guilty of sexual intimacies towards another resident who was a minor. The opinion of the regional disciplinary board was that minors and the mentally handicapped are very vulnerable groups of patients and that, also in order to protect the nurse against himself, these patients c.q. residents should no longer be cared for by the nurse. The board imposed the sanction of withdrawing the nurse’s right to practice his profession, as far as nursing care for minors and the mentally handicapped was concerned.

Study of the questionnaires

Response

Of the 3200 questionnaires sent to the nurses, 58 were returned uncompleted, due to a change of address or retirement. Of the remaining 3142 nurses, 2233 responded (71%). One third of the questionnaires concerned nurses who were not or no longer working (732). Finally, only the questionnaires returned by working nurses (1501), who were subjected to the disciplinary system, were included in the analysis.

Five members of the disciplinary boards were of the opinion that they had too little experience to complete the questionnaire, two had a prolonged illness, two could not be contacted, and one was no longer a member of a disciplinary board. Of the remaining 378 members, 336 completed and returned the questionnaire (response 89%). Both the respondents and the non-respondents among the members of the disciplinary boards consisted for one fifth of legally qualified members and for four fifths of health professional members. Two lawyers were of the opinion that they had too little experience to complete the questionnaire, and one was no longer involved in disciplinary proceedings. Of the remaining 40 practicing lawyers, 26 responded (response 65%).

Perspective of the nurses

Of the nurses, 89% were aware that the aim of the disciplinary system is ‘to monitor and foster the quality of professional practice’, and 84% that it is ‘to correct professionals who have made mistakes’. Two thirds (66%) were aware that the disciplinary system does not involve the compensation of patients in the form of damages, 60% that its aim is not to restore the care relationship with the patient, and 93% that a disciplinary board has the authority to strike a professional’s entry off the register.

Of the nurses 81% were of the opinion that the disciplinary system plays a role in monitoring the quality of nursing care. Half of the nurses (51%) stated that a published verdict about another nurse influences their professional practice, and two fifths (41%) considered that in their assessment of cases the disciplinary boards are sufficiently in agreement with what is considered to be good nursing care (but it should be noted that the majority of them answered ‘neither agree nor disagree’ to the latter statement). Nurses who said that they always read verdicts imposed on nurses (59%) more often ‘agreed’ with both statements and less often ‘neither agreed nor disagreed’, compared with those who
indicated that they did not read about these verdicts. Almost half of the nurses (45%) did not consider the possibility of disciplinary proceedings to be a threat. Most of the nurses (79%) were of the opinion that the disciplinary system should not be abolished for their profession (Table 6).

Table 6  
Views of working nurses (n= 1485) on the disciplinary system for their profession: percentage of respondents who (totally) agreed, neither agreed nor disagreed and (totally) disagreed with the statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>(Totally) agreed</th>
<th>Neither agreed nor disagreed</th>
<th>(Totally) disagreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In its assessment of complaints, the disciplinary board is sufficiently in agreement with what the nursing profession considers to be good care</td>
<td>41</td>
<td>56</td>
<td>4</td>
</tr>
<tr>
<td>• The disciplinary system plays a role in monitoring the quality of nursing care</td>
<td>81</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>• A published verdict imposed on another nurse influences my professional practice</td>
<td>51</td>
<td>22</td>
<td>27</td>
</tr>
<tr>
<td>• I consider the possibility of a complaint to be a threat</td>
<td>33</td>
<td>22</td>
<td>45</td>
</tr>
<tr>
<td>• The disciplinary system for nurses should be abolished</td>
<td>5</td>
<td>17</td>
<td>79</td>
</tr>
</tbody>
</table>

Perspective of other parties involved
Like the nurses, most of the members of the disciplinary boards and most of the practicing lawyers were of the opinion that the disciplinary system for nurses should not be abolished (80% and 89%, respectively). The members of the disciplinary boards and the practicing lawyers gave as specific explanation that, in their opinion, the disciplinary system is also a quality-promoting instrument for nurses, that nurses must also be subject to assessment, that there is therefore no reason to differentiate between the various professions in the individual health care sector, that mistakes made by nurses can be serious, and that the disciplinary system has a preventive effect. Among those who thought that the disciplinary system for nurses should be abolished, i.e. 9% of the members of the disciplinary boards and 8% of the practicing lawyers, one of the reasons that was given was that nurses often work under supervision, or that their responsibility is usually very closely related to that of a superior. Almost two thirds of the members of the disciplinary boards and practicing lawyers (64% and 62%, respectively) agreed with the statement that the general public is still not adequately aware of the possibility of making a complaint against a nurse. One quarter of the members of the disciplinary boards (26%) and 42% of the practicing lawyers were of the opinion that the number of complaints made about nurses will remain low (50% and 46%, respectively, ‘neither agreed nor disagreed’). The explanations that were given were: that nurses are considered to work according to policies and treatment decisions made by a physician, and that therefore the physician has greater responsibility and shall be the first to be accused, that the closer nurse/patient relationship prevents complaints, and that complaints about the nurses often concern attitude and are therefore brought before a complaint committee.
DISCUSSION

Background, strengths, limitations
In the Dutch health care system the disciplinary proceedings are an element in the regulation of professional practice. Not only the government (the statutory framework, the IHCP register, the establishment of disciplinary boards), but also the professionals themselves (nurses as members of the disciplinary boards, the organization of conferences, the development of protocols, reference to the disciplinary system in journals) have a role in the practical aspects of the disciplinary system. In our opinion, this study shows the position of the disciplinary system for nurses within the field of disciplinary jurisprudence and provides an indication of the contribution of the disciplinary system for nurses to monitoring the quality of nursing care in the Netherlands. This study makes it possible for researchers in other countries, with similar or different regulations for professional practice, to learn from the experiences gained in the Netherlands and also from the (restricted) comparison between the Netherlands and the UK. All the complaints dealt with by the regional disciplinary boards during the period 1998-2001 were included in the study, and the response to the questionnaires was high, from the nurses as well as from the members of the disciplinary boards and the practicing lawyers. One limitation of this study is that two statements did not only concern nurses, but also other professional groups that are subjected to the disciplinary system since the introduction of the IHCP Act. Another limitation is that the magnitude of the educative and corrective effect of monitoring the quality of nursing practice has not been investigated (or can not be measured). It was also not possible to determine the extent to which the existence of the disciplinary system for nurses, in itself, has a preventive quality-promoting effect. We found no empirical data concerning the disciplinary system for nurses in other countries than the Netherlands and the UK.

Study of the complaints dealt with
Number of complaints, complaint density and percentage of sanctions imposed
The study of the complaints dealt with by the regional disciplinary boards shows that the disciplinary system for nurses has been going through a developmental phase. Both the annual number of accused nurses and the percentage of sanctions imposed increased during the study period. Apparently, the general public is becoming more aware of the possibility of making a complaint. Although, in comparison to physicians and midwives, the number of accused per 100 working professionals is still relatively low (0.04 for nurses in the period 2000-2001 vs. 2.1 for physicians and 0.5 for midwives in the period 1999-2001), the percentage of sanctions imposed reached a similar level (16% in 2001 for nurses vs. 14% in the period 1999-2001 for physicians and 23% (small numbers: 5 out of the 22) for midwives). It is difficult to compare the disciplinary system in the Netherlands with that in the UK, among other things because of differences in the content and in the procedures. For instance, in the UK everyone has the right to complain, and the complaints are not only restricted to direct patient care. Comparisons are also difficult because the data from the UK are mainly a combination of data on both nurses and midwives. However, when the complaint density is compared, it can be seen that for nurses and midwives together in the period 1999-2000 this was 0.19 (1213/634,529), and thus 5 times as great as for nurses in
the Netherlands. The Preliminary Proceedings Committee (PPC) dealt with 1213 complaints, imposed 30 cautions (2%), and referred 164 complaints (14%) to the Professional Conduct Committee (PCC). During this period the PCC dealt with 135 cases of alleged misconduct and imposed 123 sanctions (91%).

Whether or not the number of accused nurses in the Netherlands will continue to increase will only be known in the future. Half of the members of the disciplinary boards and practicing lawyers made no comment in this respect. However, almost two thirds of them were of the opinion that the general public is not sufficiently aware of the possibility to make complaints about nurses to a disciplinary board. Other research has shown that only half of the general public know that nurses are subject to the disciplinary system. Other possible reasons for the low complaint density that have become apparent during the study are that nurses are considered to work according to a policy that is determined by the physician and that the physician will therefore sooner be accused, and that because of the closer nurse/patient relationship the patient does not bother to make a complaint, or that the complaint threshold is too high. Inability to find out a nurse’s surname or actual place of work, which are both required in order to make a plaint, can also be a reason for not making a complaint.

The fact that a number of complainants complained about more than one nurse at the same time is sometimes due to the fact that teamwork is becoming more and more frequent. However, the nature of the disciplinary system is that it focuses on individual responsibility. Further research is needed to address the question of whether a form of team responsibility should be introduced in the disciplinary system.

**Gender and field of work of the accused**

It is notable that almost half of the accused nurses were male, whereas only 16% of all the nurses were male. In the UK, half of the complaints dealt with by the PCC concerned male professionals, whereas only 10% of all registered nurses were males.

Compared with other health care sectors, complaints about nurses are made relatively more often in a penitentiary institution and relatively less often in the home care sector. This can be due to the type of patient that nurses working in a penitentiary institution have to deal with, and with the nature of the work in the home care sector. Of the cases dealt with by the PCC for which a sanction was imposed, the setting or practice of the accused was most often a nursing home (27%), a medical/surgical setting (19%) or a mental health care setting (17%, including elderly mentally ill patients), while 17% of the complaints were not work-related. Complaints in the field of midwifery amounted to 5%.

**Type of complainants**

In the UK almost half of the complaints about nurses and midwives that were dealt with by the PPC are made by employers, other important parties are the public and the police. In the Netherlands it is almost exclusively patients and members of a patient’s family who make the complaints. In the Netherlands it is not customary for an employer to make a disciplinary complaint about an employee, and moreover this was not even possible under the former Medical Disciplinary Act. Complaints made by employers in the Netherlands are usually subject to the labour law. The fact that, in spite of the increase in the percentage of
sanctions imposed, many complaints are still unfounded can also be related to the limited knowledge the general public has about the disciplinary proceedings. Many people are also not sufficiently aware of the aim or the content of the disciplinary system, and do not know which complaints they can bring before a disciplinary board. Six times the complaint contained insufficient information, so it was not clear who was accused or what exactly the complaint was. More public information about the existence of the disciplinary system for nurses and the procedure of making a complaint could increase the number of complaints and also the number of justified complaints. The Health Care Inspectorate made only 4 complaints during the study period. According to the Health Care Inspectorate this is primarily due to prioritisation. Moreover, since 1996 the Inspectorate only makes a complaint if the general interest is involved to a great extent. The complaints made by the Inspectorate always resulted in a sanction. There were no cases at all in which a physician made a complaint about a nurse who was given an order. Whether this is because there was no reason to complain, or whether it was due to insufficient knowledge about the existence of the disciplinary system for nurses, was not investigated in this study.

**Nature of complaints and verdicts; serious forms of professional misconduct**

The study further demonstrates that the disciplinary jurisprudence is an important correction instrument with regard to serious forms of professional misconduct in nursing care and in particular in the field of mental health care such as sexual intimacies and sexual/physical abuse. In this respect the disciplinary system has proved to be important. With regard to the development of standards for other aspects of professional practice, the disciplinary system (still) plays a very limited role. In the UK, the practice-related complaints for which the PCC imposes a sanction also mainly concern physical or verbal abuse of patients (31%), in addition to unsafe clinical practice (12%). In such cases, in the UK the entry is usually struck off the register, and in the Netherlands the verdict is usually a warning or a reprimand.

**Study of the questionnaires; perspective of nurses and other parties involved**

From the questionnaire study it appears that nurses are well aware of the aim of the disciplinary system. The opinions of the nurses, the members of the disciplinary boards and the practicing lawyers emphasize the importance of the disciplinary system. A large majority of the nurses, members of the disciplinary boards and practicing lawyers are of the opinion that the disciplinary system for nurses should not be abolished. The introduction of the disciplinary system seems to have given an impulse to monitoring the quality of nursing practice. In addition to the fact that most of the nurses consider the disciplinary system to be a quality-monitoring instrument, this impulse is also evident from the large number of protocols that have been developed, and the many study days and role-played hearings of a disciplinary board that have been organized by the Netherlands Centre for Excellence in Nursing (in Dutch: LEVV) and the attention that has been paid to this subject in the professional journals. The repeatedly applied option of conditional suspension of the entry in the register also contributes to quality-monitoring. Finally, published verdicts seem to have a preventive effect. Half of the nurses stated that the publication of a verdict imposed on another nurse influences their own professional practice. During the study period only
13 out of the 143 verdicts, 6 of which were justified complaints, were published in the Netherlands Government Gazette and submitted to nursing journals and other journals. If the disciplinary boards publish more verdicts in the Netherlands Government Gazette and journals, or via the internet, this will make a further contribution to quality-promotion.

References

Chapter 5

The Dutch disciplinary system for physiotherapists: practice and views

Accepted for publication as: Hout FAG, Cuperus-Bosma JM, Hubben JH, Wal G van der. The Dutch disciplinary system for physiotherapists: practice and views. Risk and Safety in Medicine.
Abstract

Background. The statutory disciplinary system for physiotherapists in the Netherlands was introduced at the end of 1997. The aim of this system is to monitor the quality of physiotherapy.

Methods. Retrospective study of all the complaints that were dealt with by the five regional disciplinary boards in the period 1998-2002. The year of each verdict was noted, the number and nature of the complaints, gender and field of work of the accused physiotherapists, type of complainants and nature of the verdicts. Furthermore, a random sample of 300 physiotherapists working in primary health care were asked about their views on the statutory disciplinary system (response 76%).

Results. During the study period 33 complaints were made about physiotherapists. The annual number of accused physiotherapists increased from zero in 1998 to 11 in 2002. Male physiotherapists were accused relatively more often than their female colleagues. A sanction was imposed 11 times (33% of the verdicts), mostly a reprimand or suspension. Most complaints concerned sexual intimacies or abuse. The majority of the respondents (88%) were of the opinion that the statutory disciplinary system for physiotherapists should subsist.

Conclusion. In spite of an increase in the annual number of accused physiotherapists, relatively few complaints are made about physiotherapists. The statutory disciplinary system appears to be an important corrective instrument by imposing sanctions for serious forms of professional misconduct in physiotherapy. However, with regard to the development of standards for other aspects of the profession, i.e. treatment and advice, the system (still) plays a limited role.

INTRODUCTION

A disciplinary system for physiotherapists already exists in various western countries, at least in the UK, the USA, Canada and Australia. In the Netherlands a statutory disciplinary system for physiotherapists was introduced at the end of 1997 when the Individual Health Care Professions Act (IHCP Act; in Dutch: BIG Act) came into effect. Until that time there had only been a statutory disciplinary system for physicians, dentists, midwives and pharmacists, and the statutory disciplinary system was governed by the Medical Disciplinary Act. The aim of the statutory disciplinary system is important to public health, i.e. to foster and monitor high standards of professional practice, and to protect the general public against incompetence and carelessness, including harm and abuse.

There were a number of reasons for the introduction of the statutory disciplinary system for physiotherapists in the Netherlands. Evaluation of the Royal Dutch Society for Physiotherapy (RDSP; in Dutch: KNGF) internal disciplinary system for the physiotherapy profession showed that almost half of the complaints could not be dealt with because the physiotherapists concerned were not members of the RDSP. Moreover, the possible sanctions had insufficient impact, because expulsion as a member is the most severe disciplinary measure.¹ Other reasons for its introduction included the high degree of dependence of the patient on the professional and the inability of the patient to assess the competence of the physiotherapist.² Physiotherapy is the only paramedical profession that has become subjected to an statutory disciplinary system. For physiotherapists this is a
definite step towards the further professionalization of physiotherapy. The most important elements of the disciplinary procedures are described in Box 1.

**Box 1**
**Definitions concerning disciplinary proceedings in the IHCP Act**

| Complainants | - a person who has a direct interest (in practice, mostly a patient or close relative of the patient)  
|              | - the inspector for health care  
|              | - the institution in which the physiotherapist is employed |

| Disciplinary norms* | - inadequate care for the patient or the patient’s relatives  
|                     | - any other act or omission that is in conflict with good practice of individual health care |

| Composition of the disciplinary boards | - the five regional disciplinary boards consist of two legally qualified members and three health professional members (i.e. physiotherapists)  
|                                       | - the central disciplinary board consists of three legally qualified members and two health professional members (i.e. physiotherapists) |

| Public access | in principle there is public access to meetings and verdicts of the disciplinary boards |

| Disciplinary actions | - warning  
|                      | - reprimand  
|                      | - fine  
|                      | - conditional suspension of the entry in the IHCP register†  
|                      | - suspension of the entry in the IHCP register†  
|                      | - combination of suspension of the entry in the IHCP register† and fine  
|                      | - partial withdrawal of the right of the person entered in the IHCP register† to practise the profession concerned  
|                      | - striking off the entry in the IHCP register† |

| Possibilities for appeals against verdicts | - the complainant, but only if declared not eligible or the complaint was rejected  
|                                           | - the accused professional and the inspector for health care are entitled to appeal against all verdicts |

against a verdict of the central court there is no other possibility than cassation to the Supreme Court, but only in the interest of the law

| Sanctions for incompetence | the Medical Supervision Board assesses professionals who, due to a physical or psychological illness or as the result of an addiction, are not competent to practice in the profession; only the Health Care Inspectorate can submit a written report to the Medical Supervision Board‡ |

* in deciding on its verdicts, the disciplinary board takes into account, among other things, the legal requirements, jurisprudence, professional codes and rules of conduct, professional-technical regulations, standards, guidelines and protocols, also collectively referred to as the professional standard. Complaints must concern actions of the physiotherapist that took place after the IHCP Act came into effect.

† the right to use a professional title only becomes effective after entry in the IHCP register

‡ in the period 1998-2002 one written report concerning a physiotherapist was submitted by the Health Care Inspectorate because of alcohol abuse. His entry was struck off the IHCP register. Moreover, as a temporary measure his entry was suspended. No appeal was made.
The aim of imposing sanctions on physiotherapists who have acted against the
disciplinary norms is public protection. It is also anticipated that the statutory disciplinary
system has a preventive effect, and that it contributes to the further development and
accentuation of the professional standard. To our knowledge, no empirical data concerning
disciplinary proceedings for physiotherapists have yet been published in scientific journals.
We found no information in Pubmed/Medline. The aim of this article is to provide insight
into the practical aspects of the statutory disciplinary system for physiotherapists now that it
has been in force for several years in the Netherlands. Furthermore, the views of
physiotherapists on this system are presented.

METHODS

Study of the complaints dealt with
Within the framework of the evaluation of the IHCP Act, a retrospective study was made of
all the complaints about physiotherapists dealt with by the regional disciplinary boards
between 1\textsuperscript{st} January 1998 and 31\textsuperscript{st} December 2002. The study period for the appeal cases
ended on 31\textsuperscript{st} July 2003. Use was made of the collection of verdicts in the archives and the
computerized database of the Health Care Inspectorate. Aspects that were studied were:
year of the verdict, number and nature of the complaints, gender and field of work of the
accused physiotherapists, type of complainants and nature of the verdicts. For the
description of various complaints and the associated verdicts, and the considerations of the
disciplinary board, reference was made to the Annual Reports of the regional disciplinary
board in Amsterdam. Data on the number of physiotherapists in employment and their field
of work during the study period were obtained from the Netherlands Institute for Health
Services Research (NIHSR; in Dutch: Nivel), and data on the gender distribution were
obtained from the NIHSR and the IHCP register. The 95\% confidence intervals were
calculated for the number of accused in 2002 (Poisson distribution), for the gender
distribution and for the distribution of the accused over the fields of work for the entire
study period (binominal distribution).

Study of the questionnaires
At the end of 2001, a questionnaire was sent to a random sample of 300 physiotherapists
who were selected from the NIHSR database of physiotherapists working in primary health
care (n = 12,234). Only physiotherapists working in primary health care were approached,
because many physiotherapists who are not (or no longer) working (an estimated 38\%) are
included in the IHCP register, and there is no database of physiotherapists working in
hospital- and/or residential health care. The sample consisted of physiotherapists who were
born after 1-1-1937, were working and living in the Netherlands, and who had started
working before 1-6-2001. These inclusion criteria were chosen in order to select
physiotherapists who were subject to the statutory disciplinary system and had at least some
experience with the IHCP Act. The questionnaire contained, among other things, questions
concerning their views about the statutory disciplinary system.

In order to achieve maximum participation, measures were taken to ensure the privacy
of the respondents. The questionnaire could be returned anonymously. In order to increase the validity of the results, considerable attention was paid not only to anonymity, but also to the content of the questionnaires, which were designed specifically for this study. The questionnaire was reviewed by various experts: practicing lawyers, physiotherapists and the RDSP. There was no need to obtain ethical approval, because patient-related research was not involved.

RESULTS

Study of the complaints dealt with

General
During the period 1998-2002 the regional disciplinary boards dealt with 33 complaints about physiotherapists, excluding seven complaints that concerned actions that had taken place before the IHCP Act came into effect. The 33 complaints were made about 30 different physiotherapists and they were made by 30 complainants. The annual number of accused increased during the study period (zero in 1998, two in 1999, six in 2000 and 11 in both 2001 and 2002; 95%-CI 2002: 4.4-17.6). A sanction was imposed 11 times (33% of the verdicts). Two different sanctions were imposed on one physiotherapist.

Gender and field of work of the accused
Of the 30 different accused physiotherapists, the field of work of 16 was known, as was the gender of 22. Almost all of the accused whose field of work was known (14/16; 88%, 95% CI: 61.6-98.5) were working in primary care; this was 71% of all physiotherapists. Twenty of the 22 accused physiotherapists whose gender was known (91%, 95% CI: 70.8-98.9) were male; during the study period this was 42% of all physiotherapists, including the non-working, and 50% of the physiotherapists working in primary health care.

Type of complainants
Most of the complainants were patients (24/30). Twice the complaints were made by the patient’s family, and once the complaint was made by a friend of the patient. The inspector for health care made two complaints, and one complainant was an employee in a physiotherapy practice (who complained about four physiotherapists).

Nature of the complaints and verdicts
Table 1 shows the nature of the complaints and the number of sanctions imposed. The complaints mainly concerned ‘sexual intimacies or abuse’, ‘incorrect treatment or diagnosis’ or ‘lack of care or inadequate care’. The category of ‘other complaints’ was large, because included in this category were: complaints consisting of several components without a clear main complaint, complaints that did not directly concern care, complaints in which the verdict contained little information about the complaint, and complaints that were difficult to classify. For sexual intimacies or abuse a sanction was imposed in seven of the ten cases.
### Table 1
Number of complaints and sanctions imposed on the basis of the nature of the complaint during the period 1998-2002; absolute numbers (%)

<table>
<thead>
<tr>
<th>Nature of the complaint</th>
<th>Number of complaints</th>
<th>Number of sanctions (% of complaints)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual intimacies or abuse*</td>
<td>10</td>
<td>7 (70)</td>
</tr>
<tr>
<td>Incorrect treatment/diagnosis</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Lack of care or inadequate care</td>
<td>4</td>
<td>1 (25)</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>2</td>
<td>1 (50)</td>
</tr>
<tr>
<td>Impolite behaviour</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Non-referral or referred too late</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Other complaints</td>
<td>10</td>
<td>2 (20)</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>11 (33)</td>
</tr>
</tbody>
</table>

* two complaints concerning sexual intimacies or abuse which were made about the same physiotherapist resulted in two different sanctions

In five cases the complainant was not eligible, and in four cases the complaint was withdrawn or the investigation was discontinued. Of the other 24 complaints, 13 were unfounded, seven of which without a hearing. With regard to the 11 complaints that were justified, the most frequent sanctions were a reprimand (in four cases) or suspension of the entry in the IHCP register (in four cases, one of which was conditional). Two physiotherapists received a warning, and one was struck off the IHCP register. The two complaints made by the inspector for health care both resulted in a sanction.

**Background of the verdicts**

In four cases the reason for non-eligibility was that the complaint did not directly concern the care (these were made by the employee in a physiotherapy practice), and in one case, according to the disciplinary board, the report did not contain sufficient information. Examples of unfounded complaints are given in Box 2. With regard to the complaints that the regional disciplinary boards considered to be justified, Table 2 and Boxes 3 and 4 provide insight into the nature of the complaints and the sanctions imposed. Seven complaints concerned sexual intimacies or abuse, one concerned incorrect treatment, and one concerned insufficient information. In two cases there were multiple complaints. The complaints were all made about male physiotherapists. With regard to the complaints concerning sexual intimacies or abuse, in all but two cases more severe disciplinary sanctions were imposed: four suspensions and one entry struck off the IHCP register.
Box 2
Complaints judged to be unfounded

- The complaint was that the physiotherapist had deliberately not enquired about oedema formation in the patient (admitted to a nursing home after a brain haemorrhage), and had therefore given her the wrong treatment, with the result that she was decompensated. Based on the reports, the disciplinary board was of the opinion that the physiotherapist had carried out adequate tests and diagnostics, that he had given appropriate treatment and that there was no reason at all to relate his treatment with the decompensation of the patient. The appeal was rejected.

- The complainant accused the physiotherapist of making her perform sexually suggestive exercises. Lying on her back she had to move her legs alternately to the left and to the right, and she also had to perform certain exercises in which she had to make her back curve inwards and outwards alternately. She also accused her of incompetence. The complaint was declared unfounded without further investigation.

- The complainant accused the physiotherapist of wanting to end the treatment agreement if the complainant did not come to the defendant’s practice before a certain date. The disciplinary board was of the opinion that the complainant took little or no interest in the success of the defendant’s treatment sessions. The treatment agreement between the complainant and the defendant has a dual character, in that it also implies collaboration from the patient. The disciplinary board was of the opinion that when the complainant frustrated the accused with regard to an appointment for subsequent treatment, the accused had the right to terminate the treatment. The complaint was declared unfounded without further investigation.

- The complainant accused the physiotherapist of unnecessarily forcing her left arm, not taking her complaints about pain seriously, and not doing his best to get the cost of the treatment refunded. After the hearing, the complaint was judged to be unfounded.

Box 3
Complaint judged to be founded, reprimand

In addition to being a physiotherapist, the defendant was also a distributor of nutritional supplements. For three years the defendant had supplied a nutritional supplement to the complainant, who was not a patient, but a professional boxer who tested positive for Eledrine during a drugs control. The physiotherapist sold the product to patients and non-patients alike, had it on the shelf in his practice, and dealt with his customers both during and outside of working hours. Consequently, he gave the impression that he sold the products in his capacity as physiotherapist, so that the customers could and did count on superior expertise and reliability with regard to the products that the defendant supplied. The disciplinary board stated that a physiotherapist, as care-provider in the health care system should, in no way, become involved in supplying products which he knows to be registered as doping, irrespective of whether or not the products are freely available. The physiotherapist received a reprimand. This verdict was published in the Netherlands Government Gazette.

Study of the questionnaires

Response

Of the 300 questionnaires sent to the physiotherapists, five were returned uncompleted, due to a change of address or retirement. Of the remaining 295 physiotherapists, 225 responded (76%). Two physiotherapists were not, or no longer working. Finally, only the questionnaires returned by working physiotherapists (223), who were subject to the statutory disciplinary system, were included in the analysis. There was very little difference between physiotherapist in general and the respondents with regard to age, gender and type of practice.
Box 4
Complaint judged to be founded, striking off the entry in the register

The physiotherapist had frequently been guilty of sexual intimacies during a treatment relationship. Moreover, according to the inspector for health care there was a real danger of recurrence. The physiotherapist had admitted to have committed the acts for which he was accused by two patients, but failed to accept the danger of recurrence. The disciplinary board considered this breach of conduct to be very serious. Such actions are totally unacceptable in a professional treatment relationship. Moreover, this was certainly not simply a question of overstepping the line just once, but intentional manipulative actions aimed at satisfying his own sexual desires. The fact that with both patients there was a question of infatuation during the treatment period in no way reduces the seriousness of this breach of conduct because this could in no way legitimise what the accused had permitted himself to do in a treatment situation. It appeared that the accused did not totally understand why he was brought before the disciplinary board. Moreover, certain psychological factors that played a role would increase, rather than decrease the future risks. The disciplinary board considered that there was a real risk of recurrence, and judged that the physiotherapist’s entry should be struck off the IHCP register. This verdict was published in the Netherlands Government Gazette.

Perspective of the physiotherapists

Of the respondents, 64% were of the opinion that the statutory disciplinary system plays a role in monitoring the quality of physiotherapy. More than half of the respondents (53%) considered that in their assessment of cases the disciplinary boards are sufficiently in agreement with what is considered to be good physiotherapy (but it should be noted that 46% of them answered ‘neither agree nor disagree’ to the latter statement) and almost half of them (48%) stated that a published verdict about another physiotherapist influenced their professional practice. Half of the respondents (50%) did not consider the possibility of disciplinary proceedings to be a threat. Most of the respondents (88%) were of the opinion that the statutory disciplinary system should not be abolished for their profession.
Table 2
Nature of the complaint and sanctions imposed by the disciplinary boards for justified complaints during the period 1998-2002

<table>
<thead>
<tr>
<th>Nature of the complaint</th>
<th>Specific nature of the (main) complaint</th>
<th>Sanction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual intimacies or abuse* n= 7</td>
<td>Sexual intimacies + inadequate explanation about the aim of the treatment on the front of the body</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Sexual intimacies + sexually suggestive remarks</td>
<td>Suspension of the entry in the register for one month</td>
</tr>
<tr>
<td></td>
<td>Unnecessary internal examination</td>
<td>Reprimand</td>
</tr>
<tr>
<td></td>
<td>Obscene actions/sexual relationship</td>
<td>Suspension of the entry in the register for six months</td>
</tr>
<tr>
<td></td>
<td>Indecent assault + obscenity</td>
<td>Suspension of the entry in the register for six months†</td>
</tr>
<tr>
<td></td>
<td>Sexual intimacies</td>
<td>Suspension of the entry in the register for six months of which three months conditional‡, appeal changed to suspension of the entry in the register for two months</td>
</tr>
<tr>
<td></td>
<td>Sexual intimacies (see also Box 4)</td>
<td>Entry struck off the register</td>
</tr>
<tr>
<td>Incorrect treatment n=1</td>
<td>Unacceptable treatment</td>
<td>Reprimand</td>
</tr>
<tr>
<td>Insufficient information n=1</td>
<td>Role confusion: supplying products registered as doping under the impression of promoting health and well-being (see also Box 3)</td>
<td>Reprimand</td>
</tr>
<tr>
<td>Others n=2</td>
<td>Breach of privacy, forced assumption of incest/rape, hard-handed massage, use of medical records, organisation of the practice</td>
<td>Reprimand, appeal changed to a warning</td>
</tr>
<tr>
<td></td>
<td>Incorrect diagnosis, wrong treatment, providing insufficient information about the nature of the problem and effect of the treatment, lies about requests for subsequent test in general practice</td>
<td>Warning</td>
</tr>
</tbody>
</table>

* the first and second complaint were made about the same physiotherapist
† also criminal proceedings
‡ three months of the suspension were conditional if no further disciplinary measures were incurred during a probation period of two years
DISCUSSION

In the Dutch public health the disciplinary system is one aspect of the regulation of professional practice. This study shows the position of the statutory disciplinary system for physiotherapists within the field of disciplinary jurisprudence, and provides an indication of the contribution of this statutory disciplinary system to monitoring the quality of physiotherapy. As there are no available empirical data from other countries, this study makes it possible for health care professionals, their professional organisations and researchers in other countries, with similar or different regulations for professional practice, to learn from the experiences gained in the Netherlands. All the complaints dealt with by the regional disciplinary boards during the period 1998-2002 were included in the study, and the response to the questionnaires was high.

The study of the complaints dealt with by the regional disciplinary boards shows that even though there has been an increase in the annual number of accused physiotherapists since the introduction of the statutory disciplinary system, relatively few complaints are made. Over the last two years of the study period the complaint density, defined as the number of accused per 100 working professionals, was 0.06 (11/18,000). This is approximately one complaint per 1600 working physiotherapists per year. In the period 1999-2001 the complaint density for physicians was 35 times greater (2.1).

Whether or not the number of accused physiotherapists will continue to increase will only be known in the future. Other research has shown that only half of the general public know that physiotherapists are subject to the statutory disciplinary system. Another important reason for the low complaint density could be the existence of other possibilities to make complaints. Since the introduction in 1995 of the act governing the right of clients of the care sector to complain, various complaint committees have been established in the health care sector. In addition to the internal disciplinary system for members of the professional organisation, a physiotherapy complaint committee also exists since 1996. It is remarkable that there was not only a decrease in the number of complaints made to the internal disciplinary board after 1999, but also in the number of complaints made to the complaint committee after 2000, probably due to the introduction of the statutory disciplinary system. Finally, it is possible that there will be no increase in the complaint density because there are no more complaints.

The complainants were found to be mainly patients. The fact that many complaints are still unfounded may be related to the limited knowledge the general public has about the statutory disciplinary proceedings. Many people are also not sufficiently aware of the aim or the content of the statutory disciplinary system, and do not know which complaints they can bring before a disciplinary board. Some of the unfounded complaints could also be due to the limited knowledge patients have about physiotherapy. More public information about the existence of the statutory disciplinary system for physiotherapists could increase the number of complaints, and possibly also the number of justified complaints. It is striking that relatively more complaints were made about male physiotherapists than about their female colleagues.

The percentage of sanctions imposed over the five-year period (33%), was high when compared to the other professional groups which are subject to the statutory disciplinary
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system. In the period 1999-2001 the percentage of sanctions imposed on physicians was 14%, for nurses it was 13%, and for health care psychologists it was 18%. The higher percentage of sanctions imposed on physiotherapists is probably related to the relatively large number of complaints about sexual intimacies or abuse, which almost always result in a sanction. It is not known how often there was a problem of sexual harassment of a physiotherapist by a patient; health professionals have to resist these harassments. The statutory disciplinary system for physiotherapists therefore appears to be an important corrective instrument with regard to serious professional misconduct. However, with regard to the development of standards for other aspects of the profession, i.e. treatment and advice, the statutory disciplinary system (still) plays a limited role.

The opinions of the physiotherapists emphasize the importance of the statutory disciplinary system. A large majority was of the opinion that the statutory disciplinary system for physiotherapists should subsist. Almost two thirds thought that the statutory disciplinary system plays a role in monitoring the quality of physiotherapy, and almost half indicated that a published verdict concerning another physiotherapist influences their professional practice. This seems to indicate that the introduction of the statutory disciplinary system has given an impetus to quality control in physiotherapy, and that published verdicts seem to have a preventive influence. However, during the study period only two verdicts were published in the Netherlands Government Gazette, which could scarcely have a quality-promoting effect or contribute to the success of the disciplinary system.

References

1. Dutch Lower House 1991/92, 19 522, nr. 46, p. 4-5.
Chapter 6

Practice of the statutory disciplinary system for health care psychologists in the Netherlands

Submitted as: Hout FAG, Cuperus-Bosma JM, Hubben JH, Wal G van der. Practice of the statutory disciplinary system for health care psychologists in the Netherlands.
Abstract
A statutory disciplinary system for health care psychologists in the Netherlands was introduced in 1998. To provide an indication of the contribution of this system to monitoring the quality of health care psychology all complaints dealt with in the period 1999-2002 were studied. Questionnaires were sent to all 388 members of the disciplinary boards (response 89%) and 43 practicing lawyers (response 65%). The regional disciplinary boards dealt with 68 complaints about health care psychologists. A sanction was imposed 16 times (25%), mainly for sexual intimacies or a sexual relationship, violation of professional secrecy or incorrect statement or reporting. The statutory disciplinary system appears to be an important corrective instrument for serious forms of professional misconduct for health care psychologists.

INTRODUCTION
Various western societies already have a statutory disciplinary system for certain mental health care professionals. In the UK, in the USA and in Canada psychiatrists and nurses are subject to a statutory disciplinary system. With regard to professionals working in the mental health care sector in the Netherlands, since the introduction of the Individual Health Care Professions Act (IHCP Act; in Dutch: Wet BIG), not only psychiatrists, but also health care psychologists and nurses are subject to the statutory disciplinary system. The aim of the statutory disciplinary system is to foster and monitor high standards of professional practice, and to protect the general public against incompetence and carelessness, including harm and abuse. This article reports on the statutory disciplinary system for health care psychologists that came into effect in April 1998.

One reason for the introduction of a statutory disciplinary system for health care psychologists was the fact that, with regard to the care provided, the patient/client is dependent on the health care psychologist and relatively vulnerable. Moreover, the patient/client is unable to assess the expertise of the health care psychologist, and there was no other effective corrective measure that could be applied to professionals who were not employed in mental health care institutions. In addition to the statutory disciplinary system, the Dutch Professional Association of Psychologists (DPAP; in Dutch: NIP) also has its own internal disciplinary system. This internal disciplinary system does not only apply to health care psychologists, but also to other psychologists (such as work and organizational psychologists) who are members of this organization.

The disciplinary proceedings are controlled by 5 regional disciplinary boards, and appeals are made to the central disciplinary board. There are two disciplinary norms against which the disciplinary board assesses a case: (1) are the acts or omissions in conflict with the care that a professional should provide for the patient or close relatives of the patient, or (2) have the acts or omissions in any other way been in conflict with the interests of good practice in individual health care. In deciding on its verdicts, the disciplinary board takes into account, among other things, the legal requirements, jurisprudence, professional codes and rules of conduct, professional-technical regulations, standards, guidelines and protocols, also collectively referred to as the professional standard. The sanctions that can
be imposed range from mild to severe: warning, reprimand, fine, (conditional) suspension of the entry in the Individual Health Care Professionals register (IHCP register; in Dutch: BIG-register), partial withdrawal of the right to practise the profession concerned, and striking off the entry in the register. Every directly interested party can make a complaint; in practice this is mainly the patient or the patient’s family. The inspector for health care is also authorized to lodge a complaint (Box 1).

**Box 1**
Definitions concerning disciplinary jurisprudence in the IHCP Act

| Complainants                        | - a person who has a direct interest (in practice, mostly a patient or close relative of the patient)  
|                                     | - the inspector for health care  
|                                     | - the institution in which the health care psychologist is employed |
| Disciplinary norms*                 | - inadequate care for the patient or the patient’s relatives  
|                                     | - any other act or omission that is in conflict with good practice of individual health care |
| Composition of the disciplinary boards | - the five regional disciplinary boards consist of two legally qualified members and three health professional members (i.e. health care psychologists)  
|                                      | - the central disciplinary board consists of three legally qualified members and two health professional members (i.e. health care psychologists) |
| Public access                       | in principle there is public access to meetings and verdicts of the disciplinary boards |
| Disciplinary actions                | - warning  
|                                     | - reprimand  
|                                     | - fine  
|                                     | - conditional suspension of the entry in the IHCP register†  
|                                     | - suspension of the entry in the IHCP register†  
|                                     | - combination of suspension of the entry in the IHCP register† and fine  
|                                     | - partial withdrawal of the right of the person entered in the IHCP register† to practise the profession concerned  
|                                     | - striking off the entry in the IHCP register† |
| Possibilities for appeals against verdicts | - the complainant, but only if declared not eligible or the complaint was rejected  
|                                      | - the accused professional and the inspector for health care are entitled to appeal against all verdicts  
|                                      | against a verdict of the central court there is no other possibility than cassation to the Supreme Court, but only in the interest of the law |
| Sanctions for incompetence          | the Medical Supervision Board assesses professionals who, due to a physical or psychological illness or as the result of an addiction, are not competent to practice in the profession; only the Health Care Inspectorate can submit a written report to the Medical Supervision Board ‡ |

* complaints must concern actions of the health care psychologist that took place after 1\(^{st}\) April 1998 (the date on which the statutory disciplinary system for health care psychologists came into effect)  
† the right to use a professional title only becomes effective after entry in the IHCP register  
‡ in the period 1999-2002 no written report concerning a health care psychologist was submitted by the Health Care Inspectorate
Protecting the general public is achieved by imposing sanctions on health care psychologists who have violated the disciplinary norms. It is also anticipated that the statutory disciplinary system has a preventive effect, and that it contributes to the further development and accentuation of the professional standard. To our knowledge, no empirical data concerning the statutory disciplinary system for health care psychologists has yet been published in scientific journals. We found no information in a Pubmed/Medline search. The aim of this article is to provide insight into the practical aspects of the statutory disciplinary system for health care psychologists, now that it has been in force for several years in the Netherlands. For this purpose, during a period of 4 years a survey was made of all the complaints against health care psychologists that were dealt with by the disciplinary boards. Furthermore, the opinions of other involved parties, members of the disciplinary boards, and practicing lawyers were investigated. Details about the complaints and the sanctions imposed show the position of the statutory disciplinary system for health care psychologists within the field of disciplinary jurisprudence. Experiences and opinions provide an indication of the contribution of the statutory disciplinary system for health care psychologists to monitoring the quality of health care psychology.

METHODS

Study of the complaints dealt with
Within the framework of the evaluation of the IHCP Act, a retrospective study was made of all the complaints about health care psychologists that were dealt with by the regional disciplinary boards between 1st January 1999 and 31st December 2002. 1999 was the first full year in which disciplinary complaints made about this professional group could be dealt with. The study period for the appeal cases ended on 31st July 2003. Use was made of the collection of verdicts in the archives and the computerized database of the Health Care Inspectorate. Aspects that were studied were: year of the verdict, number and nature of the complaints, gender and field of work of the accused health care psychologists, type of complainants, nature of the verdicts, number of appeals and amended verdicts, and nature of the amendments. Additional data on the field of work of the the accused was obtained from the 2000-2001 DPAP psychologists address book. Information about the number of appeal cases was obtained from the Annual Reports and the website of the central disciplinary board. Examples of complaints, with the resulting verdicts and considerations of the disciplinary board, were extracted from the Annual Reports of the regional disciplinary board in Amsterdam. Data on the number of registered health care psychologists and the gender distribution was obtained from the IHCP register. A 95% confidence interval was calculated for the gender distribution of the accused (binominal distribution).

Questionnaire for members of the disciplinary boards and practicing lawyers
All 388 members of the disciplinary boards (regional and central) and 43 practicing lawyers with experience of disciplinary proceedings were sent a questionnaire at the end of 2001. Their names were on a central disciplinary board list of practicing lawyers who were fairly
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regularly involved in the central disciplinary board proceedings. The questionnaire contained, among other things, questions about background characteristics of the respondent, a statement about abolishment of the statutory disciplinary system for health care psychologists, and two statements about the (as yet) relatively small number of complaints about professionals who have been subject to the statutory disciplinary system since the introduction of the IHCP Act. These two statements therefore did not only apply to health care psychologists, but also to nurses and physiotherapists. Five members of the disciplinary boards were of the opinion that they had too little experience to complete the questionnaire, two had a prolonged illness, two could not be contacted, and one was no longer a member of a disciplinary board. Of the remaining 378 members, 336 completed and returned the questionnaire (response 89%). Both the respondents and the non-respondents among the members of the disciplinary boards consisted for one fifth of legally qualified members and for four fifths of health professional members. Two lawyers were of the opinion that they had too little experience to complete the questionnaire, and one was no longer involved in disciplinary proceedings. Of the remaining 40 practicing lawyers, 26 responded (response 65%).

In order to achieve maximum participation, measures were taken to ensure the privacy of the respondents. In the covering letter it was stated that the questionnaire could be returned anonymously, and that the information contained in the questionnaire would only be used to answer the research questions addressed in the study. There was no need to obtain informed consent or ethical approval, because patient-related research was not involved.

FINDINGS

Practice

General
During the period 1999-2002 the regional disciplinary boards dealt with 68 complaints about health care psychologists, excluding 9 complaints that concerned actions that had taken place before the IHCP Act came into effect. The 68 complaints were made about 64 health care psychologists and were made by 63 different complainants. During the study period the annual number of accused health care psychologists (11 in 1999, 20 in 2000, 15 in 2001 and 18 in 2002) remained roughly the same. The 68 complaints resulted in 65 verdicts. In three cases, two complaints about the same health care psychologist resulted in one single verdict. A quarter of the verdicts resulted in a sanction (16/65; 25%) (Table 1).

Accused
An average of 16 health care psychologists were accused per year. According to the data obtained from the IHCP register, during the study period an average of over 13,000 registered health care psychologists were living in the Netherlands. This also included health care psychologists who were not practicing (in their professional capacity). The complaint density, defined as the number of accused per 100 professionals, was low: 0.12 (16/13,000), which is approximately 1 complaint per 800 health care psychologists per year. Of the accused, 60% (95%-CI: 47.1-72.9) were male; during the study period this was
42% of all health care psychologists. Of the accused whose field of work was known (73%), over three quarters (78%) were not working in a (psychiatric) hospital, but the remainder were. One health care psychologist was working both in a psychiatric hospital and elsewhere.

Table 1
Number of complaints, accused, complainants, verdicts and sanctions imposed during the period 1999-2002

<table>
<thead>
<tr>
<th>Number during the period 1999-2002</th>
<th>Background and details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints</td>
<td>68</td>
</tr>
<tr>
<td>Accused</td>
<td>64</td>
</tr>
<tr>
<td>Different complainants</td>
<td>63</td>
</tr>
<tr>
<td>Verdicts (including investigation</td>
<td>Three times two complaints about the same health care psychologist resulted in 1 verdict</td>
</tr>
<tr>
<td>discontinued, withdrawal of the</td>
<td></td>
</tr>
<tr>
<td>complaint)</td>
<td></td>
</tr>
<tr>
<td>Sanctions (% of verdicts)</td>
<td>16 (25)</td>
</tr>
</tbody>
</table>

Complainants
Two thirds of the complainants were patients or clients (66%) and over a quarter were members of a patient’s family, including ex-partners of the patients or clients (28%). The inspector for health care lodged 1 complaint. Other complainants were a fellow resident and the employer of a patient/client (Table 2).

Nature of the complaints and verdicts
Table 3 provides insight into the nature of the complaints and the number of sanctions imposed. The complaints mainly concerned ‘lack of care or inadequate care’ (13%) or ‘violation of professional secrecy’ (10%). The category of ‘other complaints’ was large (53%), because included in this category were: complaints in which the verdict (12x) or the plaint (7x) contained little information about the complaint, complaints consisting of
several components without a clear main complaint (6x), ‘nonsensical’ complaints (5x), complaints that were difficult to classify (3x) and complaints that did not directly concern care (1x). For professional misconduct, such as sexual intimacies or a sexual relationship with patients, a sanction was always imposed. For ‘violation of professional secrecy’ or ‘incorrect statement or reporting’ a sanction was mostly imposed.

Table 2
Complainants during the period 1999-2002; absolute numbers (%)

<table>
<thead>
<tr>
<th>Complainant</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/client</td>
<td>35 (66)</td>
</tr>
<tr>
<td>Member of a client’s family*</td>
<td>15 (28)</td>
</tr>
<tr>
<td>Inspector for health care</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Other complainants</td>
<td>2 (4)</td>
</tr>
<tr>
<td>Total</td>
<td>53† (100)</td>
</tr>
</tbody>
</table>

* Including ex-partner of the patient/client
† It was unknown from 10 complainants. It concerned in all complaints/complainants but one complainants that were considered not eligible or the complaints were withdrawn or the hearing was abandoned.

Table 3
Number of complaints, verdicts and sanctions imposed on the basis of the nature of the complaint during the period 1999-2002; absolute numbers (%)

<table>
<thead>
<tr>
<th>Nature of the complaint</th>
<th>Number of complaints</th>
<th>Number of verdicts</th>
<th>Number of sanctions (% of verdicts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of care or inadequate care</td>
<td>9 (13)</td>
<td>8*</td>
<td>1 (13)</td>
</tr>
<tr>
<td>Violation of professional secrecy</td>
<td>7 (10)</td>
<td>7</td>
<td>5 (71)</td>
</tr>
<tr>
<td>Incorrect statement or reporting</td>
<td>5 (7)</td>
<td>5</td>
<td>4 (80)</td>
</tr>
<tr>
<td>Sexual intimacies or a sexual relation</td>
<td>5 (7)</td>
<td>5</td>
<td>5 (100)</td>
</tr>
<tr>
<td>Incorrect treatment/diagnosis</td>
<td>4 (6)</td>
<td>3*</td>
<td>-</td>
</tr>
<tr>
<td>Impolite behaviour</td>
<td>1 (1)</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Not or belated visiting when requested</td>
<td>1 (1)</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Other complaints</td>
<td>36 (53)</td>
<td>35*</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Total</td>
<td>68 (100)</td>
<td>65</td>
<td>16 (25)</td>
</tr>
</tbody>
</table>

* A number of times several different complaints about the same health care psychologist resulted in 1 verdict.

Almost one third of the decisions (21/65; 32%) concerned a non-eligible statement from the complainant. In one fifth of the cases (13/65; 20%), either the complaint was withdrawn or the hearing was abandoned. In a quarter of the verdicts (15/65; 20%) the disciplinary board was of the opinion that the complaint was unfounded, usually before a hearing (11/15). Sixteen verdicts concerned a justified complaint, for which a sanction was imposed (16/65; 25%). One health care psychologist had his entry struck off the IHCP.
register. The most frequent imposed sanctions were a warning (7/65; 11%) or a reprimand (6/65; 9%) (Table 4).

Table 4
Nature and number of the verdicts pronounced by the regional disciplinary boards during the period 1999-2002

<table>
<thead>
<tr>
<th>Verdict</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry struck off the IHCP register</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Partial withdrawal of the right to practise the profession concerned</td>
<td>-</td>
</tr>
<tr>
<td>Combination of (conditional) suspension of the entry in the IHCP register and fine</td>
<td>-</td>
</tr>
<tr>
<td>Suspension of the entry in the IHCP register</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Conditional suspension of the entry in the IHCP register</td>
<td>-</td>
</tr>
<tr>
<td>Fine</td>
<td>-</td>
</tr>
<tr>
<td>Reprimand</td>
<td>6 (9)</td>
</tr>
<tr>
<td>Warning</td>
<td>7 (11)</td>
</tr>
<tr>
<td>Unfoundend after a hearing</td>
<td>4 (6)</td>
</tr>
<tr>
<td>Unfounded before a hearing</td>
<td>11 (17)</td>
</tr>
<tr>
<td>Not eligible</td>
<td>21 (32)</td>
</tr>
<tr>
<td>Investigation discontinued or complaint withdrawn</td>
<td>13 (20)</td>
</tr>
<tr>
<td>Total (%)</td>
<td>65 (100)</td>
</tr>
</tbody>
</table>

Background of the verdicts
Reasons for non-eligible complaints were: the plaint contained insufficient information, so the exact nature of the complaint was not clear (6x), the accused was not a health care psychologist (6x), the complaint did not directly concern care (3x), the complainant was not directly involved (1x) or the complainants file had been destroyed at the request of the complainant (1x) (Box 2). In 3 cases the reason for non-eligibility was unknown. An example of an unfounded complaint is given in Box 3.

Box 2
Violation of professional secrecy. Verdict: not eligible

This case concerned a complaint that the health care psychologist, who treated the complainant during admission into a psychiatric hospital, gave certain information to her occupational physician which was not in keeping with a previous agreement. Some time before she made her complaint, the complainant had requested that her treatment file should be destroyed, and this request had been granted. The main argument of the health care psychologist was that, since the file was no longer available, he was no longer able to defend himself properly. The board accepted this plea, and the verdict was that the complainant was not eligible.
Box 3
Other complaints. Verdict: unfounded without further investigation

A complainant made two separate complaints about a health care psychologist, in connection with a series of complaints about physicians and nurses who were all involved in his hospital treatment. All the complaints concerned accusations of involvement in a plot to have the complainant involuntarily admitted to a psychiatric hospital in order to prevent him from initiating proceedings with regard to medical mistakes that had been made. The first complaint concerned this plot, in which the health care psychologist was accused of participating, but for which the board could find no proof at all of its existence. In the second complaint the health care psychologist was accused of not being prepared to honour the complainant’s request to remove and destroy her statement in the medical file. The board was of the opinion that this could not be held against the health care psychologist, in view of the fact that she might need this information to defend herself in a case in which no final verdict had yet been reached. It also took into consideration the fact that the complainant was promised that the request would be granted as soon as there was a final verdict in the current cases. The appeal that was made in both cases was rejected.

With regard to the 16 complaints that the regional disciplinary boards considered to be justified, Table 5 and Boxes 4 through 8 provide insight into the nature of the complaints, the gender and the field of work of the health care psychologist, the type of complainants and the sanctions imposed. With regard to the complaints, five concerned sexual intimacies or a sexual relationship, five concerned violation of professional secrecy, four resulted from an incorrect statement or reporting and one was for lack of care or inadequate care. One case concerned multiple complaints. Eleven complaints were made about males and five about females. Eight of the accused were not working in a (psychiatric) hospital, three were, and where the other five worked was unknown. In half of the cases the complainant was not the patient or the client. With regard to the complaints about sexual intimacies or a sexual relationship, in all but two cases, the most severe sanction was imposed: there were two temporary suspensions and one entry was struck off the register. The remaining complaints resulted in seven warnings and four reprimands.

Box 4
Incorrect statement or reporting. Verdict: warning

This case concerned a complaint from the father of a boy who had been treated by the health care psychologist. The complainant accused the health care psychologist, when requested by the court which had to make a decision concerning an arrangement for parental access in connection with a divorce, of making a biased investigation, drawing unfounded conclusions and giving unfounded advice. The board stated that the health care psychologist had considered the complainant’s son from three perspectives: as a care-provider, as an expert in procedures concerning arrangements for parental access, and subsequently as an advisor at the school attended by the complainant’s son. The board was of the opinion that it was clear that the health care psychologist had made a thorough investigation of the problems concerning the complainant’s son, and had intended to act exclusively in the boy’s interest, but that this did not exclude the fact that she should have made allowance for the possible influence of other environmental factors, and should have made a clear distinction between investigation and reporting, on the one hand, and therapy on the other hand, and that confusion about her role as therapist or expert should have been avoided. The board considered the complaint to be partially justified, and the verdict was a warning. The appeal against this decision was rejected.
Box 5
Violation of professional secrecy and incorrect reporting. Verdict: warning

In connection with proceedings to make arrangements for parental access at the request of the complainant, the health care psychologist of the mother wrote a letter to her advisor. This letter, which contained negative comments about the complainant, was the reason for which the complaint was made to the board. Among other things, the health care psychologist was accused of writing the letter on his own initiative, with the knowledge that it would be handed over during the proceedings. In this letter the health care psychologist, without being asked to do so, had also given the judge negative advice about a possible arrangement for parental access between the complainant and his child. The complainant also accused the health care psychologist that this advice was only based on information given by the child’s mother and that the health care psychologist had never met the complainant. The board gave the health care psychologist a warning in view of the fact that he had maintained insufficient professional distance. Moreover, the board reproached the health care psychologist because the information about the complainant that was contained in his letter was not obtained from personal observations.

Box 6
Sexual relationship. Verdict: reprimand

The accused health care psychologist met the complainant in the day-clinic of the psychiatric centre of a hospital. As a locum, the health care psychologist had given the complainant a number of individual treatment sessions. During these sessions the complainant apparently showed certain feelings for her health care psychologist, which the accused reported to his supervisor. It was then decided that the individual treatment of the complainant should be discontinued. When the consequences of the treatment were not satisfactory the complainant requested the health care psychologist to give her further treatment in his private practice, which he did. After some time, the complainant invited the health care psychologist for a meal at her house, where they had sex. One month later the complainant stopped the treatment, but the affective relationship continued for several months. The complainant informed the hospital where the health care psychologist worked and the Health Care Inspectorate about the relationship. He was immediately dismissed and both the Inspectorate and the complainant lodged a complaint. The board found that the health care psychologist had failed to keep professional distance when he entered into an affective relationship with the complainant. He was in love, and apparently not able to withstand the complainants attraction. Although the board realized that falling in love can be considered as a professional risk for health care psychologists, the board reproached the health care psychologist because when this happened he had not immediately ended the treatment relationship and he had not referred the complainant to someone else for treatment. The verdict was a reprimand.

Box 7
Incorrect statement or reporting. Verdict: warning

In this case the complainant was the employer of the client of the accused health care psychologist. It was a question of a labour conflict; the employee requested the magistrate to terminate the employment contract. A letter from the health care psychologist – from whom the employee was receiving treatment – was presented to support the request. This letter included an opinion about the employer’s actions, solely based on discussions with the employee. The health care psychologist had assumed the function of advisor, whereas the letter should only have concerned the illness and the treatment of the employee. The verdict was a warning.
Table 5
Nature of the complaint, gender and field of work of the accused health care psychologist, type of complainant and sanctions imposed by the disciplinary boards for justified complaints during the period 1999-2002

<table>
<thead>
<tr>
<th>Nature of the complaint</th>
<th>Specific nature of the (main) complaint</th>
<th>Gender of the accused</th>
<th>Field of work in mental health care of the accused</th>
<th>Type of complainant</th>
<th>Sanction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual intimacies or a sexual relationship N=5</td>
<td>Sexual intimacies</td>
<td>Male</td>
<td>(Psychiatric) hospital</td>
<td>Member of a client’s family</td>
<td>Reprimand*</td>
</tr>
<tr>
<td></td>
<td>Sexual relationship (see also Box 6)</td>
<td>Male</td>
<td>(Psychiatric) hospital</td>
<td>Inspector and client</td>
<td>Reprimand, appeal is still pending</td>
</tr>
<tr>
<td></td>
<td>Sexual relationship</td>
<td>Male</td>
<td>not in a (psychiatric) hospital</td>
<td>Client</td>
<td>Suspension of the entry in the register for 6 months</td>
</tr>
<tr>
<td></td>
<td>Sexual intimacies, inadequate therapy, no contact with general practitioner, after 20 years no insight into the approach to therapy</td>
<td>Male</td>
<td>not in a (psychiatric) hospital (private practice)</td>
<td>Client</td>
<td>Suspension of the entry in the register for 6 months, appeal changed to entry struck off the register</td>
</tr>
<tr>
<td></td>
<td>Sexual relationship</td>
<td>Male</td>
<td>not in a (psychiatric) hospital</td>
<td>Client</td>
<td>Entry struck off the register</td>
</tr>
<tr>
<td>Violation of professional secrecy N=5</td>
<td>Damaging letter to lawyer about parental access to child on own initiative (see also Box 5)</td>
<td>Male</td>
<td>not in a (psychiatric) hospital (private practice)</td>
<td>Ex-friend of client</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Issue of a statement; content and method used in maintenance allowance proceedings</td>
<td>Female</td>
<td>unknown</td>
<td>Ex-husband of client</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Damaging report to child care centre without permission</td>
<td>Female</td>
<td>not in a (psychiatric) hospital (private practice)</td>
<td>Ex-husband of client</td>
<td>Warning</td>
</tr>
<tr>
<td>Nature of the complaint</td>
<td>Specific nature of the (main) complaint</td>
<td>Gender of the accused</td>
<td>Field of work in mental health care of the accused</td>
<td>Type of complainant</td>
<td>Sanction</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------------</td>
<td>---------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Violation of professional secrecy N=5</td>
<td>Giving information to the police without permission</td>
<td>Female</td>
<td>Unknown</td>
<td>Client</td>
<td>Reprimand</td>
</tr>
<tr>
<td></td>
<td>Giving information to a lawyer without permission</td>
<td>Male</td>
<td>unknown</td>
<td>Client</td>
<td>Reprimand</td>
</tr>
<tr>
<td>Incorrect statement or reporting N=4</td>
<td>Report concerning arrangements for parental access biased, unfounded and incorrect (see also Box 4)</td>
<td>Female</td>
<td>Unknown</td>
<td>Father of client</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Unfounded reporting</td>
<td>Male</td>
<td>not in a (psychiatric) hospital (e.g. private practice)</td>
<td>Member of a client’s family</td>
<td>Warning</td>
</tr>
<tr>
<td></td>
<td>Unfounded statement concerning arrangements for parental access violating professional secrecy</td>
<td>Male</td>
<td>(Psychiatric) hospital</td>
<td>Father of client</td>
<td>Reprimand</td>
</tr>
<tr>
<td>Lack of care or inadequate care N=1</td>
<td>Careless behaviour during investigation, formulation and dispatch of report about examination for work integration (see also Box 8)</td>
<td>Male</td>
<td>not in a (psychiatric) hospital</td>
<td>Client</td>
<td>Warning</td>
</tr>
<tr>
<td>Other complaints N=1</td>
<td>Role confusion employer/employee relationship, failure to comply with file procedures, violation of professional secrecy, incorrect termination of treatment</td>
<td>Female</td>
<td>not in a (psychiatric) hospital</td>
<td>Client</td>
<td>Reprimand</td>
</tr>
</tbody>
</table>

* In view of the measures taken by the employer (€455 gross a month decrease in salary for 1 year, costs of supervision, treatment of male patients only) a reprimand was considered to be adequate.
Box 8
Inadequate care. Verdict: warning

This case involved an examination for work-integration. The complainant accused the health care psychologist of careless behaviour during the examination and the formulation and dispatch of the report. In the assessment of the test results and the advice about work-integration insufficient attention had been paid to his handicap. The defendant had not informed the complainant about his right to read the report before it was sent to the employer or his right to suggest that corrections should be made. The verdict was a warning.

Appeal
An appeal was made to the central disciplinary board in 17 cases, which is 26% of all complaints and 33% of the cases in which an appeal could be made. On 31st July 2003 there was an appeal pending in at least one case. In one case the appeal resulted in entry struck off the register. Apart from this case, the appeal verdicts remained unchanged.

Perspective of other parties involved
Most of the members of the disciplinary boards and most of the practicing lawyers were of the opinion that the statutory disciplinary system for health care psychologists should not be abolished (87% and 96%, respectively). The respondents gave as specific explanation that, in their opinion, the statutory disciplinary system is also a quality-promoting instrument for health care psychology, that health care psychologists must also be subject to assessment and that there is therefore no reason to differentiate between the various professions in the individual health care sector, that mistakes made by health care psychologists can be serious, and that the statutory disciplinary system has a preventive effect. Almost two thirds of the members of the disciplinary boards and practicing lawyers (64% and 62%, respectively) agreed with the statement that the general public is still not adequately aware of the possibility of making a complaint against a health care psychologist. One quarter of the members of the disciplinary boards (26%) and 42% of the practicing lawyers were of the opinion that the number of complaints made about health care psychologists will remain low (50% and 46%, respectively, ‘neither agreed nor disagreed’).

DISCUSSION

In the Dutch health care system the disciplinary proceedings are an element in the regulation of professional practice. In our opinion, this study shows the position of the statutory disciplinary system for health care psychologists within the field of disciplinary jurisprudence and provides an indication of the contribution of the statutory disciplinary system for health care psychologists to monitoring the quality of health care psychology in the Netherlands. As there are no available empirical data from other countries, this study makes it possible for health care psychologists, their professional organisations, researchers and professionals in law and psychology in other countries, with similar or different regulations for professional practice, to learn from the experiences gained in the Netherlands. All the complaints that were dealt with by the regional disciplinary boards during the period 1990-2002 were included in the study, and the response to the
questionnaires from the members of the disciplinary boards and the practicing lawyers was high. One limitation of this study is that two statements did not only concern health care psychologists, but also other professional groups that are subject to the statutory disciplinary system since the introduction of the IHCP Act. The opinions of the health care psychologists themselves were not investigated.

The study of the complaints that were dealt with by the regional disciplinary boards shows that the annual number of accused remains roughly the same, and that a relatively small number of complaints are made against health care psychologists. For physicians the number of complaints per 100 working professionals during the period 1999-2001 was 18 times higher (2.1)\(^3\) and for psychiatrists during the period 1983-1992 it was even 28 times higher (3.3)\(^3\). However, for nurses, who have also been subject to the statutory disciplinary system since the introduction of the individual health care professions act, the complaint density during the period 2000-2001 was 3 times lower (0.04).\(^5\)

Whether or not the number of complaints made in the Netherlands will continue to increase will only be known in the future. Half of the members of the disciplinary boards and practicing lawyers made no comment in this respect. However, almost two thirds of them were of the opinion that the general public is not sufficiently aware of the possibility to make complaints about health care psychologists to a disciplinary board. This is supported by other studies among the general public.\(^5\)

Another explanation for the low complaint density could be the fact that the DPAP has its own internal disciplinary system. During the study period there were 181 verdicts concerning psychologists who were subject to this internal disciplinary system. Two thirds of these verdicts (120/181; 66%) concerned psychologists working in the health care sector. There is no evidence of a decrease in verdicts based on this professional disciplinary system (total 120: 20 in 1999, 32 in 2000, 43 in 2001 and 25 in 2002).\(^6\) Therefore, the statutory disciplinary system scarcely seems to influence the internal disciplinary system, although there is evidence of an overlap in the accused. The Association intends to maintain this internal disciplinary system by stimulating the debate on professional ethics (DPAP, verbal report, December 2003). However, very few internal verdicts are publicized and, moreover, many of the members are not subject to the statutory disciplinary system.

In addition to the already existing internal disciplinary system, the act governing the right of clients of the care sector to complain (in Dutch: Wet klachtrecht clienten zorgsector), which came into effect in 1995, has resulted in the establishment of complaint committees in the health care sector. These committees could lead to a decrease in the number of disciplinary complaints, because they now deal with some of the complaints. Within this act the core issues are patient satisfaction, reinstatement of the care/patient relationship, and quality promotion and control. Health care psychologists working in (psychiatric) hospitals and regional institutions for ambulatory mental health care resort under the complaint committee in their hospital or institution. The complaint procedure does not yet apply to health care psychologists in private practice.

The percentage of sanctions imposed over the 4-year period (25%) was high when compared to the other professional groups who are subject to the statutory disciplinary system. In the period 1999-2001 the percentage of sanctions imposed on physicians was 14%, for nurses it was 13%\(^5\) and in the period 1983-1992 it was 18% for psychiatrists.\(^3\)
Compared with the internal disciplinary system, however, this percentage of sanctions is low (25% vs. 47%).

It is interesting to note that a majority of the justified complaints made about health care psychologists concerned sexual intimacies or a sexual relationship, violation of professional secrecy or an incorrect statement or reporting, whereas the complaints made about physicians mainly concerned incorrect treatment, lack of care or inadequate care. It is not known how often there was a problem of sexual harassment of a health care psychologist by a patient; health professionals have to resist these harassments. The statutory disciplinary system for health care psychologists therefore appears to be an important corrective instrument with regard to serious professional misconduct in the provision of care. However, with regard to the development of standards for other aspects of the profession, such as diagnosis and treatment, it (still) has a limited role. This may be because of the existence, since 1960, of a professional code and an internal disciplinary system. Within the professional group and the training programmes more attention should be paid to the implications of professional secrecy and the way in which statements and reports are formulated.

The complainants were found to be almost exclusively patients/clients and their close friends and family. The fact that the majority of the complaints is still unfounded can also be related to the limited knowledge the general public has about the statutory disciplinary proceedings. Many people are also not sufficiently aware of the aim or the content of the statutory disciplinary system, and do not know which complaints they can bring before a disciplinary board. Six times the plaint contained insufficient information, so it was not clear who was accused or what exactly the complaint was. More public information about the existence of the statutory disciplinary system for health care psychologists and the procedure of making a complaint could increase the number of complaints and also the number of justified complaints. The Health Care Inspectorate made only 1 complaint during the study period. According to the Inspectorate this is primarily due to prioritization. Moreover, since 1996 the Inspectorate only makes a complaint if there is considerable general interest in the case.

Finally it is notable that male health care psychologists were accused relatively more often than their female colleagues. This can not be explained by the complaints about sexual intimacies or a sexual relationship, which concern only 5 out of the 68 complaints (see Table 2).

The opinions of the members of the disciplinary boards and the practicing lawyers emphasize the importance of the statutory disciplinary system. A large majority of them are of the opinion that the statutory disciplinary system for health care psychologists should continue to exist. During the study period only eight verdicts, six of which were justified complaints, were published in the Netherlands Government Gazette and six of the eight were submitted to journals for health care psychologists. If the disciplinary boards publish more verdicts this will make a further contribution to quality improvement.
References

Part IV

Specific aspects of the disciplinary proceedings and the disciplinary system
Chapter 7

Publication of disciplinary proceedings in the Netherlands: practice and policy


Abstract

Objective. To provide insight into practice and policy regarding the publication of disciplinary verdicts in Dutch health care.

Design. Descriptive.

Methods. All verdicts of the disciplinary boards and courts of justice, published in the Netherlands Government Gazette during the period 1995-2002, were studied with regard to the year of publication and verdict, the disciplinary board concerned, the accused professional, the type of complainant, the nature of the complaint and verdict, and the journals that were offered the verdict. The published verdicts were related to the total number of verdicts and cases during the study period. Questionnaires were used to investigate the publication policy of the disciplinary boards and the three journals which were offered the majority of verdicts for publication.

Results. A total of 4% of all verdicts were published in the Netherlands Government Gazette (323/8902). The central disciplinary board decided to publish more often than the regional disciplinary boards (8% and 2%, respectively). There were considerable differences between the various regional disciplinary boards (min-max 0.9%-5%). Per professional group the percentage of verdicts in cases that were published varied from 2% to 23%. The decisions were offered to over 20 journals, but mainly to the ‘Tijdschrift voor Gezondheidsrecht’ (TvGR) (92%) and the ‘Medisch Contact’ (MC) (88%). The TvGR published almost two thirds of the verdicts that were offered (63%), and the MC published almost three quarters (74%). With regard to decisions concerning publication, the disciplinary boards differed in their interpretation of the concept of ‘general interest’.

Conclusion. If disciplinary proceedings are to achieve the desired quality-promoting effect on professional practice, then more attention will have to be paid to the publication policy, and the disciplinary boards will have to develop a joint code of practice. More verdicts could be published, also in discipline-specific journals.

INTRODUCTION

The aim of the disciplinary system for health care is to foster and monitor high standards of professional practice, and to protect the general public against incompetence and carelessness, including harm and abuse. However, the extent to which the disciplinary system achieves this aim has scarcely been investigated. In order to answer the question about the influence of the disciplinary system on professional practice, a distinction must be made between influence on the individual professional who is subject to the verdict, and the more widespread effect on the professional group as a whole. The latter is mainly dependent on the question of whether the disciplinary board decides to publish the verdict. According to the Individual Health Care Professions Act (IHCP Act; in Dutch: Wet BIG), which came into effect at the end of 1997, the regional disciplinary boards and the central disciplinary board can, as previously was the case, decide whether, in the interest of the general public, an anonymous verdict will be entirely or partially published in the Netherlands Government Gazette and will be offered for publication to journals or newspapers indicated by the disciplinary board. Before the IHCP Act was introduced, this possibility was also available for the Courts of Justice, but this legal body no longer plays a
role in disciplinary jurisprudence. Unlike the Government Gazette, the journals and newspapers are not obliged to publish verdicts. 

Only a small percentage of the verdicts is published, and this has often been a point of criticism. However, no systematic research has yet been carried out to investigate the number and nature of the verdicts that have been published. This article describes the number and the nature of the verdicts which the disciplinary boards published in the Netherlands Government Gazette during the period 1995-2002, and the verdicts that were offered to and published in journals. A distinction is made between disciplinary cases before and after the IHCP Act came into effect, in order to determine whether there are any differences. Also studied were the considerations underlying the decisions made by the disciplinary boards to offer verdicts for publication, and the reasons why the journals that were offered many verdicts for publication decided to publish these verdicts.

METHODS

The design of the study was retrospective and descriptive. All the verdicts that were published in the Netherlands Government Gazette from 1995 to 2002 were investigated. For the period 1995-1997 use was made of the issues of ‘Medical disciplinary jurisprudence’, which later became ‘Disciplinary jurisprudence in health care’ during the period 1998-2002. These issues contained the full, anonymous text of all disciplinary verdicts published in the Government Gazette. The verdicts of the various Courts of Justice and the Supreme Court concerned complaints that were made before the IHCP Act came into force, and the verdicts of the regional disciplinary boards and the central disciplinary board concerned complaints made during the entire study period. Only the verdicts of the disciplinary boards and the Courts of Justice were investigated. The Supreme Court verdicts are always published, and were therefore not investigated.

To guarantee objectivity, two researchers studied the cases independently. The following characteristics were studied: the year of publication in the Government Gazette, the year of the verdict, the disciplinary board involved, the accused professional, the type of complainant, the nature of the complaint and verdict, and the journal that was offered the verdict. In order to investigate differences in verdicts published before and after the IHCP Act, a sub-division was made into three periods: 1995-1997 (before the introduction of the IHCP Act), 1998-1999 (transitional phase) and 2000-2002 (after the introduction of the IHCP Act). The number of verdicts published was related to the total number of verdicts and disciplinary cases during the entire study period.

The Health Care Inspectorate receives all disciplinary verdicts, and in order to determine the annual number of verdicts, use was made of its computerized database. In order to make comparison with non-published verdicts possible, the Health Care Inspectorate code for the nature of the complaint has been adhered to.

A search was made, until the end of May 2003, in the relevant year indices (1995-2002) and list of contents (2003) of the journals to which the verdicts were offered for publication, as mentioned in the verdict, to determine which verdicts were actually
published. All issues of two journals were searched for the study period: Medisch Contact (MC) and Tijdschrift voor Gezondheidsrecht (TvGR). In this way we found verdicts that had been published, but which did not state that they had been offered to the journal, including verdicts that had not been published in and had also not been offered to the Government Gazette. These verdicts were excluded from the study.

A written questionnaire was used to investigate the considerations of the disciplinary boards with regard to their publication policy. Four of the five regional disciplinary boards and the central disciplinary board responded. Another written questionnaire was sent to the editorial boards of the three journals that were offered the majority of verdicts for publication, to investigate their considerations with regard to whether or not to publish (offered) verdicts. These journals were MC, TvGR and ‘Nederlands Tijdschrift voor Geneeskunde’ (NTvG), and the editorial boards of all three responded.

An $\chi^2$-test was used to determine differences in outcome percentages between the disciplinary boards, the periods before and after the IHCP Act, the professional groups, and also differences in the nature of the complaint and the verdict.

RESULTS

Publications in the Government Gazette per disciplinary board
During the period 1995-2002, all the disciplinary boards and courts of justice together published 323 of the 8902 verdicts concerning 6803 disciplinary cases in the Government Gazette (323/8902; 4%). The central disciplinary board decided to publish more often than the regional disciplinary boards (175/2070; 8%, respectively 141/6803; 2%; p<0.001). There were differences between the various regional disciplinary boards (p<0.001). In comparison with the other boards, the disciplinary board in Groningen decided most often to publish its verdicts (32/627; 5%), and the disciplinary board in Zwolle least often (7/796; 0.9%). The Courts of Justice decided to publish the verdict in almost a quarter of the cases (7/29; 24%).

During the periods before and after the IHCP Act, approximately the same number of verdicts, including the courts of justice, were published (124/3131; 4%, respectively 151/3514; 4%; p>0.25). In the period before the IHCP Act the regional disciplinary boards decided to publish more often than in the period after the IHCP Act, namely 3% (75/2453) and 2% (47/2576) (p<0.01), respectively. In the period after the IHCP Act the central disciplinary board decided to publish more often than in the period before the IHCP Act, namely 11% (103/937) and 7% (45/663) respectively (p<0.01) (Table 1).

Publications in the Government Gazette per professional group
During the period 1995-2002, the disciplinary boards dealt with 5959 cases concerning physicians, and 274 verdicts were published in the Government Gazette (112 hearings in first instance and 162 appeals) (5%). Two physicians had the verdict (of their case) published by both the central disciplinary board and the Court of Justice. Of the 1979 cases concerning general practitioners, 111 (6%) were published, and 117 (4%) of the 2744 cases concerning hospital specialists were published: 26 psychiatrists, 20 gynaecologists and 12
surgeons. The percentage of published verdicts in disciplinary cases concerning hospital specialists varied from 2% (2/120) for cardiologists to 13% (6/47) for radiodiagnost (Table 3). Verdicts of cases concerning professionals who had only become subject to the disciplinary system since the introduction of the IHCP Act were more often published in the period 2000-2002 than verdicts concerning professionals who had been subject to the disciplinary system for a longer period of time (respectively 26/241; 11% and 125/2335; 5%; p<0.001) (Table 2).

Table 3
Number of verdicts published in the Netherlands Government Gazette (in first instance and appeals) and total number of disciplinary cases in the period 1995-2002 for physicians per specialism; absolute numbers (%)

<table>
<thead>
<tr>
<th>Specialism</th>
<th>Published verdicts</th>
<th>Disciplinary cases</th>
<th>Published verdicts per 100 cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital specialist</td>
<td>117 (43)</td>
<td>2 744 (46)</td>
<td>4</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>26 (9)</td>
<td>550 (9)</td>
<td>5</td>
</tr>
<tr>
<td>Gynaecologist</td>
<td>20 (7)</td>
<td>260 (4)</td>
<td>8</td>
</tr>
<tr>
<td>Surgeon</td>
<td>12 (4)</td>
<td>380 (6)</td>
<td>3</td>
</tr>
<tr>
<td>Neurologist</td>
<td>8 (3)</td>
<td>183 (3)</td>
<td>4</td>
</tr>
<tr>
<td>Anaesthesist</td>
<td>7 (3)</td>
<td>79 (1)</td>
<td>9</td>
</tr>
<tr>
<td>Paediatrician</td>
<td>7 (3)</td>
<td>80 (1)</td>
<td>9</td>
</tr>
<tr>
<td>Internist</td>
<td>7 (3)</td>
<td>271 (5)</td>
<td>3</td>
</tr>
<tr>
<td>Radiodiagnost</td>
<td>6 (2)</td>
<td>47 (0.8)</td>
<td>13</td>
</tr>
<tr>
<td>Plastic surgeon</td>
<td>4 (1)</td>
<td>58 (1)</td>
<td>7</td>
</tr>
<tr>
<td>Specialist in nervous and mental diseases</td>
<td>3 (1)</td>
<td>48 (0.8)</td>
<td>6</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>3 (1)</td>
<td>96 (2)</td>
<td>3</td>
</tr>
<tr>
<td>Orthopaedic surgeon</td>
<td>3 (1)</td>
<td>155 (3)</td>
<td>2</td>
</tr>
<tr>
<td>Cardiologist</td>
<td>2 (1)</td>
<td>120 (2)</td>
<td>2</td>
</tr>
<tr>
<td>Ear nose and throat specialist</td>
<td>2 (1)</td>
<td>78 (1)</td>
<td>3</td>
</tr>
<tr>
<td>Urologist</td>
<td>2 (1)</td>
<td>89 (1)</td>
<td>2</td>
</tr>
<tr>
<td>Others*</td>
<td>5† (2)</td>
<td>250 (4)</td>
<td>2</td>
</tr>
<tr>
<td>General practitioner</td>
<td>111 (41)</td>
<td>1 979 (33)</td>
<td>6</td>
</tr>
<tr>
<td>Public health physician</td>
<td>12 (4)</td>
<td>270 (5)</td>
<td>4</td>
</tr>
<tr>
<td>Other physicians‡</td>
<td>34 (12)</td>
<td>966 (16)</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>274 (100)</td>
<td>5 959 (100)</td>
<td>5</td>
</tr>
</tbody>
</table>

* neurosurgeon, radiotherapist, nuclear physician, gastro-enterologist, allergologist, dermatoologist, pathologist-anatomist, pneumonologist, reumatologist, rehabilitation specialist, microbiologist, clinical chemist, clinical geneticist, clinical geriatrist
† 2 pneumonologists, 1 reumatologist, 1 clinical geriatrist and 1 dermatologist
‡ physicians whose specialism was not defined, internals, nursing-home physicians, confidential physicians, prison physicians
Table 1

<table>
<thead>
<tr>
<th>Period</th>
<th>Groningen</th>
<th>Zwolle</th>
<th>Amsterdam</th>
<th>Den Haag</th>
<th>Eindhoven</th>
<th>Total RDBs</th>
<th>CDB</th>
<th>Courts of justice</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995-1997</td>
<td>24/220 (11)</td>
<td>3/240 (1)</td>
<td>14/724 (2)</td>
<td>12/551 (2)</td>
<td>75/2453 (3)</td>
<td>45/663 (7)</td>
<td>27/470 (6)</td>
<td>4/15 (27)</td>
<td>124/3131 (4)</td>
</tr>
<tr>
<td>1998-1999</td>
<td>0/137 (0)</td>
<td>1/172 (0.6)</td>
<td>5/441 (1)</td>
<td>6/527 (1)</td>
<td>19/1774 (1)</td>
<td>47/2576 (2)</td>
<td>103/937 (11)</td>
<td>2/13 (15)</td>
<td>48/2257 (2)</td>
</tr>
<tr>
<td>2000-2002</td>
<td>8/270 (3)</td>
<td>3/384 (0.8)</td>
<td>23/744 (3)</td>
<td>5/724 (1)</td>
<td>67/2576 (2)</td>
<td>116/815 (2)</td>
<td>27/470 (6)</td>
<td>1/1 (100)</td>
<td>151/3514 (4)</td>
</tr>
<tr>
<td>Total</td>
<td>32/627 (5)</td>
<td>7/796 (0.9)</td>
<td>52/1959 (3)</td>
<td>20/1585 (1)</td>
<td>141/6803 (2)</td>
<td>175/2070 (8)</td>
<td>7/29 (24)</td>
<td>323/8902 (4)</td>
<td></td>
</tr>
</tbody>
</table>

* not including verdicts concerning non-registered health professionals and verdicts concerning non-eligible complaints about the practice in new professions before the IHCP Act came into effect
† this concerned 8 cases (5%) before the IHCP Act; 7 from the central disciplinary board and 1 from a Court of Justice
<table>
<thead>
<tr>
<th>Period</th>
<th>Health professional</th>
<th>“Old professions” *</th>
<th>“New professions” †</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician</td>
<td>Dentist‡</td>
<td>Pharmacist</td>
<td>Midwife</td>
</tr>
<tr>
<td>1995-1997</td>
<td>112/2267 (5)</td>
<td>3/146 (2)</td>
<td>6/13 (46)</td>
<td>3/27 (11)</td>
</tr>
<tr>
<td>1998-1999</td>
<td>46/1564 (3)</td>
<td>1/103 (1)</td>
<td>0/6 (0)</td>
<td>0/21 (0)</td>
</tr>
<tr>
<td>Total</td>
<td>274/5959 (5)</td>
<td>10/418 (2)</td>
<td>8/35 (23)</td>
<td>4/70 (6)</td>
</tr>
</tbody>
</table>

* physicians, dentists, pharmacists and midwives. These professions were already subject to the disciplinary system before the IHCP Act came into effect
† nurses, physiotherapists, health care psychologists and psychotherapists. These professions became subject to the disciplinary system after the IHCP Act came into effect
‡ including oral surgeons and orthodontists
§ in 1998 34 identical complaints were made about one nurse
Publications in the Government Gazette per nature of the complaint and type of complainant

Complaints about professional misconduct (8/56; 14%) and violation of professional secrecy (18/150; 12%) were most often published during the study period (p<0.001) (Table 4). In the period 1995-2002 the inspector for health care was the complainant in 97 cases in first instance, in 8 of which together with another complainant. Almost half of these cases (whether or not appealed against) resulted in a publication (47/97; 48%). The other complainants had the verdict concerning their complaint (whether or not appealed against) published in 4% of the cases (284/6706).

Table 4
Number of verdicts published in the Netherlands Government Gazette (in first instance and appeals) and total number of disciplinary cases in the period 1995-2002 according to the nature of the complaint; absolute numbers (%)

<table>
<thead>
<tr>
<th>Nature of the complaint</th>
<th>Published verdicts</th>
<th>Disciplinary cases</th>
<th>Published verdicts per 100 cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not or belated visiting when requested</td>
<td>16 (5)</td>
<td>235 (3)</td>
<td>7</td>
</tr>
<tr>
<td>Incorrect treatment</td>
<td>72 (22)</td>
<td>1 456 (21)</td>
<td>5</td>
</tr>
<tr>
<td>Lack of care or inadequate care</td>
<td>96 (30)</td>
<td>1 960 (29)</td>
<td>5</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>11 (3)</td>
<td>177 (3)</td>
<td>6</td>
</tr>
<tr>
<td>Impolite behaviour</td>
<td>2 (0.6)</td>
<td>207 (3)</td>
<td>1</td>
</tr>
<tr>
<td>Non-referral or referred too late</td>
<td>6 (2)</td>
<td>111 (2)</td>
<td>5</td>
</tr>
<tr>
<td>Incorrect statement or reporting</td>
<td>14 (4)</td>
<td>170 (2)</td>
<td>8</td>
</tr>
<tr>
<td>Violation of professional secrecy</td>
<td>18 (6)</td>
<td>150 (2)</td>
<td>12</td>
</tr>
<tr>
<td>Professional misconduct</td>
<td>8 (2)</td>
<td>56 (1)</td>
<td>14</td>
</tr>
<tr>
<td>Other complaints</td>
<td>80 (25)</td>
<td>2 281 (34)</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>323 (100)</td>
<td>6 803 (100)</td>
<td>5</td>
</tr>
</tbody>
</table>

Publications in the Government Gazette per nature of the verdict

Verdicts in which a sanction was imposed were published more often than verdicts in which the complainant was not eligible or the complaint was unfounded (9% and 0.6%, respectively; p<0.001). Of the 141 verdicts of the hearings in first instance published in the Government Gazette in the period 1995-2002, almost a quarter concerned an unfounded complaint or a non-eligible complainant ((33+2)/141; 25%). In all the other cases a sanction was imposed; mainly a warning (59/141; 42%) or a reprimand (25/141; 18%) (Table 5).

Of the 182 published appeal verdicts, 101 (55%) remained the same, 79 (43%) were amended, and 2 (1%) cases were referred back to the disciplinary board in the first instance. Almost half of the amendments concerned an unfounded complaint or non-eligibility that was changed into a sanction (46%), and a quarter concerned a sanction that was made less severe (25%).
Table 5
Number of verdicts in first instance published in the Netherlands Government Gazette and total number of disciplinary cases in the period 1995-2002 according to nature of the verdict; absolute numbers (%)  

<table>
<thead>
<tr>
<th>Verdict</th>
<th>Published verdicts</th>
<th>Disciplinary cases</th>
<th>Published verdicts per 100 cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Entry struck off the IHCP register†/withdrawal of the right to practise</td>
<td>10 (7)</td>
<td>36 (0.5)</td>
<td>28</td>
</tr>
<tr>
<td>• Partial withdrawal of the right to practise the profession concerned†</td>
<td>-</td>
<td>2 (0.02)</td>
<td>-</td>
</tr>
<tr>
<td>• Combination of (conditional) suspension of the entry in the IHCP register* and fine†</td>
<td>1 (0.7)</td>
<td>6 (0.1)</td>
<td>17</td>
</tr>
<tr>
<td>• Suspension (of the entry in the IHCP register*)</td>
<td>7 (5)</td>
<td>63 (0.9)</td>
<td>11</td>
</tr>
<tr>
<td>• Conditional suspension of the entry in the IHCP register†</td>
<td>1 (0.7)</td>
<td>18 (0.3)</td>
<td>6</td>
</tr>
<tr>
<td>• Fine</td>
<td>3 (2)</td>
<td>19 (0.3)</td>
<td>16</td>
</tr>
<tr>
<td>• Reprimand</td>
<td>25 (18)</td>
<td>238 (3)</td>
<td>11</td>
</tr>
<tr>
<td>• Warning</td>
<td>59 (42)</td>
<td>771 (11)</td>
<td>8</td>
</tr>
<tr>
<td>Total sanctions</td>
<td>106 (75)</td>
<td>1 153 (17)</td>
<td>9</td>
</tr>
<tr>
<td>• Unfounded after a hearing</td>
<td>33 (23)</td>
<td>4 290 (63)</td>
<td>0.8</td>
</tr>
<tr>
<td>• Not eligible</td>
<td>2 (1)</td>
<td>508 (7)</td>
<td>0.4</td>
</tr>
<tr>
<td>• Investigation discontinued or complaint withdrawn</td>
<td>-</td>
<td>852 (13)</td>
<td>-</td>
</tr>
<tr>
<td>Total no sanctions</td>
<td>35 (25)</td>
<td>5 650 (83)</td>
<td>0.6</td>
</tr>
<tr>
<td>Total (%)</td>
<td>141 (100)</td>
<td>6 803 (100)</td>
<td>2</td>
</tr>
</tbody>
</table>

* the IHCP Act has a constitutive register, i.e. protected title. The right to use a professional title only becomes effective after entry in the IHCP register
† this sanction exists since the Individual Health Care Professions Act came into effect

Publications in professional journals
The verdicts that were published in the Government Gazette in the period 1995-2002 were offered to more than 20 different journals. Most of these verdicts were offered to the TvGR (297/323; 92%) and the MC (285/323; 88%). Almost two thirds of the verdicts that were offered to the TvGR were published in this journal (188/297; 63%). Moreover, this journal also published 5 cases in which it was not stated in the verdict that it had been offered to the journal. Almost three quarters of the verdicts that were offered to the MC were published (212/285; 74%). The MC also published 2 cases in which it was not stated in the verdict that it had been offered to the journal.

A number of journals were offered verdicts for publication during the period 1995-2002, but published none. The other journals were offered 1 to 17 verdicts during the period 1995-2002, 1 to 8 of which were published (Table 6).
Table 6
Journals to which verdicts published in the Netherlands Government Gazette in the period 1995-2002 (n= 323) were offered and in which they were published *

<table>
<thead>
<tr>
<th>Health professional</th>
<th>Journal</th>
<th>Published/Offered</th>
<th>Not published/Offered</th>
<th>Total offered</th>
<th>Total published</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>- Medisch Contact (MC)</td>
<td>212</td>
<td>73</td>
<td>285</td>
<td>212†</td>
</tr>
<tr>
<td></td>
<td>- Nederlands Tijdschrift v. Geneeskunde</td>
<td>-</td>
<td>40</td>
<td>40</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>- Tijdschrift v. Psychiatrie</td>
<td>-</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>- De Psychiater</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>- De Huisarts</td>
<td>-</td>
<td>3</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Dentists</td>
<td>- Nederlands Tandartsenblad</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>- Tijdschrift v. Tandheelkunde</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>- Pharmaceutisch Weekblad</td>
<td>8</td>
<td>-</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Midwives</td>
<td>- Tijdschrift v. Verloskunde</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Nurses</td>
<td>- Nursing</td>
<td>-</td>
<td>12</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>- TVZ</td>
<td>7</td>
<td>4</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>- Verpleegkundig Nieuws</td>
<td>4</td>
<td>13‡</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>- Sociale Psychiatrie</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>- Tijdschrift v. Geneeskunde en Sport</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Health care</td>
<td>- Fysiopraxis</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>psychologists</td>
<td>- De Psycholoog</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>and psychotherapists</td>
<td>- Tijdschrift v. Psychotherapie</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>All health</td>
<td>- Tijdschrift v. Gezondheidsrecht</td>
<td>188</td>
<td>109</td>
<td>297</td>
<td>188†</td>
</tr>
<tr>
<td>professionals</td>
<td>- Other journals§</td>
<td>-</td>
<td>4</td>
<td>4</td>
<td>-</td>
</tr>
</tbody>
</table>

* not including verdicts that were not published in the Government Gazette; 2 verdicts in MC and 5 in TvGR, of which 1 and 2, respectively, were offered to the journal
† not including verdicts in which it was not stated that they would be offered to the journal (2 in MC and 5 in TvGR)
‡ 8 of which were included on the website
§ the journals Maandblad v. Verstandelijk Gehandicaptenzorg "KLIK", NVO Bulletin, Maandblad v. de Geestelijke Volksgezondheid en Zorg en Ondernemen had all been offered a verdict which was not published in the journal

Considerations with regard to publication
The reasons that were stated in nearly all the verdicts with regard to publication in the Government Gazette and offering the verdicts to journals for publication were reference to general interest and/or Article 13b, Medical Disciplinary Act or Article 71, IHCP Act. In 9 verdicts the judge gave more detailed reasons: regularly recurring complaints (3x), the opinion that a professional group had not yet adequate knowledge of certain guidelines
Part IV

(5x), and that, shortly after the closed hearing, the accused physician him/herself had arranged publicity (1x).

**Publication policy of the disciplinary boards**

With regard to a publication policy, 2 regional disciplinary boards stated that they had no (written and verbal) agreements. The main considerations mentioned by the regional disciplinary boards were the learning effect in the professional group and possible standardization. With regard to its decisions concerning publication, the central disciplinary board stated that it took into consideration the aspect that it was a matter of general interest that a verdict was specifically brought to the attention of the professional group. According to the central disciplinary board, it mainly depends on the people involved as to whether or not they think that the verdict is a matter of general interest. Two boards realized the importance of developing a joint code of practice, but indicated that it is very difficult to get the various boards to agree on anything, or that a code of practice, in particular, will reflect the basic principles. According to one board, it would never be possible to achieve a joint code of practice, because all the boards are autonomous. Moreover, this board did not consider it to be necessary because a website has been developed, on which all the cases that have been heard are described, making publication according to Article 71 of the IHCP Act less relevant. Another board was more in favour of more frequent publications than further regulation. The central disciplinary board gave the following explanation about its publication policy: ‘In principle, it is not the task of the judge to determine whether or not his/her verdicts are important or should be made public. That is a matter for research and/or journalism. (…) With regard to monitoring the quality of health care, however, Article 71 of the IHCP Act does offer the disciplinary judge the exceptional authority to (…) enforce publication. However, because of the nature of the exception, this authority should be used sparingly.’ One regional disciplinary board pointed out that it was always willing to offer relevant verdicts for publication in an anonymous form if the professional group should request this, but that it seldom received such a request.

All but one of the regional disciplinary boards had a regular series of journals to which verdicts were offered for publication. One regional disciplinary board indicated that it chose journals that were willing to publish the entire verdict. The central disciplinary board stated that the publication policy of the editorial board was also a factor in the choice. Three regional disciplinary boards had sometimes received requests from journals for permission to publish a verdict, even though it had not been stated in the verdict. The regional disciplinary boards had granted these requests. The central disciplinary board made reference to the application of Article 71 of the IHCP Act and indicated that, in general, reference was also made to the website of the central disciplinary board.

**Publication policy of the journals**

During the study period the TvGR was offered cases concerning all the professions that were subject to the disciplinary system, except physiotherapy, and also published verdicts concerning those professional groups. With regard to decisions concerning publication, interest in legal standardization appeared to be the main consideration. The regional disciplinary boards were never asked for permission to publish a verdict if this was not
Chapter 7  Publication of disciplinary proceedings

stated in the verdict. However, during the study period 8 verdicts that had not been offered for publication were published.

For the editorial board of the MC an important consideration with regard to the publication of verdicts offered by the disciplinary boards was whether or not the verdict contained sufficient (new) elements of learning for physicians. Moreover, the length of the verdict also played a role, because the editorial board was not in favour of publishing shortened versions. During the study period the MC received offers of cases concerning professionals from all groups, except physiotherapists. Publications in the journal only concerned physicians, midwives and nurses. The editorial board of the MC stated that it could publish 48 verdicts each year.

The editorial board of the NTvG stated that it never published a verdict, but if a verdict is important for a large group of readers it asks an expert to comment on the verdict or on the subject. This has happened only a few times since 1996.8

**DISCUSSION**

This study provides insight into the practice and policy regarding the publication of disciplinary proceedings in the Netherlands. The study period was long enough to make it possible to compare cases before and after the introduction of the IHCP Act.

The results show that only 4% of all verdicts were published in the Government Gazette, and that there were significant differences between the various disciplinary boards, both between the central disciplinary board and the regional disciplinary boards (8% and 2% published, respectively) as well as between the individual regional disciplinary boards (min-max 0.9-5%). One of the reasons for this is probably the complex interpretation of the concept of ‘general interest’. During the period before the IHCP Act (1995-1997), almost as many verdicts were published as during the period after the Act came into effect (2000-2002). It is remarkable that the regional disciplinary boards published less often during the period after the IHCP Act, whereas the central disciplinary board published more often than in the previous period. Apparently, the central disciplinary board has a more active publication policy.

It is also remarkable that in many of the appeals that were published the verdict had been amended (43%); this was 12% of all the verdicts in 1999-2001.2 The amendment of a verdict obviously plays an important role in the decision to publish. Verdicts concerning complaints about professional misconduct and violation of professional secrecy were published most frequently during the study period.

During the study period, all the disciplinary boards together published only 2% of the verdicts concerning cardiologists, urologists, orthopedic surgeons and dentists. Previous studies have shown that in some professional fields the percentage of published verdicts is even so small that it is almost impossible to expect that the disciplinary system can have any influence on promoting quality or standardization in that specific field of practice.9,10 During the period 2000-2002, verdicts concerning professionals who became subject to the disciplinary system after the IHCP Act were published more frequently than verdicts concerning professionals who had been subject to the disciplinary system for a longer
period of time (11% and 5%, respectively). Whether or not this higher percentage of publications concerning the new professional groups is temporary will become clear in due course.

Other research has shown that half to four fifths of the professionals indicated that a published verdict concerning a colleague influenced their own professional practice. However, it is debatable whether publication in the Government Gazette is sufficient to bring the verdicts to the attention of the professional group. It is also debatable whether the internet as a source of information on verdicts is an adequate way in which to reach the professional group. Since the end of 2002 the central disciplinary board has a website containing all verdicts from 1998 onwards, and since May 2004 this has been extended to include the verdicts of the regional disciplinary board of Amsterdam. It is the intention that all the other regional disciplinary boards will follow suit. At the present time there is therefore no question of the availability of all verdicts from this website, and many of the verdicts of the central disciplinary board contain no new information because they mainly refer to related verdicts of the regional disciplinary board, not included on the website. Moreover, the search strategy leaves room for improvement. It is our opinion that publication in professional journals would produce a greater effect, because the professionals would then not have to search the internet, and this method would stimulate (editorial) comments and a forum for discussions. The MC published three quarters, and the TvGR almost two thirds of the verdicts that were offered for publication. During the study period, various journals were offered verdicts which they did not publish. This indicates that the disciplinary boards have insufficient insight into the publication policies of the journals.

CONCLUSION

If the disciplinary system is to achieve the intended quality-promoting effect on professional practice, then more attention must be paid to the publication policy, and the disciplinary boards must develop a joint code of practice. This is emphasized by the fact that earlier research has already reported that there is no clear criterion underlying the decision on whether or not to publish a verdict. Moreover, the Health Care Inspectorate, the professional associations, journalism and research all have a responsibility. In addition to systematic research into the disciplinary proceedings and/or jurisprudence in specific professional groups, more verdicts could be published, in particular in discipline-specific journals. The Health Care Inspectorate could also more frequently request a disciplinary board to publish a verdict. The editorial boards of discipline-specific journals should make (more) space available in their journal for verdicts, and could take the initiative to request the disciplinary boards for permission to publish their verdicts. More use could also be made of the verdicts available on the internet, and the monthly agendas of planned central disciplinary board hearings. The possibility of quality improvement and contribution to patient safety will be missed if the various parties involved do not make more use of the existing opportunities.

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References

Chapter 8

Views of physicians, disciplinary board members and practicing lawyers on the new statutory disciplinary system for health care in the Netherlands

Abstract
The introduction of the Individual Health Care Professions Act (IHCP Act; in Dutch: Wet BIG) at the end of 1997 brought a change in various aspects of the disciplinary proceedings. The opinions of those directly involved give an overview of the way in which the disciplinary proceedings function under the IHCP Act in daily practice, and thus an indication of the contribution made by the system to fostering and monitoring high standards of professional practice.

Questionnaires were sent to 1300 physicians: 400 general practitioners, 350 internists, 250 gynaecologists and 300 psychiatrists (response 69%, 65%, 60% and 60%, respectively), all 388 disciplinary board members (response 89%) and 43 practicing lawyers (response 65%).

Almost all of the disciplinary board members and the practicing lawyers, compared to less than one third of the physicians, were of the opinion that in their judgement of the complaints the disciplinary boards complied adequately with the concept of good professional practice. A large majority of the disciplinary board members and the practicing lawyers regretted that a complaint cannot be declared justified without imposing a sanction. Most of them were of the opinion that there would be an increase in the number of justified complaints if this possibility was incorporated in the Act. According to the majority of the disciplinary board members and practicing lawyers, the change in the composition of the disciplinary boards had not strengthened the position of the complainant. Most of the respondents were of the opinion that the inclusion of a health professional instead of a legally qualified member was necessary in order to promote consistency in the verdicts concerning professional practice, and thought that a member from the same specialism should always be involved in the judgement of a complaint.

A further contribution to the fostering and monitoring of high standards of professional practice could be made by increasing the number of health professional members, adapting the composition of the disciplinary boards to suit the specialism of the accused professional, and introducing the possibility to justify a complaint without imposing a sanction.

INTRODUCTION
The system of disciplinary proceedings for health care differs from country to country. Moreover, very little literature or empirical research has focused on this issue. This limits the opportunity to learn from each other’s experiences. In the Netherlands, a statutory disciplinary system for a number of health care professions has already been in existence for almost three quarters of a century. The aim of this disciplinary system is to foster and monitor high standards of professional practice, and to protect the general public against incompetence and carelessness, including harm and abuse. Every directly interested party can make a complaint; in practice this is mainly a patient or a patient’s family. The inspector for health care is also authorized to lodge a complaint. The disciplinary proceedings are dealt with by five regional disciplinary boards, and appeals are made to the central disciplinary board. The two disciplinary norms against which the disciplinary board assesses a case are: are the acts or omissions in conflict with the care that a professional should provide for the patient or close relatives of the patient, or have the acts or omissions in any other way been in conflict with the interests of good professional practice in
individual health care. In deciding on their verdicts, the disciplinary boards take into account, among other things, the legal requirements, jurisprudence, professional codes and rules of conduct, professional-technical regulations, standards, guidelines and protocols, also collectively referred to as the professional standard. The members of the boards include not only legally qualified members, but also health professionals from the same profession as the accused.

The disciplinary proceedings have been incorporated in the Individual Health Care Professions Act (IHCP Act) since it was introduced at the end of 1997, before which it fell under the Medical Disciplinary Act. However, over the years various complaints had been made about this Act. Some of these complaints concerned the position of the complainant in the proceedings, which, according to some people, was not strong enough and therefore resulted in the high percentage of unfounded complaints. Furthermore, the closed nature of the disciplinary proceedings made it difficult to obtain good insight into the functioning of the disciplinary system. With the introduction of the IHCP Act, the proceedings have been amended in various ways in an attempt to alleviate these deficiencies.

Important changes are the extension of the scope of the disciplinary proceedings to include four more professional groups, an increase in the number of legally qualified members in the disciplinary boards, and the fact that, in principle, the meetings are now open to the public. Also included in the IHCP Act is the possibility to summon and question witnesses and external experts (see Box 1).

**Box 1**

Some differences between the Medical Disciplinary Act and the disciplinary proceedings of the IHCP Act

<table>
<thead>
<tr>
<th>Professions subject to the disciplinary system</th>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>physicians, dentists, pharmacists and midwives</td>
<td>the regional medical disciplinary boards and central medical disciplinary board consist of one legally qualified member and four health professional members</td>
<td>the regional disciplinary board consists of two legally qualified members and three health professional members; the central disciplinary board consists of three legally qualified members and two health professional members</td>
</tr>
</tbody>
</table>

Witnesses and experts

<table>
<thead>
<tr>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>the Chairman can summon and question witnesses and experts but their attendance is not always obligatory</td>
<td>the regional disciplinary boards can summon and question witnesses and experts and their attendance is obligatory. The complainant and the accused can also invite or summon witnesses and experts but their attendance is only obligatory when summoned</td>
</tr>
</tbody>
</table>

Public nature of the meetings and verdicts

<table>
<thead>
<tr>
<th>Medical Disciplinary Act</th>
<th>IHCP Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>in principle no public access</td>
<td>in principle public access</td>
</tr>
</tbody>
</table>
In accordance with the requirements, the IHCP Act was evaluated within five years after its introduction. One of the aspects that were investigated are the opinions of physicians, disciplinary board members and practicing lawyers with regard to (changes in) the statutory disciplinary proceedings. The opinions of these individuals who are directly involved give an overview of the way in which the disciplinary proceedings functions under the IHCP Act in daily practice, and thus also an indication of the contribution of the disciplinary system to fostering and monitoring the high quality of professional practice.

METHODS

Questionnaire for physicians
Half way through 2001, within the framework of the evaluation of the IHCP Act, a written questionnaire was sent to 400 general practitioners, 350 internists, 250 gynaecologists and 300 psychiatrists. These professional groups were chosen because they are relatively large, and have considerable involvement with the disciplinary proceedings. Moreover, this included not only primary health care and hospital health care, but also mental health care. The professionals were selected from the IHCP register, except for the general practitioners, who were selected from the database of the Netherlands Institute for Health Services Research (NIHSR; in Dutch: Nivel). Included were all professionals who were living and working in the Netherlands (it was not possible to comply with the latter criterium in the IHCP register), who were born after 1937 and who had been registered before 1-1-2001 (IHCP register) or were already practicing before 1-1-2001 (NIHSR). The questionnaire contained, among other things, questions about certain background characteristics of the respondents and their opinions about the standards set by the disciplinary boards, the sanctions imposed, and the public nature of the disciplinary proceedings.

Questionnaires for disciplinary board members and practicing lawyers
At the end of 2001 a questionnaire was sent to all 388 disciplinary board members (regional and central) and practicing lawyers with experience of disciplinary proceedings. Their names were on a central disciplinary board list of lawyers who were fairly regularly involved in the central disciplinary board proceedings. The questionnaire contained, among other things, questions about background characteristics of the respondents and their opinions about the standards set by the disciplinary boards, the sanctions imposed, the public nature of the disciplinary proceedings, the change in composition of the disciplinary boards, the involvement of experts, and the criteria for terminating the membership of the disciplinary boards.

With regard to the disciplinary board members, in this article a differentiation is made between physician-members and legally qualified members, between those who were members before the introduction of the IHCP Act (members for longer than 4 years) and those who had become members since or after the IHCP Act was introduced (members for 4 years or less), and between members with less than average experience and members with more than average experience in dealing with disciplinary complaints. Their experience
was determined by multiplying the number of years as a member of the disciplinary board by the number of disciplinary complaints dealt with per year (as estimated by the respondent) (median 36). Average experience was considered to be dealing with 35 complaints per year.

Differences in outcome percentages between the various groups were tested for statistical significance by applying the $\chi^2$-test, and in one case the Fischer’s Exact test.

RESULTS

Response
Of the general practitioners, internists, gynaecologists and psychiatrists, 6, 3, 6 and 1, respectively, did not participate, either because they had changed their address or were no longer practicing. Of the remaining 394 general practitioners, 247 gynaecologists, 344 internists and 299 psychiatrists, 271 (69%), 160 (65%), 207 (60%) and 180 (60%), respectively, responded. Seventeen internists, 8 gynaecologists and 5 psychiatrists were not practicing (any longer). Eventually, only the questionnaires from practicing physicians were included in the analysis (a total of 788: 271 general practitioners, 190 internists, 152 gynaecologists and 175 psychiatrists) because, in fact, only these professionals are subjected to the disciplinary system. There was very little difference between the sampled professionals and the respondents with regard to age and gender.

Five disciplinary board members considered that they had too little experience to be able to complete the questionnaire, 2 had a long-term illness, 2 could not be reached, and 1 was no longer a member of a disciplinary board. Of the remaining 378 members, 336 returned a completed questionnaire (response 89%). Both the respondent group and the non-respondent group of disciplinary board members consisted for one fifth of legally qualified members and for four fifths of health professional members. Since the majority of complaints are made about physicians, eventually only the questionnaires from physician-members (n=108) and legally qualified members (n=70) were included in the analysis. When further reference is made in this article to disciplinary board members, we therefore refer to the physician-members and the legally qualified members. Two lawyers considered that they had too little experience to be able to fill in the questionnaire, and one was no longer very much involved in disciplinary proceedings. Of the remaining 40 practicing lawyers, 26 (65%) responded.

Background characteristics of the disciplinary board members and the practicing lawyers
Of the disciplinary board members, 49% were already members before the introduction of the IHCP Act, and 51% had become members since or after the IHCP Act was introduced (physicians: min/max 0-25 years, median 5; legally qualified members: min/max 0-27 years, median 3). It was unclear how long 4 physicians and 3 legally qualified members had been members. Of the members, 52% had already dealt with 35 or more disciplinary complaints, and 48% had dealt with less than 35 (physicians: min/max 0-1200 complaints, median 32; legally qualified members: min/max 0-5400 complaints, median 40). The
opinions of 10 members (5 physicians and 5 legally qualified members) could not be determined because the duration of their membership or the number of complaints they had dealt with per year was unclear. With regard to the physician-members, 16% were no longer practicing, 7% of whom for the past 0-2 years, 5% for the past 3-5 years, and 5% for longer than 5 years (min/max 0.5-10 years).

With regard to the practicing lawyers, 69% were already involved in disciplinary proceedings before the introduction of the IHCP Act, and 31% had been involved since or after the IHCP Act was introduced (min/max 2-21 years, median 8.5). All the practicing lawyers had dealt with at least 20 disciplinary complaints (min/max 20-585, median 196). The majority of the practicing lawyers had dealt with disciplinary complaints for professionals (88%), and 38% had (also) dealt with disciplinary complaints for (relatives of) patients.

**Standards, sanctions and public nature of the disciplinary proceedings (Table 1)**
The opinions of the physicians were quite different from those of the disciplinary board members and the practicing lawyers with regard to the statement that the disciplinary boards complied adequately with the concept of good professional practice in their judgement of disciplinary complaints (32% agreed vs. 94% and 92%, respectively; in both cases p<0.001); this applied, in particular, to the general practitioners (15%, not shown in Table 1). Compared with the disciplinary board members, the practicing lawyers more often (partially) agreed with the criticism that has been published in recent years in the media and in the professional journals, that in setting their standards the disciplinary boards sometimes show little affinity with the professional practice (65% vs. 37%; p<0.01) (not shown in Table 1). The physician-members more often (partially) agreed than the legally qualified members (46% vs. 21%; p<0.001). The disciplinary board members and the practicing lawyers mainly remarked that members from the professional groups often have too little practical experience, that the composition of the disciplinary boards is not always appropriate for the specialism of the accused professional, that there is tension between standard-setting and daily practice, in which the workload or the feasibility of the standards in daily practice is often not taken into account. The other disciplinary board members, with the exception of 6% who had no specific opinion, and practicing lawyers were of the opinion that the criticism was unfounded (57% and 35%, respectively). They indicated that the health professional members actually do have the necessary practical experience, and that in the composition of the disciplinary boards the specialism of the accused professional is taken into account and that, if necessary, an expert is questioned. They considered the cause of the criticism to be the tension between standard-setting and daily practice that occurs because the disciplinary boards must guard against non-compliance with the standards, inadequate knowledge and insight of the critics with regard to the disciplinary proceedings, and the lack of motivation of the verdicts, or unfortunate formulation by the editors of a journal if a short description of a verdict is given. Approximately half of the physicians, physician-members and legally qualified members (48%, 56% and 43%, respectively) and almost one third of the practicing lawyers (31%) were of the opinion that the disciplinary system protects the general public against errors in health care. Hardly any.
Table 1
Opinions concerning standard-setting, sanctions and public access: percentage of respondents who totally agreed or agreed more than disagreed with the statements

<table>
<thead>
<tr>
<th></th>
<th>Physicians n=778</th>
<th>Disciplinary board members Physicians n=105</th>
<th>Legally qualified n=69</th>
<th>Total n=175</th>
<th>Practicing lawyers n=26</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard-setting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In its judgement of disciplinary complaints, the disciplinary boards adequately comply with the concept of <em>good professional practice</em></td>
<td>32</td>
<td>92</td>
<td>97</td>
<td>94</td>
<td>92</td>
</tr>
<tr>
<td>• The disciplinary system protects the general public against errors in health care</td>
<td>48</td>
<td>56</td>
<td>43</td>
<td>51</td>
<td>31</td>
</tr>
<tr>
<td>• The disciplinary boards protect the professionals</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td><strong>Sanctions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In general, a professional is scarcely impressed by a warning</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>• It is a deficiency that it is not possible to justify a complaint without imposing a sanction</td>
<td>84</td>
<td>89</td>
<td>86</td>
<td>89</td>
<td></td>
</tr>
<tr>
<td>• The number of justified complaints will increase when the Act includes the possibility to justify a complaint without imposing a sanction</td>
<td>60</td>
<td>73</td>
<td>65</td>
<td>73</td>
<td></td>
</tr>
<tr>
<td><strong>Public access to disciplinary proceedings</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Public access to the disciplinary proceedings, in itself, damages the reputation of an accused professional</td>
<td>74</td>
<td>41</td>
<td>29</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>• The public nature of the meetings inhibits accused professionals with regard to providing information</td>
<td>21</td>
<td>14</td>
<td>19</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>• The public nature of the meetings inhibits complainants with regard to providing information</td>
<td>11</td>
<td>14</td>
<td>12</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

*for general practitioners this was ‘good general practice’, for gynaecologists it was ‘good gynaecological practice’, for internists it was ‘good internal medical practice’ and for psychiatrists it was ‘good psychiatric practice’
of the physicians or disciplinary board members (1-2%), and only 12% of the practicing lawyers, were of the opinion that the disciplinary boards protect the professionals.

A small minority of the physicians, disciplinary board members and practicing lawyers were of the opinion that, in general, professionals are scarcely impressed by a warning (1-8%). A large majority of the disciplinary board members and practicing lawyers regretted that a complaint cannot be declared justified without imposing a sanction (86% and 89%, respectively). Almost three quarters of the legally qualified members and practicing lawyers (both 73%), compared with 60% of the physician-members, thought that the number of justified complaints would increase if this possibility was included in the Act.

Almost three quarters (74%) of the physicians were of the opinion that the reputation of an accused professional is already damaged by the public nature of the disciplinary proceedings; this percentage was lower for physician-members (41%; p<0.001), and even lower still for legally qualified members and practicing lawyers (29% and 39%, respectively; in both cases p<0.001). Approximately one fifth of the physician-members, legally qualified members and practicing lawyers (21%, 14% and 19%, respectively) agreed that the public meetings inhibit accused professionals in providing information. In answer to the same statement about complainants, 11-14% of the disciplinary board members and none of the practicing lawyers agreed. With regard to the statements that were discussed, no (significant) differences were found between members who had dealt with more or less than 35 disciplinary complaints (not shown in Table 1).

Composition of disciplinary boards and involvement of experts (Table 2)
Approximately 90% of the disciplinary board members and practicing lawyers were of the opinion that in the judgement of a complaint a member from the same specialism should always be involved (89% and 96%, respectively), and approximately half of them thought that the regional boards and the central disciplinary board should return to their former composition of 1 legally qualified member (Chairman) and 4 health professional members (53% respectively 48% and 45% respectively 44%). Even more disciplinary board members, but less practicing lawyers were of the opinion that including a health professional member instead of a legally qualified member in the regional boards and the central disciplinary board is necessary in order to maintain consistency in the verdicts concerning professional practice (58% respectively 40% and 63% respectively 46%). One fifth to one quarter of them thought that the change in composition of the regional boards and the central disciplinary board, i.e. strengthening the legal element, has strengthened the position of the complainant (20% respectively 16% and 25% respectively 12%). A large majority of the disciplinary board members and practicing lawyers agreed with the statement that the inclusion of more health professional members in the disciplinary boards makes it less necessary to involve experts (78% and 62%, respectively).

The opinions of the disciplinary board members and the practicing lawyers differed most with regard to the statement that the majority of complaints can be adequately dealt with in the regional disciplinary boards by 1 legally qualified- and 2 health professional members, instead of 2 legally qualified- and 3 health professional members (48% disciplinary board members vs. 85% practicing lawyers; p<0.001), and that the composition of the central disciplinary board should be changed (from 3 legally qualified members) to 2
Table 2
Opinions concerning the composition of the disciplinary boards and the involvement of experts: percentage of respondents who totally agreed or agreed more than disagreed

<table>
<thead>
<tr>
<th>Composition of the disciplinary boards</th>
<th>Physicians</th>
<th>Disciplinary board members</th>
<th>Practicing lawyers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=103</td>
<td>Legally qualified n=68</td>
<td>After IHCP n=84</td>
</tr>
<tr>
<td>• In the judgement of a complaint a member from the same specialism should always be involved</td>
<td>86</td>
<td>93</td>
<td>93</td>
</tr>
<tr>
<td>• Most of the complaints brought before the regional disciplinary boards can be adequately dealt with by 1 legally qualified member (Chairman) and 2 health professional members (limited composition)</td>
<td>49</td>
<td>47</td>
<td>45</td>
</tr>
<tr>
<td>• The regional disciplinary boards should return to their former composition of 1 legally qualified member (Chairman) and 4 health professional members</td>
<td>52</td>
<td>55</td>
<td>31</td>
</tr>
<tr>
<td>• The central disciplinary board should return to its former composition of 1 legally qualified member (Chairman) and 4 health professional members</td>
<td>49</td>
<td>39</td>
<td>26</td>
</tr>
<tr>
<td>• The composition of the central disciplinary board should be changed to 2 legally qualified members (one of whom is Chairman) and 3 health professional members</td>
<td>67</td>
<td>52</td>
<td>61</td>
</tr>
<tr>
<td>• The inclusion of a health professional instead of a legally qualified member in the regional disciplinary boards is necessary to maintain consistency in the verdicts concerning professional practice</td>
<td>69</td>
<td>42</td>
<td>46</td>
</tr>
</tbody>
</table>
### Composition of the disciplinary boards

- The inclusion of a health professional instead of a legally qualified member in the central disciplinary board is necessary to maintain consistency in the verdicts concerning professional practice.

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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The inclusion of a health professional instead of a legally qualified member in the central disciplinary board is necessary to maintain consistency in the verdicts concerning professional practice</td>
<td>73</td>
<td>48</td>
<td>52</td>
</tr>
<tr>
<td>The change in the composition of the regional disciplinary boards, i.e. strengthening the legal element, has strengthened the position of the complainant</td>
<td>19</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>The change in the composition of the central disciplinary board, i.e. strengthening the legal element, has strengthened the position of the complainant</td>
<td>23</td>
<td>27</td>
<td>39</td>
</tr>
</tbody>
</table>

### Involvement of experts

- The inclusion of more health professional members in the disciplinary boards makes it less necessary to involve experts.

- The disciplinary boards usually adhere to the judgement made by the experts involved.

- The involvement of experts often results in delaying the procedure.

- The quality of the judgement made by experts involved by the disciplinary boards is better than the judgement made by experts involved by complainants and accused.

<table>
<thead>
<tr>
<th>Involvement of experts</th>
<th>Physicians</th>
<th>Disciplinary board members</th>
<th>Practicing lawyers</th>
</tr>
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<td></td>
<td></td>
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<tr>
<td>The inclusion of more health professional members in the disciplinary boards makes it less necessary to involve experts</td>
<td>76</td>
<td>83</td>
<td>77</td>
</tr>
<tr>
<td>The disciplinary boards usually adhere to the judgement made by the experts involved</td>
<td>58</td>
<td>64</td>
<td>58</td>
</tr>
<tr>
<td>The involvement of experts often results in delaying the procedure</td>
<td>50</td>
<td>62</td>
<td>64</td>
</tr>
<tr>
<td>The quality of the judgement made by experts involved by the disciplinary boards is better than the judgement made by experts involved by complainants and accused</td>
<td>32</td>
<td>24</td>
<td>24</td>
</tr>
</tbody>
</table>
legally qualified members and (from 2 to) 3 health professional members (61% disciplinary board members vs. 28% practicing lawyers; p<0.01).

Compared with individuals who had become members since or after the IHCP Act was introduced, those who were already members before the introduction of the IHCP Act agreed much more frequently with the statement that the regional boards and the central disciplinary board should return to their former composition (76% vs. 31% and 67% vs. 26%, respectively; in both cases p<0.001), and that the inclusion of a professional member instead of a legally qualified member in the regional boards and the central disciplinary board is necessary in order to promote consistency in verdicts concerning professional practice (71% vs. 46% and 76% vs. 52%, respectively; in both cases p<0.001). These members less often agreed with the statement that the change in the composition of the regional boards and the central disciplinary board has strengthened the position of the complainant (7% vs. 33% and 11% vs. 39%, respectively; in both cases p<0.001). This also applied, although to a lesser degree, between members who had dealt with more or less than 35 complaints (not shown in Table 2).

Criteria for termination of disciplinary board membership
The disciplinary board members and the practicing lawyers were also asked how long they considered it to be appropriate for a health professional member who is no longer practicing to continue as member of a disciplinary board. The answers to this question varied from direct resignation when no longer practicing (10% and 12%, respectively) to a maximum period of 5 years, respectively until registration is terminated (28% and 20%, respectively). Compared with legally qualified members, physician-members more often stated that this should be a maximum period of 5 years (38% vs. 13%; p<0.001). Some disciplinary board members were of the opinion that health professional members should be allowed to continue to participate in the disciplinary board for as long as they felt affiliation with professional practice.

Of the disciplinary board members and practicing lawyers, 48% and 46%, respectively were of the opinion that the maximum age for health professional members should be 65; 41% and 42%, respectively mentioned a maximum age of 70. Others mentioned different age-limits (e.g. 60 or 75 years of age) or indicated that discontinuation of the practice, and not age, should be a criterium for membership of a disciplinary board.

Of the physician-members who were no longer practicing (17%), approximately three quarters (72%) stated that after discontinuation of the practice, participation in a disciplinary board as health professional member should be restricted to a maximum of 5 years, respectively until registration is terminated, and approximately half (47%) were of the opinion that the maximum age of a health professional member should be 70 years.

DISCUSSION
In the Dutch health care system the disciplinary proceedings are an element of the regulation of professional practice. This study provides insight into the opinions of physicians, disciplinary board members and practicing lawyers with regard to the functioning of the disciplinary system under the IHCP Act. It provides an opportunity for
other countries, with similar or different regulations of professional practice, to learn from the Dutch experience. The response to the questionnaires was high, not only from the physicians, but also from the disciplinary board members and the practicing lawyers.

Verdicts pronounced by the disciplinary boards concerning physicians regularly cause a stir in the media and in the professional journals. In this study it was found that physicians, and general practitioners in particular, are quite critical of the standards set by the disciplinary boards. A (small) minority of them were of the opinion that, in their judgement of disciplinary complaints, the disciplinary boards adequately comply with the concept of good professional practice. Almost all the disciplinary board members and practicing lawyers considered that there was adequate compliance. On the other hand, almost two thirds of the practicing lawyers and over a third of the disciplinary board members (partially) agreed with the criticism in the media and the professional journals. It is remarkable that not only those who (partially) agreed with the criticism, but also those who disagreed, mentioned that there is tension between standard-setting and daily practice.

There are noticeable differences of opinion between the general public and the respondents discussed in this article, i.e. physicians, disciplinary board members and practicing lawyers, with regard to the statement ‘The disciplinary boards protect the professionals’ (36% agreed vs. 1-12% disagreed) and the statement ‘In general, a professional is scarcely impressed by a warning’ (59% vs. 1-8%). Apparently, the general public has less confidence in the independent status of the disciplinary proceedings, and are less able to realize what the impact of even the least severe sanction is on the professional in question.

The number of justified complaints is low; over a period of 20 years, 18% of the complaints about physicians, dentists, pharmacists and midwives were declared justified. What is important, in this respect, is that the threshold over which the disciplinary boards must step in order to declare a complaint justified is quite high. After all, under both the Medical Disciplinary Act and the IHCP Act, a justified complaint always implies that a sanction is imposed. More than once, therefore, in their judgement of a complaint the disciplinary boards take into consideration the fact that the reason for the complaint is serious, but not serious enough to justify the imposition of a sanction. A large majority of the disciplinary board members and practicing lawyers therefore regretted that a complaint cannot be declared justified without imposing a sanction. Most of them were of the opinion that there will be an increase in the number of justified complaints if this possibility is included in the IHCP Act, also because it will probably lead to more accurate standard-setting. On the other hand, the low percentage of justified complaints is also due to the limited knowledge the general public has with regard to the disciplinary proceedings. Many people are not aware of the aim or the content of the disciplinary system, and do not know what type of complaints can be brought before a disciplinary board. Providing the general public with more information about the disciplinary proceedings, and other procedures for lodging complaints, can therefore also contribute to an increase in the number of justified complaints and thus the number of justified verdicts.

The basic assumption of the IHCP Act, i.e. that in principle the meetings of the disciplinary boards are open to the public, appears to cause very few practical problems. The doors are seldom closed, and a request for a closed meeting is seldom made.
majority of the disciplinary board members and practicing lawyers were of the opinion that public meetings inhibit neither the accused nor the complainant with regard to providing information. On the other hand, three quarters of the physicians and more than one third of the disciplinary board members and practicing lawyers were of the opinion that the public nature of the disciplinary proceedings, in itself, damages the reputation of an accused professional. It should not be underestimated that in incidental cases publicity about the proceedings during the meeting can have a very negative effect on a professional, even though at that stage there is no indication that the complaint will be justified.

The inclusion of more legally qualified members in the disciplinary boards was intended to strengthen the position of the complainant. After all, they would not be members from the same profession, would not protect the accused professionals, and their judgement would therefore be more impartial. Our study shows that, according to the majority of the disciplinary board members and practicing lawyers, the change in composition of the disciplinary boards has not strengthened the position of the complainant. In the first few years after the introduction of the IHCP Act, there was no increase in the number of justified complaints, but a further decrease from 19% to 15%. Although the extra legally qualified member in the disciplinary board does not seem to have any added value, the decrease in contribution from the profession is considered to be a limitation in the judgement of the complaint. The majority of respondents were of the opinion that the inclusion of a health professional in the disciplinary board instead of a legally qualified member would be more appropriate in order to maintain consistency in the verdicts concerning professional practice. Members who were able to compare the situation before and after the IHCP Act, because they were already members before the introduction of the Act, more often considered the change in the composition of the disciplinary boards to be detrimental, and were more often in favour of including a health professional instead of a legally qualified member in order to promote consistency in the verdicts.

Another argument in favour of increasing the number of health professional members in the disciplinary boards is that this would make it easier to comply with the wish that became apparent from this study, that a member of the same specialism as the accused professional should participate in the hearing. The fact that a member of the same specialism is not always involved during the assessment of a complaint has strengthened the already mentioned criticism concerning inadequate affinity with daily practice in the standard-setting. It is obviously important that this member from the same specialism is still practicing, or is adequately aware of current practice. In our study, 17% of the participating physicians were no longer practicing, 5% of whom for longer than 5 years.

Yet another argument for including more health professionals in the disciplinary boards is that, according to a large majority of the disciplinary board members and practicing lawyers, this makes it less necessary to involve external experts. The advantage is that these members can participate in discussions within the board, to which external experts have no access.
CONCLUSIONS

This overview of the opinions of the disciplinary board members and the practicing lawyers, has revealed the weaker aspects in the functioning of the disciplinary system under the IHCP Act. A number of amendments to the disciplinary proceedings could make a further contribution to fostering and monitoring the quality of professional practice. Amendments that could be taken into consideration are an increase in the number of health professional members in the disciplinary boards, a composition of the boards that is appropriate for the specialism of the accused professional, and the introduction of the possibility to justify a complaint without imposing a sanction.

References

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Part V

General discussion
This chapter begins with a description of the position and character of the disciplinary system for health care, within the general context of instruments that regulate the quality of care (9.1). Subsequently, answers will be given to the research questions underlying this thesis, as formulated in the General introduction (9.2). The practical aspects of various legal instruments, other than the statutory disciplinary system, and self-regulation will then be discussed (9.3), followed by an attempt to investigate further the functioning of the disciplinary system and the contribution of this functioning to the aims of the disciplinary system (9.4). Finally, the limitations and strengths of this research will be discussed (9.5), and some implications for policy, practice and research (9.6).

9.1 POSITION AND CHARACTER OF THE DISCIPLINARY SYSTEM FOR HEALTH CARE

The statutory disciplinary system, as an instrument to foster and monitor the quality of professional practice and as a procedure for complaints, should be considered within the general context of legal regulations, jurisprudence and self-regulation that regulate the quality of care. In this section a brief description will be given of the relevant legislation and certain other legal instruments that are important in this respect. This will be followed by a description of certain forms of self-regulation, including the internal disciplinary systems for the members of the professional associations and other complaint procedures. Finally, the specific character of the statutory disciplinary system will be discussed.

9.1.1 Legislation for the quality of professional practice

There are many laws that concern the quality of professional practice in health care. In addition to the Individual Health Care Professions Act (IHCP Act; in Dutch: Wet BIG) that was introduced in 1997, the following should also be mentioned: the 1996 Health Care Institutions Quality Act (in Dutch: Kwaliteitsweg zorginstellingen [KWZ]), the 1995 Medical Treatment Agreement Act (in Dutch: Wet op de geneeskundige behandelingsovereenkomst [WGBO]), the 1995 Act governing the right of clients in the care sector to complain (in Dutch: Wet klachtrecht cliënten zorgsector [WKCZ]), and the 1992 Psychiatric Hospitals Compulsory Admissions Act (in Dutch: Wet bijzondere opnemingen in psychiatrische ziekenhuizen [BOPZ]).

Within the IHCP Act the disciplinary system represents the most important way in which to take legal action against physicians, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists. The aim of this system is to foster and monitor the quality of professional practice and to protect the general public against incompetence and carelessness. Every person who is directly involved can lodge a complaint; in practice, however, this is usually a patient or a member of the patient’s family. Moreover, the inspector for health care has the authority to make a complaint. The sanctions that can be imposed range from mild (e.g. a warning or a reprimand) to severe (e.g. suspension or striking off the entry in the IHCP register).

In addition to the disciplinary system, the IHCP Act also contains other legal corrective instruments which can influence the functioning of the disciplinary system. The
Health Care Inspectorate can submit a written report to the Medical Supervision Board in a case involving incompetent professional practice due to physical or mental illness or as a result of an addiction. This Board can have the entry of the professional (partially) struck off the register, or stipulate conditions for practicing the profession. This regulation only applies to the professions which are subject to the disciplinary system. The Health Care Inspectorate can order sanctions to be imposed or prohibit the professional from practicing if a solo practitioner does not provide the required quality of care (Article 40, IHCP Act). The Health Care Inspectorate also has this right to intervene on the grounds of the Health Care Institutions Quality Act. The IHCP Act also includes regulations in which, among other things, causing (a serious possibility of) damages is also an offence.

General regulations for criminal offences in the Penal Code can also be applied in the field of health care. For instance, the regulations concerning euthanasia, assisted suicide, manslaughter, physical damages, mishandling or sexual abuse in care situations. The judge can impose a fine and/or an imprisonment. In extreme cases, in combination with an imprisonment, the right to practice the profession can be withdrawn. Finally, the Civil Law provides patients and employers with the opportunity to accuse a professional of causing damages. Figure 1 gives an overview of the more or less formal legal regulations concerning activities in the individual health care professions, and the professionals who are subject to these regulations.

9.1.2 Self-regulation: internal disciplinary system and other complaint procedures

With regard to the quality of health care, not only the legal regulations apply, but self-regulation by the professional organizations or institutions, whether or not stimulated by legislation, is also important. Some examples are: codes of conduct and professional codes, the standards of the Dutch College of General Practitioners, (in Dutch: Nederlands Huisartsen Genootschap [NHG-standaarden]), quality institute guidelines for health care; the Central Supervisory Organization for inter-collegial assessment (in Dutch: Centraal BegeleidingsOrgaan voor intercollegiale toetsing [CBO-richtlijnen]), the Health Care Information and Complaint Service (in Dutch: Informatie- en Klachtenbureaus Gezondheidzorg [IKG]), complaints officers, complaint committees, hospital dispute committees, committees for reporting incidents and mistakes or near-accidents in patient care (in Dutch: commissies voor Meldingen Incidente Patiëntenzorg en voor Fouten Ongevallen Near Accidents [MIP- en FONA-commissies], inter-collegial or other assessment procedures, locum regulations, and arrangements for refresher courses and further education.

All the professional groups that are subject to the statutory disciplinary system also have their own professional codes or codes of conduct. Internal disciplinary systems can be established to maintain the standards and regulations contained in these professional codes and codes of conduct. The professional organizations for physicians (Royal Dutch Medical Association [RDMA; in Dutch: KNMG]), dentists (Dutch Dental Association [DDA; in Dutch: NMT]), physiotherapists (Royal Dutch Society for Physiotherapy [RDP; in Dutch: KNGF]), and psychologists (Dutch Association for Psychologists [DAP; in Dutch: NIP]) all have an internal disciplinary system for their members, and patients can make complaints against members of these organizations. Since 1989 patients can no longer make a
complaint about physicians who are members of the RDMA\(^1\), and since July 2004 patients can no longer make a complaint about dentists who are members of the DDA (DDA, personal communication, May 2005). However, the opportunities to uphold codes of conduct with the associations are limited, because there is often inadequate authorization for the investigation of offences, and the co-operation of the professional involved is not obligatory. Other problems are that the code only applies to members of the association, and these members can avoid any consequences by resigning their membership. Moreover, the possible sanctions have insufficient impact, because expulsion as a member is the most severe disciplinary measure.

### Figure 1

**Legal regulations concerning the practice in individual health care**

<table>
<thead>
<tr>
<th>Legal regulations</th>
<th>Applies to the following professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disciplinary system</td>
<td>Physicians, dentists, pharmacists, midwives, nurses, physiotherapists and health care psychologists</td>
</tr>
<tr>
<td>Violation of disciplinary standards:</td>
<td></td>
</tr>
<tr>
<td>• Actions or lack of actions in conflict with the care for the patient and the patient’s relatives</td>
<td></td>
</tr>
<tr>
<td>• Actions or lack of actions in conflict with good professional practice in individual health care</td>
<td></td>
</tr>
<tr>
<td>Penalty clauses in the IHCP Act</td>
<td>Everyone</td>
</tr>
<tr>
<td>• (Considerable chance of) causing damages to health</td>
<td></td>
</tr>
<tr>
<td>• Unauthorized performance of reserved procedures</td>
<td></td>
</tr>
<tr>
<td>• Illegal use of a protected title</td>
<td></td>
</tr>
<tr>
<td>Civil Law</td>
<td>Employer; care institution; everyone who provides individual health care professionally</td>
</tr>
<tr>
<td>Liability for damages resulting from agreement or illegal actions</td>
<td></td>
</tr>
<tr>
<td>• Labour law (Civil Law)</td>
<td>Employee</td>
</tr>
<tr>
<td>Failure to perform the duties of an employee</td>
<td></td>
</tr>
<tr>
<td>• Criminal law</td>
<td>Everyone</td>
</tr>
<tr>
<td>Committing a criminal offence, such as mishandling, manslaughter, murder</td>
<td></td>
</tr>
</tbody>
</table>

Source: In line with Boomen IJHC van den, Vlaskamp AAC. Conditional. Information concerning the authority regulations for reserved procedures. [in Dutch: Onder voorbehoud. Informatie over de bevoegdheidsregeling voorbehouden handelingen]. Rijswijk: Ministry of Public Health, Welfare and Sport; 1996.\(^2\)
Within the framework of self-regulation, in addition to the internal disciplinary system, there are other opportunities for the general public to make a complaint about a professional, whether or not on the grounds of legislation (e.g. the Act governing the right of clients in the care sector to complain). All these possibilities, in addition to the possibility of liability for damages on the grounds of the Civil Law mentioned in the previous section, have an influence on the functioning of the disciplinary system.

There is assistance with complaints in the following ways:
1. support, consisting of information and advice, assistance and arbitration (no legal regulation, no formal procedure),
2. complaint assessment, resulting in a non-obligatory verdict (legal regulation, but less formal procedure),
3. complaint assessment, resulting in an obligatory verdict (legal regulation and formal procedure), and
4. investigation of compliance with standards or quality measures (legal regulation and formal procedure).

Complaints can be made as follows:
1. complain to the care-giver in question, make a complaint to a complaints officer, or to the Health Care Information and Complaint Service (IKG),
2. complaint assessment by a complaint committee,
3. assessment of claims for damages by the hospital dispute committee, and
4. complaint assessment by a disciplinary judge.

The first two possibilities for making a complaint focus, in particular, on reinstatement of the care relationship. The third possibility mainly concerns satisfaction through compensation for damages. In the disciplinary proceedings, which permits not only the general public to make complaints, the personal interest of the patient is less relevant. In this case, as has already been explained, the main focus is on fostering and monitoring the quality of care.

9.1.3 The specific character of the statutory disciplinary system
The statutory disciplinary system has a unique legal position. It is sui generis legislation (has its own character) and has similarities and dissimilarities with civil law, criminal law and administrative law. The disciplinary system focusses explicitly on maintaining the professional standard, and this is what makes it different from criminal law, civil law and administrative law. Criminal law focusses on restoring law and order by punishing those who commit criminal acts and offences, whereas civil law focusses on defending the rights of the general public by awarding compensation for damages. Administrative law focusses on safeguarding the rights and duties of the general public and administrative organizations in their mutual relationship. The affinity between the disciplinary law and the civil law is closest in the nature of the standards and the fact that the defendant, just like the complainant in civil law, can initiate proceedings. However, the disciplinary system should not only been seen as jurisprudence for complaints. As mentioned before, the main focus of
The disciplinary system is to maintain the professional standard, and not primarily to compensate those who are directly involved. There are similarities with the criminal law with regard to the aim of the sanctions and the fact that, just as in the criminal law, the general interest (in this case good professional practice) must be taken into account. However, there is one crucial difference: the disciplinary standards are based on the actions that are expected from the professional, and less on the guilt or intent requirements that apply in the criminal law. A parallel with administrative law can be found in the fact that also in the disciplinary proceedings it is the person with authority – the disciplinary judge – who imposes the sanction.

The effects of the specific aim of the statutory disciplinary system are determined as follows:

- The right to complain
It is noteworthy that not only those directly involved (usually a patient or a member of the patient’s family) have the right to complain, but also the Health Care Inspectorate; the disciplinary proceedings therefore have both private and public legal aspects. Therefore, the initiative to make a complaint to the disciplinary board will mainly be taken by the person who feels that he/she has been unfairly treated by the professional, or possibly by the Health Care Inspectorate if it is of the opinion that the disciplinary standards have been violated and the case is primarily of interest to the general public.

- The judges
The disciplinary proceedings differ from other legal proceedings in that members of the same profession participate: predominantly in first instance and to a considerable extent in appeal cases. In the legal assessment, their professional opinions and expertise are taken into account.

- The nature of the standards
The standards are mainly transparent and broadly formulated (both in the Medical Disciplinary Act and in the IHCP Act). The standards in the disciplinary system refer to the professional standard, and are specified in more detail and further developed in the disciplinary proceedings.

- The nature of the sanctions
The sanctions are not intended to compensate the complainant, but to change the behaviour or the actions of the accused (corrective), and more in general they focus on prevention and standard-setting. The preventive aspect has been further emphasized by increasing the sanctions included in the IHCP Act with, for instance, conditional suspension.
9.2 Answers to the research questions

This section discusses the extent to which the research questions, formulated in the General introduction of this thesis, have been answered.

The following research questions were addressed:

1. What is the practical application of the Dutch statutory disciplinary system for health care for the different ‘old’ and ‘new’ professions with regard to the characteristics of the complaints dealt with, including the complainants, the accused and the verdicts, and how has this developed over time (for the ‘old’ professions), in particular since the introduction of the IHCP Act?

2. What is the practice and policy concerning the publication of disciplinary proceedings in the Netherlands?

3. What are the perspectives of those directly involved (professionals, board members, practicing lawyers) in the Dutch statutory disciplinary system for health care, in particular with regard to the changes in the disciplinary proceedings with the introduction of the IHCP Act?

9.2.1 Practical application of the Dutch statutory disciplinary system for health care

‘Old’ professions (Chapter 2)

Complaints and accused professionals. The study of verdicts concerning the ‘old’ professions showed an annual number of approximately 660 complaints during the period 1983-2002, most of which (92%) concerned physicians. The risk of being brought before a disciplinary board appeared to be different for the various professions. The complaint density was highest for physicians (1.6), higher for general practitioners than for hospital specialists, and higher for surgical specialists than for non-surgical specialists. Half of the complaints concerned ‘lack of care or inadequate care’ or ‘incorrect treatment’.

Complainants. Over two thirds of all complaints were made by the patient and almost one third by someone else, in most cases a member of the patient’s family. In comparison, the inspector for health care lodged only a small number of complaints, but these mainly concerned serious cases, and often resulted in a (severe) sanction.

Verdicts and sanctions. Almost two thirds of the complaints were declared unfounded. In a considerable number of cases the investigation was not continued or the complaint was withdrawn, especially by the patients themselves (12%). Five percent of the complainants were ineligible. Of all the complaints, 18% were declared to be justified, and thus resulted in a sanction. Most sanctions concerned ‘lack of care or inadequate care’ or ‘incorrect treatment’. ‘Professional misconduct’, ‘violation of professional secrecy’ and ‘not, or belated visiting when requested’ resulted relatively most often in a sanction. The most frequently imposed sanctions were a warning and a reprimand. An appeal was made against almost one third of the verdicts, and after 13% of these appeals the verdict was amended. In
the 20-year period there were 45 entries permanently struck off the register/withdrawals of the right to practice. The sanction density was 0.25 sanctions per 100 professionals.

**Trends (Chapters 2 and 3)**

*Comparison of 10-year figures.* A comparison of outcomes between 1983-1992 and 1993-2003 showed that the number of complaints increased more rapidly than the number of professionals. The sanctions/complaints ratio decreased from 20% to 17%. The percentage of unfounded complaints remained roughly the same, but the number of verdicts of ‘unfounded without further investigation’ increased in contrast to the number of verdicts of ‘unfounded after a hearing’. The number of ineligible complainants increased, and this increase seems to be continuing: in 2002, 11% of the complaints were declared not eligible. The percentage of complaints lodged by the inspector decreased from 2.4% to 1.6%.

While the percentage of sanctions decreased and the number of complaints per professional increased during the study period, the total sanction density remained the same: 0.25 sanctions per 100 professionals. (Chapter 2)

*Introduction of the IHCP Act.* During the years immediately following the introduction of the IHCP Act, the two previously mentioned developments - the decrease in the sanctions/complaints ratio and the decrease in the percentage of complaints lodged by the inspector - seem strengthened instead of weakened. In the years immediately following the introduction of the IHCP Act (1999-2001) the number of justified complaints was even as low as 15%, and the percentage of complaints lodged by the inspector decreased to 0.8%. (Chapter 3)

*‘New’ professions (Chapters 4-6)*

*Complaints and accused professionals.* The study of verdicts concerning the ‘new’ professions during a 4 or 5-year period after the introduction of the IHCP Act showed an increase in the annual number of nurses and physiotherapists who were accused (Chapters 4 and 5), but the annual number of accused health care psychologists remained roughly the same. (Chapter 6) The study showed that, certainly in comparison with physicians, a relatively small number of complaints were made against nurses, physiotherapists and health care psychologists. For physicians the number of complaints per 100 working professionals during the period 1999-2001 was 2.1 (Chapter 3); this was more than 50 times greater than for nurses during the period 2000-2001 (0.04) (Chapter 4), 35 times greater than for physiotherapists during the period 2001-2002 (0.06) (Chapter 5), and 18 times greater than for health care psychologists during the period 1999-2002 (0.12). (Chapter 6) Male nurses, physiotherapists and health care psychologists were accused relatively more often than their female colleagues. (Chapters 4-6)

*Sanctions.* The percentage of all verdicts of the regional disciplinary boards that resulted in a sanction was 12% for nurses (Chapter 4), 33% for physiotherapists (Chapter 5) and 25% for health care psychologists. (Chapter 6) In the period 1999-2001 15% of the sanctions of all complaints were imposed on the ‘old’ professions. (Chapter 3) The sanctions imposed on nurses, physiotherapists and health care psychologists mainly concerned complaints about serious professional misconduct, such as sexual intimacies or a sexual relationship (Chapters 4-6), whereas the sanctions against physicians mainly concerned
complaints about incorrect treatment or lack of care or inadequate care. (Chapter 3) For physiotherapists serious professional misconduct was even the most important category of all complaints, including the not justified complaints. (Chapter 5) For nurses, as for physicians, another important category of justified complaints concerned ‘lack of care or inadequate care’. (Chapter 4) For health care psychologists other important categories of justified complaints concerned ‘violation of professional secrecy’ and an ‘incorrect statement or reporting’. (Chapter 6) A total of 5 entries were permanently struck off the register during the study periods; 2 nurses (Chapter 4), 1 physiotherapist (Chapter 5) and 2 health care psychologists. (Chapter 6)

9.2.2 Practice and policy of the publication of disciplinary proceedings

Practice of published verdicts (Chapter 7)

A total of 4% of all verdicts were published in the Netherlands Government Gazette during the period 1995-2002. The central disciplinary board decided to publish more often than the regional disciplinary boards (8% versus 2%). There were considerable differences between the various regional disciplinary boards (min-max 0.9%-5%). During the period 2000-2002, verdicts concerning the ‘new’ professions were published more frequently than verdicts concerning the ‘old’ professions (11% versus 5%). Per professional group the percentage of verdicts in cases that were published varied from 2% to 23%. ‘Medisch Contact’ (MC) published three quarters and the ‘Tijdschrift voor Gezondheidsrecht’ (TvGR) almost two thirds of the verdicts that were offered for publication. Various journals were offered verdicts which they did not publish.

Publication policy (Chapter 7)

Disciplinary boards. With regard to decisions concerning the publication of the verdicts, the disciplinary boards differed in their interpretation of the concept of ‘general interest’. The main considerations mentioned by the regional disciplinary boards were the learning effect in the professional group and possible standardization.

Journals. During the study period the TvGR was offered, and also published, verdicts concerning all professions that were subject to the disciplinary system, except physiotherapy. With regard to decisions concerning publication, interest in legal standardization appeared to be the main consideration. For the editorial board of MC an important consideration with regard to the publication of verdicts offered by the disciplinary boards was whether or not the verdict contained sufficient (new) elements of learning for physicians. MC received offers of verdicts concerning professionals from all groups, except physiotherapists. Publications in the journal only concerned physicians, midwives and nurses.

9.2.3 Perspectives of those directly involved in the Dutch statutory disciplinary system for health care

Disciplinary system for the ‘new’ professions’ (Chapters 4-6)

Disciplinary board members and the practicing lawyers. Most of the disciplinary board members and the practicing lawyers thought that the disciplinary system for each of the ‘new’ professions should not be abolished. Half of the disciplinary board members and
practicing lawyers did not know whether or not the number of complaints against the ‘new’ professions will remain low. However, almost two thirds of them were of the opinion that the general public is not sufficiently aware of the possibility to make complaints against the ‘new’ professions. (Chapters 4 and 6)

Nurses and physiotherapists. The majority of the nurses and physiotherapists were of the opinion that the disciplinary system plays a role in monitoring the quality of nursing care, respectively physiotherapy, and half of them stated that a published verdict about another nurse, respectively physiotherapist, influenced their own professional practice. (Chapters 4 and 5)

(Other changes in) the disciplinary proceedings (Chapter 8)

Standard-setting and sanctions. Almost all of the disciplinary board members and the practicing lawyers, compared to less than one third of the physicians, were of the opinion that in their judgement of complaints the disciplinary boards complied adequately with the concept of good professional practice. A large majority of the disciplinary board members and the practicing lawyers missed the possibility for a complaint to be declared justified without a sanction being imposed. Most of them were of the opinion that there would be an increase in the number of justified complaints if this possibility was incorporated in the Act.

Composition of the disciplinary boards. According to the majority of the disciplinary board members and practicing lawyers, the change in the composition of the disciplinary boards had not strengthened the position of the complainant. Most of the respondents were of the opinion that the inclusion of a health professional instead of a legally qualified member was necessary in order to promote consistency in the verdicts concerning professional practice, and thought that a member from the same specialism should always be involved in the judgement of a complaint.

9.3 Practical application of other legal instruments and self-regulation

It has already been mentioned that the statutory disciplinary system is not the only regulation that influences the quality of professional practice in health care. In section 9.1 other legal instruments, internal disciplinary systems and other complaints procedures, have been discussed. This section focuses, for the professions that are subject to the statutory disciplinary system, on the practical aspects of some of the other legal instruments, the internal disciplinary system and complaint procedures, and their possible influence on or relationship with the number of disciplinary complaints.

9.3.1 Legislation concerning the quality of professional practice

Up until the end of July 2003, the Health Care Inspectorate presented 12 proposals for sanctions to the Medical Supervision Board, 9 of which resulted in a verdict, and in most cases a severe sanction was imposed. The Health Care Inspectorate must sometimes choose whether the case is brought before the regional disciplinary board or the Medical Supervision Board, because not only incompetent professional practice is concerned, but also the disciplinary standards. In certain cases the Health Care Inspectorate will approach a
disciplinary board because the procedure is quicker and there should be more chance of 'success'.

The Health Care Inspectorate seldom uses its authority on the grounds of the IHCP Act (or the Quality Act). Up until the end of July 2002, the Health Care Inspectorate used its authority under Article 87a of the IHCP 7 times in connection with inadequate compliance with Article 40. The cases which resulted in an injunction mainly concerned serious cases, such as malfunctioning due to abuse of substances mentioned in the alcohol or opium regulations, lack of provisions for adequate hygiene, or irresponsible care. In 6 of the 7 cases proceedings in a regional disciplinary board or the Medical Supervision Board commenced simultaneously or subsequentially. Recently, the Health Care Inspectorate ordered the closure of an intensive care ward in a general hospital.

The Public Prosecution is reluctant to initiate proceedings on the basis of the IHCP, possibly because it is not adequately 'fed' by the Health Care Inspectorate. In most of the criminal cases concerning health care the offences conform with the general description of offences in the criminal code. Most of the cases concern abortus, euthanasia and assisted suicide. There was much publicity surrounding a case against a nurse who was sentenced to life imprisonment in 2003 for four murders and three attempts to murder patients.

The number of claims for medical damages is discussed in Section 9.3.2.

9.3.2 Self-regulation: internal disciplinary systems and other complaint procedures

The internal disciplinary system has played an important role in the field of dentistry. As already mentioned, since July 2004, mainly due cost considerations, patients can no longer make a disciplinary complaint against members of the Dutch Dental Association (DDA). There are, however, still internal DDA regulations concerning disciplinary proceedings for members. Patients who wish to complain about members can now make use of the DDA complaint regulations within the framework of the Act governing the right of clients in the care sector to complain (DDA, personal communication, May 2005). The DDA internal disciplinary board dealt with approximately the same number of complaints as the statutory disciplinary boards (364 and 353 in the period 1994-2000, respectively). The DDA disciplinary system was attractive for patients, because the judge had the authority in contrast to the statutory disciplinary system to order the dentist to repair the damage if the complaint was justified. In over half of the justified complaints this actually happened, often without a sanction being imposed. The DDA disciplinary system therefore had an element of civil law.

It is interesting to note the mutual influence of the internal and the statutory disciplinary systems for the professional groups that have only become subject to the statutory disciplinary system since the introduction of the IHCP Act: physiotherapists and health care psychologists. The statutory disciplinary system scarcely seems to influence the DPAP internal disciplinary system, since there is no evidence of a decrease in verdicts concerning psychologists working in the health care sector based on this internal disciplinary system, although there is evidence of an overlap in the accused (DPAP, personal communication, December 2003). The complaints brought before the RDSP internal disciplinary board, and those about physiotherapists brought before the statutory disciplinary board, mainly concerned sexual intimacies. It is remarkable that there
was a decrease in the number of complaints made to the RDSP internal disciplinary board after 1999, probably due to the introduction of the statutory disciplinary system.\(^{14}\) (Chapter 5)

As a result of the introduction, in 1995, of the Act governing the right of clients in the care sector to complain, there has been widespread establishment of complaint committees in the health care sector. From research on the complaint assessment in hospitals it appears that relatively few people made a complaint to hospital complaint committees; an average of 18 complaints per year per hospital. The majority of the complaints and dissatisfactions are made and dealt with at a lower level (an average of 238 per hospital in 2002).\(^{15}\) The complaints committees, and also complaint assistance, probably result in a decrease in the number of complaints made to the disciplinary boards because they deal with some of the complaints and only a few of these complaints will be brought before the disciplinary boards at a later stage.\(^{16,17}\)

It is interesting to note the mutual influence of the complaint regulations and the statutory disciplinary system. The RDSP complaint committee, which mainly deals with complaints about impolite behaviour and incorrect treatment\(^{18}\), existed before the disciplinary system for physiotherapists. The introduction of the statutory disciplinary system seems to have decreased the number of complaints made to the complaint committee after 2000\(^{18}\), just like the number of complaints made to the RDSP internal disciplinary board after 1999.\(^{18}\) (Chapter 5)

In the Netherlands, over the past 20 years there has been a limited increase in the number of claims for medical damages, most of which were dealt with without the intervention of the civil court. In the period 1993-2001 the number of claims for medical damages per 100 specialists was higher for surgical specialists than for non-surgical specialists. The majority of the claims concerned operative procedures, followed by claims for damages due to an incorrect diagnosis or non-observance of a disorder, inadequate (after-)care, guidance and control, and delayed diagnostics. One in ten cases were also dealt with in the proceedings of a complaint committee, a civil court or a disciplinary board. The number of cases in which disciplinary board proceedings were involved decreased during the study period.\(^{19}\)

### 9.4 Functioning of the disciplinary system and contribution to the aims

This section discusses briefly the changes in the aims of the disciplinary system with the introduction of the IHCP Act and the limits of this research in the assessment of the contribution of the disciplinary system to these aims. Subsequently, various aspects related to the phases before, during and after the assessment of complaints will be discussed, indicating what influence these had on the functioning of the disciplinary system. Finally, an attempt is made to indicate, for a number of these aspects, what their contribution is to the quality of professional practice and the protection of the general public against incompetence and carelessness.
9.4.1 Aims of the disciplinary system

Changes in the aims of the disciplinary system

It has already been stated that the aim of the disciplinary system is to foster and monitor the quality of professional practice and to protect the general public against incompetence and carelessness. There has been little or no change in the aims of the disciplinary system since the introduction of the IHCP Act. Since the end of 1997 the judge does not assess the content of the complaint according to any different standards than under the Medical Disciplinary Act. However, it can be said that the disciplinary proceedings under the IHCP Act are intended to strengthen the position of the patient in the disciplinary procedure. Moreover, more attention is paid to the professional expertise of the care-giver. With regard to professional practice and the relationship with the patient more attention is paid to certain new aspects: locum arrangements, problems concerning home visits, hospital admissions and reporting, and also the patient’s right to information, approval and insight. However, among others, Gevers concludes that the function of the disciplinary proceedings, as such, has not changed. ‘From the disciplinary proceedings and other relevant sources – including, for instance, the Memorandum Explanatory (in Dutch: Memorie van Toelichting) when the IHCP Bill was introduced in parliament – it is not possible to determine whether this aim has been changed or that it has been subordinated or co-ordinated with regard to other aims. (...) The judge focuses on the interests of the patients, but this general interest differs from the interests of the individual complainant. The increase in the attention that is paid to direct patient care only means that this gives the disciplinary judge more opportunity to perform his/her real task – monitoring the standard of professional practice – because, of course, the essence of this professional practice is the care that is provided for the individual patient’. 10

Assessment of the contribution of the disciplinary system to its aims

In the study design there was no provision for a pre-test measurement or a controle situation, which would make it possible to compare findings from the period after the introduction of the IHCP Act with findings from the period before the introduction. Moreover, there were no predetermined indicators to measure the quality of care. There was also no investigation of how many mistakes were actually made, or how many professionals actually malfunctioned. The magnitude of the preventive and corrective effect of monitoring the quality of professional practice and the effect on the professional standard has not been investigated (or could not be measured). It was also not possible to determine the extent to which the existence of the disciplinary system, in itself, has a preventive quality-promoting effect. For these reasons it is difficult to assess the contribution of the disciplinary system to fostering and monitoring the quality of professional practice. However, it is possible to assess the functioning of the disciplinary system, and this will be discussed in the following section.

9.4.2 Functioning of the disciplinary system

In this section, in which the findings of the research questions listed in Section 9.2 will be discussed, specific attention will be paid to aspects of the (optimal) functioning of the disciplinary proceedings in the phases before, during and after the assessment of
Aspects before the assessment of complaints

**General.** Between 1983 and 2002 the number of complaints about the ‘old’ professions increased more rapidly than the number of professionals, but since 2001 there seems to be a decrease in the number of disciplinary complaints. Whether or not this development is structural, only the future can tell. The increase in the number of tasks per professional (more surgical work, prescription of medication, etc.) and the increasing autonomy of the patient can lead to an increase in complaints, but quality policy development and growing self-regulation can lead to a decrease. It has already been mentioned that the complaint assistance (i.e. complaint officer or the Health Care Information and Complaint Service) and assessment (via a complaint committee) probably result in less complaints because they deal with some of the complaints. It is also possible that physicians deal with the complaints more appropriately, or that, because of the public nature of the disciplinary proceedings, the general public is less inclined to lodge a complaint concerning a private matter.

Ideally, optimal use of the opportunity to make a complaint by an authorized complainant should result in complaints of various nature that ‘deserve’ to be assessed by the disciplinary judge, and therefore ‘belong’ in disciplinary proceedings. With regard to the general public, the following aspects provide insight into the possibilities to make a complaint: knowledge about the disciplinary proceedings, access to the disciplinary proceedings, the opportunity given to the complainant to discuss the complaint, and confidence in the disciplinary proceedings. For the Health Care Inspectorate, information about possible incidents and available time provide insight into the possibility to make a complaint.

**Knowledge.** Disciplinary proceedings in the Netherlands are highly dependent on complaints made by the general public. However, over a quarter of the general public have never heard of the statutory disciplinary system. The majority know that physicians and
dentists are subject to the statutory disciplinary system, but with regard to the new professions, only approximately half of the general public know that nurses and physiotherapists are, and less than a third know that health care psychologists are.\footnote{8} Although the number of complaints about nurses and physiotherapists has increased, the complaint density remains far behind that of the ‘old’ professions (with the exception of pharmacists [Chapter 3]). Whether or not the number of complaints about the ‘new’ professions in the Netherlands will continue to increase, will only be known in the future. Many people are not aware of the purpose or content of the disciplinary system, and they do not know which complaints they can bring before a disciplinary board.\footnote{9} Complaints are often made to the wrong authorities, and many complaints are made during an emotional period of mourning, or with little or no expert legal support.\footnote{20} This limited knowledge among the general public with regard to the disciplinary system is probably one reason for the low percentage of justified complaints.

**Accessibility.** The increasing number of ineligible complainants and the number of verdicts of ‘unfounded without further investigation’ is another signal of the limited knowledge among the general public, and also possibly indicates that the accessibility of the disciplinary proceedings is too low. It is, however, possible that the number of ‘nonsensical’ complaints, often made by notorious complainants, has increased. Approximately two thirds of the general public agree with the introduction of the following procedures or thresholds that ensure that complaints are made correctly and more seriously: before a complaint is made it must always be discussed with the professional involved, the complaint must first be made to a complaint committee, a complaint must be made via the Health Care Inspectorate, or payment of a fee for the registration of a complaint.\footnote{8}

**Opportunity for discussing the complaint.** Patients who make a complaint often want more than just satisfaction. Not only do they want the professional involved to acknowledge that mistakes have been made, but they also want to hear how it happened that these mistakes could be made, and what the hospital management or the professional intends to do in order to ensure that they do not happen again with other patients.\footnote{15} Inadequate communication, or a lack of communication, is often one of the reasons underlying a complaint. Dissatisfaction with the communication is also often part of complaints that are of a medical or a medical-technical nature. An open discussion about a failure or a mistake often works wonders.\footnote{21} Refusal to accept the fact that mistakes have been made, in itself, can make a patient decide to make a complaint.

**Confidence.** The confidence of the general public in the disciplinary proceedings is not optimal. This is clear from differences of opinion between the general public\footnote{8} and physicians, disciplinary board members and practicing lawyers (Chapter 8), with regard to the statement ‘The disciplinary boards protect the professionals (36% agreed vs. 1-12%)’ and the statement ‘In general, a professional is scarcely impressed by a warning (59% vs. 1-8%).’ Apparently, the general public has less confidence in the independent status of the disciplinary proceedings, and is less able to realize what the impact of even the least severe sanction is on the professional in question.

**Prioritization and information.** The limited number of complaints made by the Inspector is, according to the Health Care Inspectorate, primarily the result of prioritization. It states that lodging a complaint is extremely labour intensive, especially concerning the
relatively serious cases that the Inspectorate is usually involved in. Moreover, since the end of 1996 the Health Care Inspectorate is no longer involved in dealing with complaints, and is therefore less well informed about the incidents that occur. A new Bill has recently been introduced to propose changes in the Health Care Institutions Quality Act and the Act governing the right of clients in the care sector to complain, in order to ensure that through notification the health Care Inspectorate is better informed about health care incidents. Resuming, we can conclude that the functioning of the disciplinary proceedings seems to be impeded by sub-optimal use by the general public of the possibilities to make a complaint. Their knowledge about, and confidence in the disciplinary proceedings is limited. On the other hand, the accessibility of the disciplinary proceedings seems to be too great for totally unfounded complaints. It is important that the general public are given the opportunity to discuss complaints with the professional involved. Limited opportunity for such a discussion could be one of the reasons why totally unfounded complaints are made. Prioritization by the Health Care Inspectorate with regard to lodging complaints and the limited information it receives about possible incidents also contribute to the sub-optimal functioning of the disciplinary proceedings in the phase before the assessment of complaints. 

Aspects during the assessment of complaints

General. Ideally, optimal functioning of the disciplinary proceedings in the assessment of complaints should result in jurisprudence with a certain minimum number of justified complaints for which corrective sanctions can be imposed. A high percentage of ineligible and totally unfounded complaints very probably indicates a waste of time and money, because this does not result in corrective sanctions, and moreover it can result in less confidence in the disciplinary proceedings among the general public. In their assessment of the complaints the disciplinary boards should comply adequately with the concept of good professional practice. The percentage of justified complaints is related to the threshold over which the disciplinary boards must step in order to declare a complaint justified, and could possibly be influenced by the composition of the disciplinary boards and, as mentioned earlier, the limited knowledge among the general public. Finally, the number and the nature of the sanctions and the sanction density give insight into the corrective effect of the disciplinary system.

Compliance with the concept of good professional practice. In this study it was found that physicians, and general practitioners in particular, are quite critical of the standards set by the disciplinary boards. Only a (small) minority of the physicians were of the opinion that, in their judgement of the disciplinary complaints, the disciplinary boards adequately comply with the concept of good professional practice. Almost all the disciplinary board members and practicing lawyers considered that there was adequate compliance. On the other hand, almost two thirds of the practicing lawyers and over a third of the disciplinary board members (partially) agreed with the criticism in the media and the professional journals that verdicts regularly provoke. It is remarkable that not only those who (partially) agreed with the criticism, but also those who disagreed, mentioned that there is tension between standard-setting and daily practice.
Threshold to justify a complaint. The number of justified complaints is low; over a period of 20 years, 18% of the complaints about the ‘old’ professions were declared justified.(Chapter 2) What is important, in this respect, is that the threshold over which the disciplinary boards must step in order to declare a complaint justified is quite high. After all, under both the Medical Disciplinary Act and the IHCP Act, a justified complaint always implies that a sanction is imposed. More than once, therefore, in their judgement of a complaint the disciplinary boards take into consideration the fact that the reason for the complaint is serious, but not serious enough to justify the imposition of a sanction. Gevers differentiates four situations in which the judge does not impose a disciplinary sanction: if there is no generally accepted standard, if the codes of conduct have not penetrated the professional group, if the standards contain conflicting requirements, or if there is uncertainty about which course of action is the most appropriate in the concrete situation.

Composition of the disciplinary boards. The change in the composition of the disciplinary boards is a possible cause of a further decrease, from 19% to 15%, in justified complaints about the ‘old’ professions in the first few years after the introduction of the IHCP Act.(Chapter 3) The threshold for the justification of a complaint is apparently higher for lawyer members than for health professional members. The inclusion of more lawyer members in the disciplinary boards was, in fact, intended to strengthen the position of the complainant. After all, they would not be members from the same profession, would not protect the accused professionals, and their judgement would therefore be more impartial.

Number and nature of the sanctions. During the study period, for the ‘old’ and the ‘new’ professions together, there were a total of 50 entries permanently struck off the register/withdrawals of the right to practice.(Chapters 2, 4, 5 and 6) The new sanction in the IHCP Act, i.e. conditional suspension of the entry in the register, increases the preventive effect of the disciplinary system, at least with regard to the accused. This sanction has been imposed many times, and appears to fill a need. The corrective effect is most evident in the imposition of the most severe sanction. The decrease in the percentage of justified complaints after the introduction of the IHCP Act was mainly due to the warning and the reprimand. Very little difference was observed with regard to the more severe sanctions.(Chapter 3)

Sanction density. During the study period from 1983 to 2002, in spite of the decrease in the percentage of sanctions imposed, the sanction density for the ‘old’ professions remained constant: 0.25 per 100 professionals. This would suggest that the corrective effect is an important constant factor.(Chapter 2)

Resuming, we can conclude that in the complaint assessment phase the disciplinary proceedings do not function optimally. There is criticism concerning compliance with the concept of good professional practice in the standard-setting, and the percentage of justified complaints would be higher if the threshold for justification was lower. The change in the composition of the disciplinary boards and the limited knowledge among the general public seem to decrease the percentage of justified complaints further, and thus impede the functioning of the disciplinary system. A positive sign is that the corrective effect seems to be an important constant factor; during the study period there was little or no change in the
number of severe sanctions imposed and the number of sanctions per professional, i.e. the sanction density.

Aspects in the phase after the assessment of the complaints

General. Characteristics of optimal functioning of the disciplinary proceedings in the phase after the assessment of complaints are good supervision of the enforcement of the imposed sanction (with the exception of the warning and the reprimand), standard-setting by the professional groups, prevention as a result of the publication of verdicts, the use of verdicts in training and (further) education, and new research focusing on the disciplinary proceedings. Attention should also be paid to the emotional impact of verdicts on the accused.

Supervision. There is inadequate supervision from the Health Care Inspectorate with regard to the enforcement of striking off the entry in the register, temporary suspension, and the conditions in the IHCP register concerning conditional suspension. This also applies to the receipt of fines imposed by the judge, and supervision of the partial withdrawal of the right to practice the registered profession. There is also no definition of the exact time of enforcement of a sanction that restricts the professional practice.

Standard-setting. Standard-setting by the professional organizations is urgently needed with regard to the categories of complaints for which sanctions are imposed. The statutory disciplinary system for nurses, physiotherapists and health care psychologists has a role in confirming professional codes and rules of conduct with regard to serious professional misconduct, such as sexual intimacies or a sexual relationship. However, with regard to the development of professional codes and rules of conduct for other aspects of the profession, such as advice, diagnosis and treatment, the disciplinary system (still) has a limited role. This applies, in particular, to physiotherapists and health care psychologists. This limited standard-setting is less of a problem for the ‘old’ professions because the disciplinary system for these professions has existed for a long time and there are, in particular about physicians, more justified complaints.

Publication of verdicts. In practice, it appears that only 4% of all verdicts are published in the Netherlands Government Gazette, and significant differences were found between the various disciplinary boards, probably due to differences in the interpretation of the concept of ‘general interest’. Other studies have reported that half to four fifths of the professionals indicated that a published verdict about a colleague in the profession influenced their own professional practice, but also that in some professional fields the percentage of published verdicts is so small that it is scarcely possible to expect that the disciplinary proceedings can have a quality-promoting or standard-setting influence on the professional practice in question. Moreover, it is not certain that the verdicts that are published in the Government Gazette adequately reach the professional group. It is also questionable whether the professional groups can be adequately reached through verdicts that can be found on the internet. Since 2002 the central disciplinary board has a website containing all its verdicts since 1998, and since May 2004 the verdicts of the Amsterdam regional disciplinary board can also be found on this site. It is the intention that the other regional disciplinary boards will follow suit. As yet, though, not all the verdicts can be found on this site. Moreover, many of the central disciplinary board verdicts provide
very little new information, because they mainly refer to appeals against regional disciplinary board verdicts, which are not on the site. Finally, there is room for improvement in the search strategy. Publication in a professional journal can have more effect, because this implies that the professionals do not have to search the internet, and publication provides the opportunity for (editorial) comments and can be used as a forum for discussion. (Chapter 7)

**Education and new research.** In addition to the publication of verdicts, further preventive effects can be achieved by paying attention to the further development of professional standards, based on the considerations of the disciplinary boards in their verdicts, in the basic medical curriculum, during specialization and in further training courses. The results of studies of the disciplinary system can also have a preventive effect. However, the opportunities for empirical research on the disciplinary proceedings appear to be far from optimal. The computerized database of the Health Care Inspectorate has very few possibilities for analysis, contains few variables, and the coding is sometimes much too global. Due to the differences in classification between the central disciplinary board and the Health Care Inspectorate, it was almost impossible to investigate pending appeals against regional disciplinary board verdicts in a certain year. Moreover, a number of disciplinary boards do not comply with the legal requirements for an annual report, which limits the publicity of their responsibilities. However, in future the (central disciplinary board) website will provide an overview of the verdicts of all the disciplinary boards.

**Emotional impact.** A complaint is not only very emotional for the complainant. It can also have considerable impact on the accused professional, even if the complaint is totally unfounded. A health professional often experiences a disciplinary complaining as a personal accusation, and, above all, it comes from his/her own patient for whom he/she has been caring. The least severe sanction, the warning, is considered by the disciplinary boards and the professionals to be serious. A considerable problem for all parties involved is the long time-period of the disciplinary procedures which, in the case of an appeal, can be an average of two and a half years. Moreover, publication can also be damaging for unjustly accused professionals. Research has shown that three quarters of the physicians are of the opinion that the reputation of an accused professional is already harmed by the public access to the disciplinary proceedings. (Chapter 8)

Resuming, we can conclude that in the phase after the assessment of the complaint the disciplinary proceedings do not function optimally. There seems to be inadequate supervision of the enforcement of imposed sanctions, there is limited standard-setting by the ‘new’ professional groups, and the preventive effect also seems to be restricted by the limited number of verdicts published, the limited amount of attention that is paid to verdicts and standard-setting in education and further training, and the limited opportunity for research. The emotional impact of verdicts on the accused, which is also influenced by the public access to the disciplinary proceedings, is in conflict with the aims if it results in constant fear of new complaints and uncertainty with regard to functioning.
9.4.3 Contribution to the aims of the disciplinary system
It has already been stated that it is very difficult to determine the contribution of the disciplinary system to the quality of professional practice and protection of the general public against incompetence and carelessness. However, it was possible to assess some aspects of the functioning of the disciplinary system. Standard-setting by the professional groups, prevention, and corrective sanctions are instruments that certainly contribute to the aims. However, the limited standard-setting by the ‘new’ professional groups probably implies that these professional groups have made little contribution to the aims of the disciplinary system. The preventive contribution to fostering and monitoring the quality of care and protecting the general public will also be sub-optimal, due to the publication of only 4% of all verdicts in the Government Gazette and the limited publication of disciplinary cases in the professional journals, the limited attention that is paid to verdicts and standard-setting in education and further training, and the limited opportunities for research. The 50 entries that were permanently struck off the register/withdrawals of the right to practice during the study period (Chapters 2, 4, 5 and 6) form the most concrete contribution to the aims of the disciplinary system, and have probably also made a considerable contribution to the safety of patients. The contribution of the constant sanction density for the ‘old’ professions (0.25 per 100 professionals) (Chapter 2) is also clear.

Furthermore, for one of the ‘new’ professional groups, the nurses, the introduction of the disciplinary system, in itself, seems to have given an impetus to monitoring the quality of nursing practice. In addition to the fact that most of the nurses consider the disciplinary system to be a quality-monitoring instrument, this impetus is also evident from the large number of protocols that have been developed, the many study days and role-played hearings of a disciplinary board that have been organized by the Netherlands Centre for Excellence in Nursing (in Dutch: LEVV), and the attention that has been paid to this subject in the professional journals. (Chapter 4)

9.5 Limitations and strengths of the research
This section describes the limitations and the strengths of the research with regard to the methods, the data and the discussions.

9.5.1 Limitations
This study has certain methodological limitations. As has been mentioned earlier, it is difficult to assess the contribution of the disciplinary system to fostering and monitoring the quality of professional practice, because there were no pre-test measurements and no control situation, and there were no predetermined indicators of how to measure the quality of care. Moreover, the perspectives of important people who were involved, i.e. the complainants and the accused, were not investigated.
9.5.2 Strengths
In addition to limitations, this study also has certain strengths. Very little international literature or empirical research has focussed on the subject of disciplinary proceedings. This study provides an opportunity for other countries, with similar or different regulations for professional practice, to learn from the Dutch experience.

This is (also) the first time that comprehensive empirical research has focussed on the statutory disciplinary system in the Netherlands. The research not only investigated the practical aspects of the disciplinary system for health care, by means of a study of (published) verdicts, but questionnaires were also used to investigate the perspectives of those directly involved in the disciplinary system for health care (professionals, board members and practicing lawyers).

Another strength is the size and quality of the databases. The length of the various periods in which the (published) verdicts were studied varied from 4 to 20 years, and during the study periods all the (published) verdicts were studied. The response to the questionnaire for the various people who were involved varied from more than adequate to high, namely 60-89%. The groups of respondents were representative for the sample frameworks.

9.6 Implications for policy, practice and research
This section discusses the implications for policy, practice and research in the same order as in the previous section, in which aspects of the functioning of the disciplinary proceedings were assessed: in the phases before, during and after the assessment of the complaints.

9.6.1 Before the assessment
Informing the general public. The general public should be better informed about the aims and procedures of the disciplinary system, the nature of the complaints that can be brought before a disciplinary board, the way in which a complaint should be made, and the relationship with other possibilities to make a complaint. Specific attention should be paid, in this respect, to the ‘new’ professions. Among other things, it should be clearly explained what the difference is between an unavoidable mistake (such as a complication), or a blameless mistake, and violation of the standards, i.e. inadequate individual health care or any other act or omission that is in conflict with good individual health care practice. Moreover, the importance of a discussion with the professional before making a complaint should be emphasized, because this might prevent complaints from being made. Providing good information can also increase the percentage of justified complaints, and thus also increase the confidence of the general public in the disciplinary proceedings. In his standpoint, as a result of the evaluation of the IHCP Act, the Minister of Health stated that he is prepared to develop a good plan for providing the public with information about the different ways in which complaints are dealt with, and about the procedures.\(^2\)

More attention to openness about (assumed) mistakes. Before making a complaint, patients should be given more opportunity to discuss the complaint with the professional involved. Too little opportunity for discussion can be one of the reasons why totally
unfounded complaints are made. This pleads for a culture of more openness about (assumed) mistakes. It is clear that within institutions and during training more attention should be paid to the importance of openness.

**Limited accessibility.** Access to the disciplinary proceedings seems to be too easy for the totally unfounded complaints. Compulsory prior discussion of the complaint with the professional involved should be taken into consideration. In general, the imposition of a fine is not a sensible option, because it could be in conflict with the aim of promoting quality, resulting in a threshold for serious complaints. With regard to the problem of access (and a number of other bottlenecks), the Minister has promised to ‘talk to’ the disciplinary boards.32 This has not yet (April 2005) happened.

**More active role for the Health Care Inspectorate.** Because of the decrease in the number of complaints made by the Health Care Inspectorate, further clarification is needed of the task and responsibility of the Inspectorate with regard to maintaining quality through disciplinary assessment. In this respect the Inspectorate indicated that, due to its prioritization in making complaints, it tends to restrict itself to cases that are certain to result in a disciplinary verdict.8

**Study of complainants and accused.** It is recommended that the perspectives of the complainants and the accused are also investigated. It is necessary to have insight into the considerations underlying the complaint, the efforts of the complainant and the accused to prevent a complaint from being made (e.g. a discussion with the professional), the experiences and satisfaction with the disciplinary proceedings and the verdict, and the impact on the complainant and the accused. The results can then be used to improve the disciplinary proceedings and to prevent complaints from being made.

### 9.6.2 During the assessment

**Increasing the number of health professional members in the regional disciplinary boards.** While the extra legally qualified member in the disciplinary boards does not seem to offer any added value, the decrease in the involvement of health professionals is experienced as a limitation in the basic assessment of a complaint. In order to increase the intrinsic professional basis of disciplinary verdicts, it is recommended that the number of health professional members in the regional disciplinary boards should be increased, and that the composition of the boards should be the same as it was when subject to the Medical Disciplinary Act, i.e.: changed from two legally qualified members and three health professional members to one legally qualified member (Chairman) and four health professional members. This might result in an increase in the percentage of justified complaints, and thus also increase the confidence of the general public in the disciplinary proceedings.

**Introduction of justified complaints without imposing a sanction.** Other types of disciplinary systems, such as the statutory disciplinary system for accountants and notaries include the possibility to justify a complaint without imposing a sanction. The DDA internal disciplinary system also includes this possibility, and in the DDA disciplinary proceedings many more complaints were found to be justified, but this did not seem to result in a decrease in the number of sanctions imposed. In fact, the percentages of
sanctions imposed in the DDA and the statutory disciplinary system were almost the same if the justified complaints without a sanction were not taken into count. A large majority of the disciplinary board members and practicing lawyers regretted that a complaint cannot be declared justified without imposing a sanction. Most of them were of the opinion that there will be an increase in the number of justified complaints if this possibility is included in the IHCP Act, also because it will probably lead to more accurate standard-setting. (Chapter 8) A possible disadvantage is that it could strengthen the impression that professional colleagues protect each other, and can result in (even) less confidence of the general public in the disciplinary proceedings. The introduction of the possibility to justify a complaint and to order the accused to restore the damage that has been done, whether or not in combination with a disciplinary sanction, as is possible in the DDA disciplinary proceedings, offers less perspective in the statutory disciplinary proceedings. In the field of dentistry, in contrast to other fields of health care, there is often an agreement of results which makes it easier to determine liability than in an agreement of efforts.

In view of the advantages of the justified complaint without a sanction, and experiences in other forms of disciplinary proceedings, serious consideration must be given to including this possibility. In this respect, it is recommended that the possibilities of a certain form of compensation for the complainant should be investigated. It is also recommended that justified complaints without a sanction should only be possible in situations in which the accused professional has apologized or has amended his/her behaviour or practice organization. For the complainant it should be clear what the accused has done or will do in order to ensure that other patients are not confronted with the same problem.

9.6.3 After the assessment

Attention for publications, standard-setting and the professional standard. The professional organizations of the ‘new’ professions should pay more attention to standard-setting with regard to categories of complaints other than just professional misconduct. In the basic medical curriculum, during specialization and during further education in all the professional groups more attention should be paid to published verdicts and (in particular, changes in) the professional standard (the legal requirements, jurisprudence, professional codes and rules of conduct, professional-technical regulations, standards, guidelines and protocols).

Attention for publication policy and increasing the number of publications. More attention should be paid to the publication policy of the disciplinary boards, and the disciplinary boards should develop a joint code of practice for this purpose. In this respect it is important to endeavour to offer more verdicts for publication, in particular to discipline-specific journals. The editorial boards of these journals could make (more) space available for verdicts in their journal, and could take the initiative to request the disciplinary boards for permission to publish verdicts. The Health Care Inspectorate, the professional associations, the journalism and research also have a responsibility in this respect. In order to clarify its task and responsibility in disciplinary cases, the Health Care Inspectorate could request the disciplinary boards more often to publish verdicts concerning complaints that it
has brought before the boards. The professional organizations, the journalism and research could make more use of the monthly agendas of planned central disciplinary board hearings and the verdicts that are available on the internet. In this respect, an attempt should be made to include all verdicts on this site by also providing a list of all disciplinary board verdicts in first instance. Therefore, the regional disciplinary boards in Groningen, Zwolle, Eindhoven and The Hague should also provide the website with all their verdicts. Finally, the website search strategy could be improved.

Extending and including more possibilities for analysis in the computerized database of the Health Care Inspectorate. The computerized database of the Health Care Inspectorate has very few possibilities for analysis, a limited number of variables, and coding that is often too global. This database could be made into a programme with more possibilities for analysis (such as SPSS), and could be extended with a number of variables and codes. For instance, the gender and field of work of the accused, more specific coding of the nature of the complaint, and coding of the reasons for ineligibility and unfounded complaints. Analysis of these data would provide more insight into the background of the accused, the nature of the complaints and the reasons for rejecting complaints and the ineligibility of complainants, and can be used to improve the quality policy of the disciplinary proceedings and for the prevention of complaints.

Study of the effects of publication. Research has shown that half to four fifths of the professionals are of the opinion that a published verdict concerning a colleague influences their own professional practice. However, it is debatable whether publication in the Government Gazette is sufficient to bring the verdicts to the attention of the professional group. It is recommended that research is carried out to investigate the extent to which and the way in which publications reach the professional groups, and also to investigate the effects this has on professional practice. As stated earlier, it is also recommended that research should be carried out to investigate the experiences of the complainants and the accused and their satisfaction with the disciplinary proceedings and the verdicts.

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SUMMARY

The Dutch disciplinary system for health care: an empirical study

Quantitative data on the disciplinary proceedings in the Netherlands are scarce, and mainly concern the professions that were subject to the disciplinary system before the introduction of the Individual Health Care Professions Act (IHCP; in Dutch: Wet BIG). The aim of this thesis is to provide empirical-based insight into certain aspects of the functioning of the Dutch statutory disciplinary system for health care, in particular since the introduction of the IHCP Act. This is the first time that comprehensive empirical research has been carried out to investigate the disciplinary system in the Netherlands. The thesis consists of five parts.

Part I, the General introduction, describes the background, the objective, the research questions and the research methods.

In the Netherlands there has been a statutory disciplinary system for physicians, dentists and midwives since 1928, and for pharmacists since 1951 (the ‘old’ professions). The aim of this system is to foster and monitor the quality of professional practice and to protect the general public against incompetence and carelessness. The disciplinary proceedings have been incorporated in the IHCP Act since it was introduced at the end of 1997, before which it fell under the Medical Disciplinary Act (MD Act; in Dutch: Medische Tuchtwet). With the introduction of the IHCP Act certain aspects of the disciplinary proceedings have been amended. By increasing the number of legally qualified members in the disciplinary boards, the intention was to strengthen the position of the complainant. Since the introduction of the IHCP Act the disciplinary board meetings are, in principle, open to the public. The former closed situation made it impossible for the public to obtain adequate insight into the disciplinary procedures. Other important changes include extending the scope of the disciplinary proceedings to include four ‘new’ professional groups, namely nurses, physiotherapists, health care psychologists and psychotherapists. The arsenal of sanctions has also been increased and made more specific.

The research underlying this thesis focussed on the practical aspects of dealing with complaints and (published) verdicts, the publication policy and the perspective of those involved, in particular with regard to changes in the disciplinary proceedings with the introduction of the IHCP Act. To investigate the way in which complaints are dealt with, the characteristics of over 13,500 complaints and verdicts were studied retrospectively. The study period for the ‘old’ professions was 1983-2002, and for the ‘new’ professions this was a period of 4 or 5 years after the introduction of the IHCP Act. Use was made of the collection of verdicts in the archives and computerized database of the Health Care Inspectorate. A retrospective study was also carried out to investigate the characteristics of all 323 verdicts that were published in the Netherlands Government Gazette (in Dutch: Nederlandse Staatscourant) from 1995 to 2002. To investigate the publication policy, written questionnaires were sent to the chairmen of the disciplinary boards and to the editorial boards of three journals: ‘Medisch Contact’ (MC), ‘Tijdschrift voor
Gezondheidsrecht’ (TvGR) and ‘Nederlands Tijdschrift voor Geneeskunde’ (NTvG). Four of the five regional disciplinary boards, the central disciplinary board, and all three editorial boards responded. To investigate their knowledge and opinions, questionnaires were sent to 1,300 physicians (400 general practitioners, 350 internists, 250 gynaecologists and 300 psychiatrists: response 69%, 65%, 60% and 60%, respectively), 3,200 nurses (response 71%), 300 physiotherapists (response 76%), all 388 members of the disciplinary boards (response 89%) and 43 practicing lawyers (response 65%).

Part II describes the practical application of the disciplinary proceedings for the ‘old’ professions.

From Chapter 2 it appears that in the period 1983-2002 the regional disciplinary boards dealt with 13,228 complaints: an average of 662 a year. The number of complaints increased more rapidly than the number of professionals. The majority of complaints were made about physicians (92%), and the complaint density (the number of complaints per 100 professionals per year) was also highest for physicians (1.6); for general practitioners (2.8) it was higher than for hospital specialists (2.2), and for surgical specialists it was higher than for non-surgical specialists. Half of the complaints concerned ‘lack of care or inadequate care’ or ‘incorrect treatment’. The majority of complaints were made by the patient or by someone else, usually a member of the patient’s family. In comparison, the inspector for health care made only a limited number of complaints, but these were usually more serious, and often resulted in a (severe) sanction. The sanction-complaint ratio decreased during the study period, and was an average of 18%. The most frequently imposed sanctions were a warning (68%) and a reprimand (20%). In the 20-year period there were 45 entries struck off the register/withdrawals of the right to practice the profession. The complaint density remained constant during the study period: 0.25 sanctions per 100 professionals.

It is concluded that there has been a limited increase in the number of complaints during the past 20 years. The corrective effects of the disciplinary system are clear, and ways of increasing the effects on the quality of care should be sought in prevention and education. More attention should be paid to the disciplinary proceedings in (further) education and in the publication of verdicts.

Chapter 3 investigates the differences in the number and nature of the complaints, the complainants and the accused, and the verdicts before and after the introduction of the IHCP Act (period 1995-1997, respectively 1999-2001).

The regional disciplinary boards dealt with a total of 2453 complaints in the period 1995-1997, and 2527 in the period 1999-2001. The majority of the complaints were made about physicians (both periods 92%). The number of justified complaints decreased from 19% to 15%. In both periods approximately half of the complaints concerned ‘lack of care or inadequate care’ or ‘incorrect treatment’, the warning was the most frequently imposed sanction, and an appeal was made against almost one third of the verdicts. The number of complaints made by the inspector for health care decreased from 47 to 19.
It is concluded that in certain important aspects the IHCP Act has not improved the disciplinary proceedings. The decrease in the number of justified complaints seems to be the result of the change in the composition of the disciplinary boards since the introduction of the IHCP Act. Providing the general public with more information about the disciplinary proceedings and other ways of making complaints could help to increase the number of justified complaints, and therefore probably also the number of justified verdicts. Furthermore, the task and responsibility of the Health Care Inspectorate in the disciplinary proceedings should be defined more clearly.

Part III describes the practical application and opinions about the disciplinary proceedings for the ‘new’ professions

From Chapter 4 it is clear that during the period 1998-2001 the regional disciplinary boards dealt with 187 complaints about nurses. During the study period there was an increase in the number of accused (20 in 1998, 12 in 1999, 54 in 2000, and 56 in 2001) and the percentage of sanctions imposed (0% in 1998, 8% in 1999, 13% in 2000, and 16% in 2001). In 2000 and 2001 there was approximately 1 complaint per 2500 practicing nurses (per year). Male nurses were more often accused than their female colleagues. A total of 17 sanctions were imposed (12%), and these mainly concerned lack of care or inadequate care or professional misconduct, such as sexual intimacies or a sexual relationship. The most frequently imposed sanctions were a warning (41%) or a reprimand (24%). Most of the nurses were of the opinion that the disciplinary system plays a role in monitoring the quality of nursing care (81%). They were also of the opinion, as were most of the members of the disciplinary boards and practicing lawyers, that the disciplinary system for nurses should be maintained (79%, 80% and 89%, respectively).

It is concluded that the disciplinary system is an important corrective instrument with regard to serious forms of professional misconduct in the nursing profession. However, in the development of standards for other aspects of nursing care, the disciplinary system has (as yet) only a very limited role. The introduction of the disciplinary system seems to have given an impulse to monitoring the quality of nursing care.

Chapter 5 shows that in the period 1998-2002 the regional disciplinary boards dealt with 33 complaints about physiotherapists. During the study period there was an increase in the number of accused (0 in 1998, 2 in 1999, 6 in 2000, 11 in 2001, and 11 in 2002). In 2001 and 2002 there was approximately 1 complaint per 1,600 practicing physiotherapists (per year). Male physiotherapists were more often accused than their female colleagues. Sanctions were imposed 11 times (33% of the verdicts), and mainly concerned a reprimand or suspension of the entry in the IHCP register. The majority of complaints concerned sexual intimacies or sexual abuse. The majority of physiotherapists were of the opinion that the disciplinary system for their professional group should be maintained (88%).

The disciplinary system seems to be an important corrective instrument by imposing sanctions for serious forms of professional misconduct in physiotherapy. However, in the
development of standards for other aspects of physiotherapy, such as treatment and advice, it has (as yet) only a limited role.

Chapter 6 shows that in the period 1999-2002 the regional disciplinary boards dealt with 68 complaints about health care psychologists. The annual number of accused remained approximately the same (11 in 1999, 20 in 2000, 15 in 2001, and 18 in 2002). Approximately 1 complaint per 800 health care psychologists was made each year. Male health care psychologists were more often accused than their female colleagues. Sanctions were imposed 16 times (25% of the verdicts), mainly for sexual intimacies or a sexual relationship, violation of professional secrecy or an incorrect statement or report. The most frequently imposed sanctions were a warning (44%) or a reprimand (38%). Most of the members of the disciplinary boards and practicing lawyers were of the opinion that the disciplinary system for health care psychologists should be maintained (87% and 96%, respectively).

It is concluded that the disciplinary system is an important corrective instrument with regard to serious forms of professional misconduct in health care psychology. However, in the development of standards for other aspects of the profession, such as diagnosis and treatment, the disciplinary system has (as yet) only a limited role.

Part IV describes specific aspects of the disciplinary proceedings.

The focus of the research described in Chapter 7 is the practice and policy with regard to publication of the verdicts.

Of all the verdicts in the period 1995-2002, 4% were published in the Netherlands Government Gazette (323/8902). The central disciplinary board published verdicts more often than the regional disciplinary boards (8% and 2%, respectively), and there were considerable differences between the various regional disciplinary boards (min-max 0.9-5%). Per professional group the number of published verdicts varied from 2% to 23%. During the period 2000-2002 verdicts concerning the ‘new’ professions were published more frequently than verdicts concerning the ‘old’ professions (11% and 5%, respectively). The verdicts were offered to over 20 journals; the majority were offered to the TvGR (92%) and MC (88%). The TvGR published almost one third of the verdicts offered (63%) and MC published almost three quarters (74%). In their decision to publish a verdict the disciplinary boards differed in their interpretation of the concept of ‘general interest’. The main reason given by the disciplinary boards for the publication of a verdict was the learning effect in the professional group and possible standardization.

In order to achieve the intended quality-fostering effect on professional practice, more attention must be paid to the publication policy, and the disciplinary boards should develop a joint code of practice. More verdicts could be published, also in discipline-specific journals.
Chapter 8 describes the opinions of physicians, members of the disciplinary boards and practicing lawyers with regard to the disciplinary proceedings, and in particular concerning the changes that have been made since the introduction of the IHCP Act.

Almost all of the members of the disciplinary boards and the practicing lawyers were of the opinion that, in their judgement of complaints, the disciplinary board was complied adequately with the concept of good professional practice. Less than one third of the physicians shared this opinion. A large majority of the members of the disciplinary boards and the practicing lawyers considered it to be a shortcoming that it is not possible to declare a complaint as justified without imposing a sanction. Most of them were of the opinion that the number of justified complaints will increase if this possibility is incorporated in the Act. According to the majority of the members of the disciplinary boards and the practicing lawyers, the change in the composition of the disciplinary boards had not strengthened the position of the complainant. The majority of the respondents considered it necessary to include a health professional instead of a legally qualified member in the disciplinary boards in order to promote the consistency of verdicts concerning professional practice, and they were of the opinion that a health professional from the same specialism as the accused should always be involved in the judgement of a complaint.

It is concluded that increasing the number of health professional members, a composition of the disciplinary board that is related to the specialism of the accused health professional, and including the possibility to consider a complaint justified without imposing a sanction would make a further contribution to fostering and monitoring the quality of care.

Part V is the General discussion.

A description is first given of the position and the specific character of the disciplinary system in the context of legal instruments which regulate the quality of care. Based on the answers to the research questions listed in the Introduction, the most important findings reported in Chapters 2 to 8 are discussed. These concern the practical aspects of dealing with complaints and (published) verdicts, the publication policy, and the opinions of those involved, in particular with regard to changes in the disciplinary proceedings since the introduction of the IHCP Act.

An attempt has made to assess the functioning of the disciplinary system in the phases before, during and after complaints are dealt with, also taking into consideration the contribution of the disciplinary system to the quality of professional practice and the protection of the general public against incompetence and carelessness. In the phase before the complaints are dealt with it appears that the disciplinary proceedings are impeded, among other things, by the sub-optimal use made by the general public of the possibility to make complaints. The knowledge of the general public with regard to disciplinary proceedings and their confidence in the system appear to be limited. It is important that the general public is given the opportunity to discuss complaints with the health professional in question. The limited opportunity that is available for such discussions could be one of the reasons why totally unfounded complaints are made. With regard to the phase of dealing
with complaints, the high threshold to declare a complaint justified, the change in composition of the disciplinary boards, and the limited knowledge of the general public appear to lower the percentage of justified complaints even further, and thus impede the functioning of the disciplinary system. One positive sign is that the corrective influence seems to be a constant factor; there was little or no change in the number of severe sanctions imposed and the number of sanctions imposed per professional (the sanction density) during the study period. In the phase after the complaint is dealt with there seems to be inadequate supervision of the enforcement of sanctions that are imposed, the development of standards by the new professional groups is limited, and the preventive role seems to be limited as a result of the small number of published verdicts, the limited attention that is paid to verdicts and the development of standards in training and (further) education, and the limited opportunities for research.

Following this description of the functioning of the disciplinary system, the limitations and strengths of the research are discussed, and some recommendations are made for practice, policy and scientific research. With regard to research, one of the recommendations is that studies should be carried out to investigate the extent to which and the way in which publications reach the professional group, and what effect this has on professional practice. It is also recommended that the perspectives of the complainants and the accused should be investigated. There is a need for insight into the reasons for making a complaint, the efforts made by a complainant and an accused health professional to prevent an official complaint from being made, the experiences and satisfaction with the disciplinary procedures and the verdicts, and the impact on the complainant and the accused. Finally, it is suggested that the opportunities for research could be increased if the computerized database of the Health Care Inspectorate was converted into a programme with more access and was extended to include more variables and codes. For instance, the gender and field of work of the accused, more specific coding of the nature of the complaint, and coding of the reasons of ineligible and unfounded complaints. Analysis of these data would provide much more insight into the background of the accused, the nature of the complaints, and the reasons for the rejection of complaints and ineligible complaints, and could be used for quality policies concerning the disciplinary procedures and the prevention of complaints.
SAMENVATTING

Het Nederlandse wettelijk tuchtrecht voor de gezondheidszorg: een empirische studie

Kwantitatieve gegevens over de Nederlandse tuchtrechtspraak zijn slechts in beperkte mate voorhanden. Deze gegevens betreffen met name beroepen die al vóór de introductie van de Wet BIG tuchtrecht kenden. Met dit proefschrift wordt beoogd door middel van empirisch onderzoek inzicht te geven in bepaalde aspecten van het functioneren van het Nederlandse wettelijk tuchtrecht voor de gezondheidszorg met name sinds de introductie van de Wet BIG. Het is voor het eerst dat uitvoerig empirisch onderzoek is gedaan naar het wettelijk tuchtrecht in Nederland. Het proefschrift bestaat uit vijf delen.

Deel I, de introductie, beschrijft de achtergrond, de doelstelling en vraagstellingen en de methoden van onderzoek.

In Nederland bestaat sinds 1928 wettelijk tuchtrecht voor artsen, tandartsen en verloskundigen; voor apothekers vanaf 1951 (de ‘oude’ beroepen). Het doel van het tuchtrecht is de kwaliteit van de beroepsuitoefening te bewaken en te bevorderen en burgers tegen ondeskundig en onzorgvuldig handelen. Sinds de inwerkingtreding van de Wet op de beroepen in de individuele gezondheidszorg (Wet BIG) eind 1997 is het wettelijk tuchtrecht in deze wet geïncorporeerd. Tot die tijd was het tuchtrecht in de Medische Tuchtwet (MT) geregeld. Met de Wet BIG is de tuchtrechtspraak op verschillende onderdelen gewijzigd. Met het vergroten van het aantal jurist-leden in de tuchtcolleges is beoogd de positie van de klager te versterken. De zittingen van tuchtcolleges zijn sinds de Wet BIG in beginsel openbaar. Het voorheen besloten karakter belemmerde het publiek bij het verkrijgen van een goed inzicht in de werking van het tuchtrecht. Andere belangrijke wijzigingen betreffen de uitbreiding van de reikwijdte van het tuchtrecht met vier ‘nieuwe’ beroepen, namelijk verpleegkundigen, fysiotherapeuten, gezondheidszorgpsychologen en psychotherapeuten en de uitbreiding en verfijning van het arsenaal maatregelen.

Voor dit proefschrift is onderzoek gedaan naar de praktijk van behandelde tuchtklachten en (gepubliceerde) uitspraken, het publicatiebeleid en het perspectief van betrokkenen met name ten aanzien van veranderingen in de tuchtrechtspraak met de introductie van de Wet BIG. Voor het onderzoek naar de praktijk is een retrospectieve studie verricht naar kenmerken van ruim 13500 behandelde tuchtklachten en tuchtuitspraken. De onderzoeksperiode voor de ‘oude’ beroepen was 1983-2002, voor de ‘nieuwe’ beroepen was dit een periode van 4 of 5 jaar na introductie van de Wet BIG. Er is gebruik gemaakt van de verzamelde tuchtuitspraken in het archief en in het geautomatiseerde gegevensbestand van de Inspectie voor de Gezondheidszorg (IGZ). Daarnaast is retrospectief onderzoek gedaan naar kenmerken van alle 323 in de Nederlandse Staatscourant gepubliceerde uitspraken in de periode 1995-2002. Voor het onderzoek naar publicatiebeleid zijn vragenlijsten gestuurd naar de voorzitters van tuchtcolleges en de redacties van Medisch Contact, Tijdschrift voor Gezondheidsrecht en het Nederlands Tijdschrift voor Geneeskunde. Vier van de vijf regionale tuchtcolleges en
het centrale tuchtcollege, en de drie benaderde redacties reageerden. Voor het onderzoek van kennis en opvattingen zijn vragenlijsten gestuurd naar 1300 artsen (400 huisartsen, 350 internisten, 250 gynaecologen en 300 psychiatrie: respons respectievelijk 69%, 65%, 60% en 60%); 3200 verpleegkundigen (respons 71%), 300 fysiotherapeuten (respons 76%), alle 388 leden van de tuchtcolleges (respons 89%) en 43 advocaten (respons 65%).

Deel II beschrijft de praktijk van de tuchtrechtpraak voor de 'oude' beroepen.

Uit hoofdstuk 2 blijkt dat de regionale tuchtcolleges in de periode 1983-2002 13228 tuchtklachten behandelden; dat is gemiddeld 662 zaken per jaar. Het aantal tuchtklachten steeg sneller dan het aantal beroepsbeoefenaren. De meeste klachten waren tegen artsen gericht (92%). Ook de klachtendichtheid (het aantal klachten per 100 beroepsbeoefenaren per jaar) was voor artsen het grootst (1,6), voor huisartsen (2,8) groter dan voor medisch specialisten (2,2) en voor snijdende specialisten groter dan voor niet-snijdende specialisten. De helft van de klachten betrof 'geen of onvoldoende zorg' of 'onjuiste behandeling'. De meeste klachten werden ingediend door de patiënt of door een ander persoon, meestal een familieled van de patiënt. Verhoudingsgewijs diende de inspecteur een beperkt aantal klachten in, maar daarbij ging het doorgaans wel om ernstige zaken die vaak tot een (zware) maatregel leidden. De ratio maatregelen-klachten daalde in de onderzoeksperiode en was gemiddeld 18%. De meeste opgelegde maatregelen betroffen een waarschuwing (68%), respectievelijk een berisping (20%). Er waren in die 20 jaar 45 definitieve doorhalingen/ontzeggingen. De maatregeldichtheid bleef in de onderzoeksperiode constant; 0,25 maatregelen per 100 beroepsbeoefenaren.

Geconcludeerd wordt dat er een beperkte stijging was van het aantal tuchtklachten over de afgelopen 20 jaar. De corrigerende effecten van het tuchtrecht zijn duidelijk. Vergroting van effecten op de kwaliteit van zorg dient gezocht te worden in preventie en opleiding. Tuchtrechtpraak verdient meer aandacht in (na-) scholing en via publicatie van tuchttuitspraken.

In hoofdstuk 3 is nagegaan of er verschillen zijn in aantal en aard van de tuchtklachten, klagers en aangeklaagden en uitspraken vóór en na de inwerkingtreding van de Wet BIG (periode 1995-1997 respectievelijk periode 1999-2001).

De regionale tuchtcolleges behandelden in de eerste periode 2453 tuchtklachten, in de tweede periode 2527. De meeste klachten waren tegen artsen gericht (beide periodes 92%). Het aantal gegrondverklaarde klachten daalde van 19% naar 15%. In beide periodes betrof ongeveer de helft van de klachten 'geen of onvoldoende zorg' of 'onjuiste behandeling', was de waarschuwing de meest opgelegde maatregel en werd tegen bijna eenderde van de uitspraken beroep aangetekend. Het aantal door de inspecteur ingediende klachten daalde van 47 naar 19.

Geconcludeerd wordt dat de Wet BIG op belangrijke punten niet tot een verbetering heeft geleid van de tuchtrechtpraak. De daling van het aantal gegrondverklaarde klachten lijkt een gevolg van de met de Wet BIG veranderde samenstelling van de tuchtcolleges. Voorlichting aan burgers over het tuchtrecht en andere klachtmogelijkheden kan bijdagen
aan meer terechte klachten en dus waarschijnlijk meer gegrondverklaringen. Een nadere verduidelijking van de taak en verantwoordelijkheid van de IGZ in tuchtzaken is gewenst.

Deel III beschrijft de praktijk en opvattingen betreffende de tuchtrechtspraak voor de ‘nieuwe’ beroepen.

Uit hoofdstuk 4 blijkt dat in de periode 1998-2001 door de regionale tuchtcolleges 187 klachten over verpleegkundigen werden behandeld. Zowel het aantal aangeklaagden (20 in 1998, 12 in 1999, 54 in 2000, and 56 in 2001) als het percentage opgelegde maatregelen (0% in 1998, 8% in 1999, 13% in 2000 and 16% in 2001) stegen in de onderzoeksperiode. In 2000 en 2001 was er ongeveer één klacht per 2500 werkzame verpleegkundigen (per jaar). Mannelijke verpleegkundigen werden vaker aangeklaagd dan hun vrouwelijke collega’s. In totaal werd 17 keer een maatregel opgelegd (12%). Hierbij was meestal sprake van onvoldoende zorg of grensoverschrijdend gedrag zoals sexuele intimitieën of een sexuele relatie. Het meest werd een waarschuwing (41%) of berisping (24%) opgelegd. De meeste verpleegkundigen gaven aan dat het tuchtrecht een rol speelt bij de kwaliteitsbewaking van verpleegkundige zorg (81%). Ook vonden zij, evenals de meeste leden van de tuchtcolleges en advocaten, dat het tuchtrecht voor verpleegkundigen moet blijven bestaan (respectievelijk 79%, 80% en 89%).

Geconcludeerd wordt dat het tuchtrecht een belangrijk correctie-instrument blijkt bij ernstige vormen van grensoverschrijding in de verpleegkunde. Wat betreft de normontwikkeling ten aanzien van andere aspecten van de verpleegkundige zorg speelt het tuchtrecht echter (nog) een zeer bescheiden rol. Invoering van het tuchtrecht lijkt een impuls te hebben gegeven aan de bewaking van de kwaliteit van het verpleegkundig handelen.

Uit hoofdstuk 5 blijkt dat in de periode 1998-2002 door de regionale tuchtcolleges 33 klachten over fysiotherapeuten werden behandeld. Het aantal aangeklaagden stieg in de onderzoeksperiode (0 in 1998, 2 in 1999, 6 in 2000, 11 in 2001 en 11 in 2002). In 2001 en 2002 was er ongeveer één klacht per 1600 werkzame fysiotherapeuten (per jaar). Mannelijke fysiotherapeuten werden vaker aangeklaagd dan hun vrouwelijke collega’s. Een maatregel werd 11 keer opgelegd (33% van de uitspraken), meestal een berisping of schorsing van de inschrijving in het BIG-register. De meeste klachten betroffen sexuele intimitieën of sexueel misbruik. De meeste fysiotherapeuten vonden dat het tuchtrecht voor hun beroepsgroep moet blijven bestaan (88%).

Het tuchtrecht blijkt een belangrijk correctie-instrument door het opleggen van maatregelen bij ernstige vormen van grensoverschrijding in de fysiotherapie. Wat betreft de normontwikkeling ten aanzien van andere aspecten van de fysiotherapie zoals behandeling en advies speelt het echter (nog) een bescheiden rol.

In 2002. Er werd ongeveer één klacht per 800 gezondheidspsychologen en psychotherapeuten per jaar ingediend. Mannelijke gezondheidszorgpsychologen en psychotherapeuten werden vaker aangeklaagd dan hun vrouwelijke collega's. Zestien keer werd een maatregel opgelegd (25% van de uitspraken), meestal voor sexuele intimiteiten of een sexuele relatie, schending van het beroepsgeheim of een onjuiste verklaring of rapportage. De meest opgelegde maatregelen betroffen een waarschuwing (44%) of een berisping (38%). De meeste leden van de tuchtcolleges en advocaten vonden dat het tuchtrecht voor gezondheidszorgpsychologen en psychotherapeuten moet blijven bestaan (respectievelijk 87% en 96%).

Geconcludeerd wordt dat het tuchtrecht een belangrijk correctie-instrument blijkt bij ernstige vormen van grensoverschrijding in de gezondheidszorgpsychologie en psychotherapie. Wat betreft de normontwikkeling ten aanzien van andere aspecten van deze beroepsuitoefening, zoals diagnose en behandeling, speelt het tuchtrecht echter (nog) een bescheiden rol.

Deel IV beschrijft specifieke aspecten van de tuchtrechtspraak

In hoofdstuk 7 is de praktijk en het beleid ten aanzien van publicaties van de tuchtrechtspraak object van onderzoek.

Van alle tuchtuitspraken uit de periode 1995-2002 werd 4% bekend gemaakt in de Staatscourant (323/8902). Het centrale tuchtcollege besloot vaker tot publicatie dan de regionale tuchtcolleges (8% respectievelijk 2%). Tussen de regionale tuchtcolleges onderling bestonden forse verschillen (min-max 0,9-5%). Per beroepsgroep liepen de gepubliceerde uitspraken in tuchtzaken uiteen van 2 tot 23%. Gedurende de periode 2000-2002 werden beslissingen in tuchtzaken over de ‘nieuwe’ beroepen vaker gepubliceerd dan die over de ‘oude’ beroepen (respectievelijk 11% en 5%). De beslissingen werden aan ruim 20 tijdschriften aangeboden; de meeste aan het Tijdschrift voor Gezondheidsrecht (TvGR) (92%) en Medisch Contact (MC) (88%). Het TvGR plaatste bijna tweederde van de aangeboden uitspraken (63%), MC bijna driekwart (74%). Bij besluiten om tot publicatie over te gaan interpreteerden de tuchtcolleges het begrip ‘algemeen belang’ niet eenduidig. Als voornaamste overwegingen voor het bekendmaken van een beslissing noemden de colleges het leereffect voor de beroepsgroep en de mogelijke normvorming.

Om het beoogde kwaliteitsbevorderend effect op de beroepsuitoefening in de tuchtrechtspraak te bereiken dient het publicatiebeleid meer aandacht te krijgen en dienen de colleges een gezamenlijke gedragslijn te ontwikkelen. Er zou meer gepubliceerd kunnen worden, ook in discipline gebonden tijdschriften.

Hoofdstuk 8 beschrijft de opvattingen van artsen, leden tuchtcolleges en advocaten over de tuchtrechtspraak met name ten aanzien van veranderingen hierin na de introductie van de Wet BIG.

Vrijwel alle leden tuchtcolleges en advocaten waren van mening dat het tuchtcollege bij het beoordelen van tuchtklachten voldoende aansluit bij hetgeen in de beroepsgroep als zorgvuldig handelen wordt aangemerkt. Van de artsen had minder dan eenderde deze
mening. Een ruime meerderheid van de leden tuchtcolleges en advocaten vond het een gemis dat het niet mogelijk is een klacht gegrond te verklaren zonder het opleggen van een maatregel. De meesten van hen dachten dat het aantal gegrondverklaringen zal toenemen wanneer deze mogelijkheid in de wet wordt opgenomen. De gewijzigde samenstelling van de tuchtcolleges had volgens het merendeel van de leden tuchtcolleges en advocaten de positie van de klager niet versterkt. Het merendeel van de respondenten achte het opnemen van een beroepsbeoefenaar in plaats van een lid-jurist bij de tuchtcolleges nodig om de consistentie van beslissingen over het professionele handelen te bevorderen en vond dat bij de beoordeling van een klacht altijd een vakgenoot op het betreffende vakgebied betrokken dient te zijn.

Geconcludeerd wordt dat uitbreiding van het aantal beroepsgenoten in het tuchtcollege, een bij het specialisme van de aangeklaagde beroepsbeoefenaar passende samenstelling van het college en het introduceren van de mogelijkheid van een gegrondverklaring zonder toepassing van een maatregel een verdere bijdrage aan de kwaliteitsbewaking en -bevordering kunnen leveren.

Deel V betreft de generale discussie.

Een beschrijving is gegeven van de positie en het specifieke karakter van het tuchtrecht in de context van juridische instrumenten die de kwaliteit van zorg sturen. Aan de hand van de beantwoording van de vraagstellingen uit de inleiding worden de belangrijkste bevindingen uit hoofdstuk 2 tot en met 8 weergegeven. Het betreft de praktijk van behandelde tuchtklachten en (gepubliceerde) uitspraken, het publicatiebeleid en de opvattingen van betrokkenen, met name ten aanzien van veranderingen in de tuchtrechtspraak na de introductie van de Wet BIG.

Gepoogd is het functioneren van het tuchtrecht nader te beoordelen in de fasen vóór, tijdens en ná de behandeling van tuchtclachten en daarbij is ook ingegaan op de bijdrage van het tuchtrecht aan de kwaliteit van de beroepsuitoefening en bescherming van burgers tegen ondeskundig en onzorgvuldig handelen. In de fase vóór de behandeling van tuchtklachten lijkt de werking van de tuchtrechtspraak onder andere te worden belemmerd door een niet optimaal gebruik van de mogelijkheid voor burgers om tuchtklachten in te dienen. Hun kennis over de tuchtrechtspraak en hun vertrouwen hierin zijn beperkt. Het is belangrijk dat burgers de ruimte krijgen om klachten te bespreken met de betrokken beroepsbeoefenaar. Een beperkte ruimte voor die bespreking kan mede een oorzaak zijn van het indienen van zonder meer ongegronde klachten. Ten aanzien van de fase van behandeling van tuchtklachten lijken de hoge drempel voor gegrondverklaring, de veranderde samenstelling van de tuchtcolleges en de beperkte kennis van burgers het percentage gegrondverklaringen verder te verlagen en belemmeren daarmee het functioneren van het tuchtrecht. Een positief teken is dat de corrigerende werking een constante factor van belang lijkt; zowel het aantal opgelegde zware maatregelen als het aantal opgelegde maatregelen per beroepsbeoefenaar, de maatregeldichtheid, veranderden niet of nauwelijks in de onderzoeksperiode. In de fase na behandeling van de tuchtklacht is er sprake van onvoldoende toezicht op de ten uitvoerlegging van opgelegde maatregelen, de
normontwikkeling door de nieuwe beroepsgroepen is beperkt en ook de preventieve rol lijkt klein als gevolg van het geringe aantal publicaties van uitspraken, de geringe aandacht voor uitspraken en normontwikkeling in het onderwijs en bij/nascholing en de beperkte mogelijkheden van onderzoek.

Na de beschrijving van het functioneren van het tuchtrecht zijn beperkingen en sterke punten van het onderzoek aangegeven en zijn aanbevelingen gedaan voor de praktijk, het beleid en wetenschappelijk onderzoek. Ten aanzien van deze laatste categorie wordt onder andere aangegeven dat het aanbeveling verdient onderzoek in welke mate en op welke wijze publicaties de beroepsgroep bereiken en wat de effecten daarvan op de beroepsuitoefening zijn. Daarnaast wordt genoemd dat het aanbeveling verdient het perspectief van klagers en aangeklaagden te onderzoeken. Er is inzicht nodig in de overwegingen voor het indienen van een tuchtklacht, de inspanningen van een klager en aangeklaagde om een tuchtklacht te voorkomen, de ervaringen en tevredenheid met de tuchtprocedure en de uitspraak, en de impact op de klager en aangeklaagde. Tot slot wordt aangegeven dat de mogelijkheden voor onderzoek kunnen worden verruimd door het automatische gegevensbestand van de IGZ om te zetten in een programma met meer bewerkingsmogelijkheden en uit te breiden met enkele variabelen en codes. Te denken valt aan het geslacht en het werkveld van de aangeklaagden, het specifieker coderen van de aard van de klacht en het coderen van de redenen van niet ontvankelijkheid en ongegrondverklaring. Analyse van deze data leidt tot een groter inzicht in de achtergrond van aangeklaagden, de aard van de klachten en de redenen van afwijzing van klachten en niet-ontvankelijk verklaring van klagers en kan gebruikt worden voor kwaliteitsbeleid van de tuchtprocedure en voor preventie van tuchtklachten.
Dankwoord

Toen ik in september 2000 als een van de sociaal wetenschappelijk onderzoekers begon aan de evaluatie van de Wet op de Beroepen in de Individuele Gezondheidszorg vermoedde ik nog niet dat dit zou leiden tot een promotie. Na deze evaluatie heb ik verder empirisch onderzoek gedaan naar het wettelijk tuchtrecht voor de gezondheidszorg en ben ik wetenschappelijke artikelen gaan schrijven hetgeen heeft geleid tot dit proefschrift. Verschillende mensen hebben hieraan een bijdrage geleverd. Een aantal daarvan wil ik met name noemen.

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Na zijn studie was hij aanvankelijk met name betrokken bij kwalitatief onderzoek en onderzoek op het gebied van toerisme en recreatie. Later is de focus meer komen te liggen op kwantitatief onderzoek en onderzoek op het gebied van de gezondheidszorg. Na onderzoekservaringen te hebben opgedaan bij onder andere het Loopbaancentrum Wageningen, diverse marktonderzoeksbureau’s en Stichting Consument en Veiligheid is hij in september 2000 begonnen als onderzoeker aan het Instituut voor Extramuraal Geneeskundig Onderzoek, afdeling Sociale Geneeskunde, van het Vrije Universiteit medisch centrum Amsterdam. Na meegewerkt te hebben aan de landelijke evaluatie van de Wet op de Beroepen in de Individuele Gezondheidszorg (Wet BIG) heeft hij verder empirisch onderzoek gedaan naar het tuchtrecht voor de gezondheidszorg waarvan het resultaat is beschreven in dit proefschrift.

Thans is hij als post-doc betrokken bij het landelijke onderzoeksprogramma patiëntveiligheid in Nederland dat wordt uitgevoerd door het EMGO Instituut van het VUmc en het NIVEL.
List of publications

- Hout FAG. Dynamiek in kampeertijlen?! De achtergronden van verandering en stabiliteit in het kampeergedrag van ANWB-leden in de loop van de tijd, Wageningen: Werkgroep Recreatie, rapport nr. 25; 1993.