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Addressing Harm in Healthcare: A Responsive Perspective

ARTICLE

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ABSTRACT

The Dutch legal framework that addresses the response to harm in healthcare falls short in meeting the needs of both patients and healthcare professionals. The adversarial nature of legal procedures often exercabates the initial harm of patient safety incidents for patients and healthcare professionals, who can be second victim of the incident. In this paper, a responsive perspective is used to explore how the response to patient safety incidents can be better aligned with the needs of patients and healthcare professionals. A responsive approach takes into account the specifics of each situation, the needs of the people involved, and the consequences of legal decisions for society. Analysis of complaint law and self regulation in healthcare demonstrates a shift in thinking from reactive to proactive claim management. Proactive claim management is further explored through the examples of Communicate and Resolution Programmes in the US and the principles of Restorative Justice.

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'Bring your lawyer
And I'll bring mine
Get together, and we could have a bad time'
George Harrison

1. INTRODUCTION

The Dutch legal framework that addresses the response to harm in healthcare falls short in meeting the needs of both patients and healthcare professionals.[1] Due to their adversarial nature, legal procedures that follow after medical harm can even cause additional harm.[2] In this paper, I will demonstrate that a traditional, adversarial response to patients' claims and complaints is at odds with the principles of Dutch complaint law and self-regulation. I will argue for a responsive approach to addressing harm in healthcare; put simply, one that better meets the needs of those involved. Following others,[3] I will place this approach both in the key of Nonet and Selznick's concept of 'responsive law' and of restorative justice, although the merits of the needs-oriented approach which I am advocating do not depend on the merits of these theories. The concept of 'responsive law' was first introduced by Nonet and Selznick in their influential paper of 1978.[4] Nonet and Selznick describe an evolution of law in society from repressive, through autonomous, to responsive. Law is responsive when it is a 'facilitator of response to social needs and aspirations'.[5] A responsive approach takes into account the specifics of each situation, the needs of the people involved, and the consequences of legal decisions for society.[6] It considers the legal system from the perspective of the needs of its users.

A needs-based orientation has also become the hallmark of much of health law. An important milestone was the establishment of patients' rights in 1991, alongside statutory provisions regarding the management of patients' complaints in the same year. Since then, a shift has occurred from a paternalistic, 'doctor knows best' approach to a more responsive, patient-centred approach, placing the needs and wishes of patients at the heart of healthcare treatment and policy.[7] While the practical significance of this shift in thinking should not be overstated, when openness became a statutory duty in 2016 the recognition that openness is both an ethical duty and aligns with patients' needs has generally been accepted as a compelling rationale to be as open as possible.[8]

A relatively new consideration in determining the response to patient safety incidents is the position of the healthcare professional.[9] Patient safety incidents can have a devastating impact on the healthcare professional, who can themselves become 'second victims'.[10] These are defined as 'any health care worker, directly or indirectly involved in an unanticipated adverse patient event, unintentional healthcare error, or patient injury and who becomes victimized

1 B Laarman and A Akkermans, 'Compensation Schemes for Damage Caused by Healthcare and Alternatives to Court Proceedings in the Netherlands', (van Vliet (ed.), *Netherlands Reports to the twentieth International Congress of Comparative Law* (Wolf Legal Publishers, 2018), 1–30, Available at SSRN: https://ssrn.com/abstract=3143320.

2 N Elbers et al., 'Do compensation processes impair mental health? A meta-analysis' (2013) 44 *Injury*, no. 5, https://doi.org/10.1016/j.injury.2011.11.025, 674–683.

3 I Becx & A Akkermans, 'Some thoughts on the concept of "Responsive Law" as an overarching conceptual framework for the many "vectors" of current innovations within the legal systems of the world' (2022).

4 P Nonet & P Selznick, *Law and Society in Transition: Toward Responsive Law* (Harper & Row, 1978).

5 ibid.

6 A Mein & B Marseille, 'De bezwaarmaker gehoord: een zoektocht naar responsiviteit in de bezwaarpraktijk' (2020) 16 *Tijdschrift voor Klachtrecht*, no.2, DOI: 10.5553/TvK/1871-41022020016002002, 7.

7 D Berwick, 'Era 3 for Medicine and Health Care' (2016), 315 *JAMA*, no.13, DOI: 10.1001/jama.2016.1509, 1329–1330.

8 *Kamerstukken I* 2013/14, 32402, I.

9 E van Gerven, 'Health professionals as second victims of patient safety incidents: impact on functioning and well-being' (2016) https://research.kuleuven.be/portal/en/project/3M110357.

10 A Wu, 'Medical error: the second victim. The doctor who makes the mistake needs help too' (2000) 320 *British Medical Journal (BMJ)*, no. 7237, DOI: 10.1136/bmj.320.7237.726, 726–727.

in the sense that they are also negatively impacted'.[11] In line with international findings, Ruitenbeek-Bart has demonstrated that liability law can also have adverse effects on Dutch healthcare professionals.[12] A responsive approach should, therefore, also take into account the interests of healthcare professionals.

In what follows, I will first describe patients' needs after experiencing harm in healthcare (Section 2), moving on to set out new perspectives on law (Section 3) suggesting responsive law as an overarching conceptual framework. In order to increase comparability to other jurisdictions, I will describe some particularities of the Dutch system for compensating medical harm (Section 4), then describing how these procedures work out in practice (Section 5). Following on from the insight that adversarial procedures are harmful to all parties involved, I will argue for a proactive approach in healthcare (Section 6), guided by the principles of restorative justice. I will end with a short conclusion (Section 7).

A short note on terminology. In accordance with Dutch legal terminology, I will use the terms healthcare provider and healthcare professional. The provider is the institution, the professional the individual doctor, nurse, or dentist. In some instances, such as independently practising general practitioners, the provider and the professional are one and the same.

2. PATIENTS' NEEDS AFTER EXPERIENCING HARM IN HEALTHCARE

Patients have several needs after an incident, the most important of which are honest information and good communication. Patients want the healthcare provider and/or the professional to acknowledge what happened and take responsibility. Apologies are important, as is being informed about improvement measures preventing similar incidents from occurring in the future. Finally, patients who suffer harm want to be compensated.[13] A response that addresses these needs is called 'open disclosure'. Failure to address these needs can be an important motivation to complain or claim for compensation.[14] Filing a claim or a disciplinary complaint for non-financial reasons (such as receiving an apology or finding out what happened) sets many patients up for disappointment, because adversarial legal remedies are notoriously bad at meeting such needs.[15] For this reason, the Dutch legislature introduced the Healthcare Quality, Complaint and Disputes Act (Wkkgz). In the Wkkgz, the legislature tries to attack the problem from both sides. In order to provide for patients' needs and prevent conflict, being open became a statutory duty. In those cases where problems do arise, the Wkkgz places stricter requirements on healthcare providers to provide a quick solution.

3. THEORETICAL PERSPECTIVES ON LAW

3.1 RESPONSIVE LAW AS AN OVERARCHING FRAMEWORK

Much thought has gone into how conflict can be settled in a better way and with better outcomes, with numerous schools of legal thought as a result. Many of these have developed, independently, in different areas of law, ranging from family law to criminal law. The main common goal could be identified as optimizing the well-being of those involved in legal proceedings. The approaches differ depending on which aspect of well-being is emphasized (well-being in an emotional sense or relational sense, the moral development or reintegration of offenders, and so on) or which mechanism is at the forefront (different procedures, different

11 K Vanhaecht et al., 'An Evidence and Consensus-Based Definition of Second Victim: A Strategic Topic in Healthcare Quality, Patient Safety, Person-Centeredness and Human Resource Management (2022) 19 *International Journal of Environmental Research and Public Health*, no. 16869, DOI: https://doi.org/10.3390/ijerph192416869.

12 F Ruitenbeek-Bart, *En de veroorzaker dan? Een empirisch-juridisch onderzoek naar de plaats van de veroorzaker in de civiele letselschadepraktijk* (Boom juridisch, 2023).

13 JL Smeehuijzen et al., *Opvang en schadeafwikkeling bij onbedoelde gevolgen van medische handelen* (Vrije Universiteit Amsterdam, 2013).

14 C Vincent et al., 'Why do people sue doctors? A study of patients and relatives taking legal action' (1994) 343 *The Lancet*, no. 8913, DOI: 10.1016/s0140-6736(94)93062-7, 1609–1613.

15 A Akkermans, 'Achieving justice in personal injury compensation: The need to address the emotional dimensions of suffering a wrong' in P Vines & A Akkermans (eds.), *Unexpected Consequences of Compensation Law* (Hart Publishing, 2020), 15–37.

approach by advocates, different role conception by the judge or a different conception of damages). The development of new perspectives and practices lacks a common language.[16] To make sense of the multitude of theoretical approaches and proposed practical solutions Becx and Akkermans propose Nonet and Selznicks' *responsive justice* as an overarching theoretical framework.[17]

Previous attempts to integrate perspectives on law are the Comprehensive Law Movement[18] and Non-Adversarial Law.[19] Daicoff identifies nine 'vectors' or perspectives on law that can be seen as part of the Comprehensive Law Movement (for instance, procedural justice,[20] restorative justice,[21] therapeutic jurisprudence[22] and problem-solving justice or problem-solving courts[23]). 'Comprehensive Law' is not linked to one method or even one theoretical approach. The vectors have in common that they look beyond legal rights and search for the interests behind the legal conflict so that work can be done to restore relationships and the emotional well-being of the people involved. Comprehensive Law is not exclusively non-adversarial, but it does consider the 'tournament model' the least optimal method of conflict resolution.

Comprehensive Law is a useful label to demonstrate the general movement towards alternative approaches to law. In addition, bringing perspectives together offers an opportunity for cross-pollination and cooperation between schools of thought that are traditionally distinct. As a label, Comprehensive Law demonstrates where schools of thought overlap and, in some cases, are intertwined. For instance, restorative justice grants people a say in the solution to their problem, which contributes to experiencing 'having a voice'. Having a voice is an important element of procedural justice, which assesses whether people feel they have been treated fairly. Perceived justice is an important factor for recovery; therefore, from the perspective of therapeutical jurisprudence, restorative justice might offer practical guidance as to how to resolve conflict more therapeutically, in short, in a way that promotes recovery. From an academic perspective, however, Comprehensive Law does not offer much guidance in understanding new theory and practice because it lacks focus – in every vector the emphasis lies elsewhere.

King et al. use the term non-adversarial justice as an umbrella term for various approaches to law that focus on reconciliatory modes of conflict resolution in the civil and public sectors.[24] Non-adversarial justice focuses on prevention rather than after-the-fact solutions, cooperation rather than conflict, and resolution of the underlying problem rather than pure dispute resolution. King et al. emphasize that (in spite of its name) they propose non-adversarial justice as complementary and not a replacement for more traditional and adversarial approaches to law, but as an overarching definition it is nonetheless defined by what it is not: non-adversarial.

In their work, *Towards responsive law,*[25] Nonet and Selznick identify a need for a legal and social theory that is capable of explicating conflicting perspectives on law. In order to do so, Nonet and Selznic develop an abstract and theoretical model that makes it possible to assess the characteristics of a legal state. The model consists of three basic legal 'states' based on political and jurisprudential elements of law, such as the view on rules, discretion, coercion, and morality, and the relationship between the law and politics. The three basic legal states

16 A Akkermans, 'Het geheel is meer dan de som der delen' in A Akkermans et al. (eds.), *Het probleemoplossend vermogen van het rechtssysteem* (Boom juridisch, 2020), 11–26.

17 Becx & Akkermans (n 3).

18 S Daicoff, 'The Comprehensive Law Movement: An emerging approach to legal problems' (2006) 49 *Scandinavian Studies in Law*, 109–130.

19 M King et al., *Non-adversarial justice* (The Federation Press, 2009).

20 T Tyler, 'What is procedural justice?: Criteria used by citizens to assess the fairness of legal procedures' (1988) 22 *Law & Society Review*, no. 1, DOI: https://doi.org/10.2307/3053563, 103–135; E Lind et al., *The perception of justice: Tort litigants' views of trial, court-annexed arbitration, and judicial settlement conferences* (The RAND Corporation, 1989).

21 H Zehr, *The Little book of restorative justice: Revised and updated* (Good Books, 2015).

22 D Wexler, 'Therapeutic jurisprudence: An overview' (2000) 17 *Thomas M.Cooley, Law Review*, 125–134.

23 S Verberk, *Probleemoplossend strafrecht: en het ideaal van responsieve rechtspraak (dissertation Rotterdam)* (Erasmus University Rotterdam, 2011); M Boone & P Langbroek, 'Problem-solving justice: European approaches' (2018) 14 *Utrecht Law Review*, no 3, DOI: http://doi.org/10.18352/ulr.478, 1–6.

24 King et al. (n 19).

25 Nonet & Selznick (n 4).

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identified in *Towards Responsive Law* are 'repressive law', 'autonomous law' and 'responsive law'. Whether a legal state is repressive, autonomous or responsive is something to be learned in the course of empirical enquiry.

If law is repressive, law is used as an instrument by the ruling elite. The main function of repressive law is to ensure order and obedience. In a repressive system, legitimacy is weak because the law is *ad hoc* and arbitrary. It needs political power to ensure obedience. Autonomous law can be seen as a reaction to the problem of legitimacy in a repressive system. Autonomous law is characterized by the principle of 'the rule of law' that binds the state and civilians. In order to minimize arbitrariness, the focus lies on procedural correctness and fairness. Autonomous law, however, can lead to rigidity and, through strict adherence to the law, the law can become disconnected from the intended purposes of the law. In a responsive system, the problems of rigidity are overcome by a focus on substantive justice. Legality remains important, but legality does not overrule justice: rules and procedures must ensure the right outcomes. Although the model is developmental, legal states will often be mixed in character and possess elements of all three 'states' of law. Responsive law is not a replacement for autonomous law, but builds upon the foundations provided by autonomous law:

> a responsive institution retains a grasp on what is essential to its integrity while taking account of new forces in its environment. To do so, it perceives social pressures as sources of knowledge and opportunities for self-correction. To assume that posture, an institution requires the guidance of purpose.[26]

Responsive law counters arbitrariness by the guidance of 'purpose'. Nonet and Selznick believe that, in order to criticize the authority of specific rules or policies, it is possible to objectively uncover implicit values within rules and policies.[27]

The work of Nonet and Selznick addresses the question of the proper place of law in a democratic society and, in their 1978 work, the focus lies on the (often problematic) relationship between politics and the law. Akkermans identifies a movement from autonomous law towards responsive law that can be seen across differing areas of law.[28] Akkermans distinguishes the following characteristics of traditional and innovative approaches to law and conflict:[29]

TRADITIONAL APPROACH (AUTONOMOUS)	INNOVATIVE APPROACH (RESPONSIVE)
Juridification	De-juridification
Procedural correctness	Solution oriented
Adversarial (parties compete in a legal arena)	Reconciliatory (both parties contribute to a solution)
Legal 'dispute resolution' (surface level of conflict)	Comprehensive 'conflict resolution' (addressing the underlying issues and causes of conflict)
Narrow scope of needs and interests (mostly financial needs and interests)	Broad scope of needs and interests (also: emotions, immaterial needs and interests)
Decision by third party	Solution (also) by parties themselves
Decisionmaker passive	Decisionmaker active (proactive judge, judge who coordinates proceedings)
System perspective is dominant	Perspective of the users is dominant ('people centred justice')
Various separate legal avenues and procedures	Integrating procedures, one service counter, triage

The characteristics of innovative, responsive practices can be recognized in the Dutch Healthcare Quality, Complaints and Disputes Act (Wkkgz) that sets out requirements for the handling of complaints and claims in healthcare, which will be further described in Section 4.2.

26 Nonet & Selznick (n 4).

27 ibid; Verberk (n 23), 62.

28 Akkermans (n 16), 11–25.

29 ibid, 14., translations by the author.

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4. THE DUTCH LEGAL FRAMEWORK FOR HANDLING HARMFUL EVENTS IN HEALTHCARE

4.1 PATIENT SAFETY

Provisions concerning openness and the management of quality and safety in healthcare are laid down in the first part of the Healthcare Quality, Complaints and Disputes Act (Wkkgz). All patient safety incidents have to be reported internally. The Wkkgz requires the healthcare institution to take steps to ensure that this procedure is 'safe', in the sense that information from the report cannot be used in a procedure against the reporting healthcare professional.[30] Incidents resulting in severe harm or death[31] are also reported to the Dutch Healthcare Inspectorate (IGJ) and investigated, usually through (a form of) root cause analysis (RCA).[32] The results of the investigation are then shared with the Healthcare Inspectorate and, in many cases, the patient and/or their relatives. Last, but certainly not least, the Wkkgz provides a duty of candour that obligates healthcare providers to disclose all incidents resulting in (potentially) noticeable harm to the patient.[33]

4.2 COMPLAINTS AND DISPUTES

Besides patient safety, the Wkkgz regulates the management of complaints in healthcare. Complaint law derives from situations of power imbalances; in the Netherlands, tenants can make complaints against landlords, citizens against the state and, indeed, patients against their healthcare provider(s), etc. The patient, in this case, is the weaker party who needs to be assisted towards finding a solution to their problem. The Wkkgz emphasizes an open, informal and proactive response to both claims and complaints. The Wkkgz requires healthcare institutions to (1) adequately investigate complaints; (2) have an independent complaints officer to help patients in finding a solution to their problem; (3) respond to complaints within short timeframes (six weeks with a maximum extension to a total of ten). If the provider fails to respond to the complaint or the patient is unsatisfied with the healthcare provider's response, patients can resort to a disputes committee that takes binding decisions, including awards of damages up to €25,000. A potentially important element of the Wkkgz is the inclusion of claims in the definition of complaints ('a complaint with or without a financial aspect'). In theory, extending the statutory duties concerning complaints to the management of claims can have far-reaching consequences as it would entail the use of informal, inexpensive, and quick avenues for the resolution of both claims and complaints.

4.3 DUTCH COMPENSATION LAW

The Dutch system for compensation for damage resulting from health care is fault based. The rights of patients and the corresponding duties of healthcare professionals are laid down in the Medical Treatment Contracts Act (WGBO) which is part of the Dutch Civil Code (DCC) and the Wkkgz. The WGBO is an act relating to healthcare professionals' duties concerning individual patient care; the Wkkgz provides patients with an instrument to exercise these rights by setting out obligations on complaint management and quality of care, as described in Section 4.2. The relationship between the healthcare professional and the patient is laid down in the medical treatment contract (Article 7:446 DCC). The WGBO sets out general obligations regarding the treatment of patients, such as requirements concerning privacy, informed consent, maintaining an adequate medical file, and so forth.

Acting in breach of the duty of providing good care is qualified as failure to fulfil a contractual duty (Article 6:74 in conjunction with Article 7:453 DCC). In case law on the contractual liability

30 This procedure is called *Veilig Incidenten Melden* (VIM), which translates as safe or blame free reporting of incidents. J Legemaate, 'Veilig melden van incidenten wettelijk regelen?' (2008) 32 *Tijdschrift voor Gezondheidsrecht (TvGR)*, 99–104; J Legemaate, 'Blame free reporting: international developments' in J Tingle & P Bark (eds.), *Patient Safety, Law Policy and Practice* (Routledge, 2011).

31 '*Calamiteiten*'; in addition to serious harm or death, causality needs to be established in order for an incident to be defined as '*calamiteit*'.

32 For a critique on the use of RCA for learning, see M de Vos, *Healthcare improvement based on learning from adverse outcomes (thesis Leiden University Medical Centre)* (Optima Grafische Communicatie, 2018); D de Kam, *Through the Regulator's Eyes: On the Effects of Making Quality and Safety of Care Inspectable (thesis Erasmus University)* (Erasmus University Rotterdam, 2020).

33 Art. 10 section 3 Wkkgz.

of professionals,[34] the criterion of the 'reasonably able and reasonably acting'[35] professional has been developed to describe the general standard of care that is expected of all professions, i.e. not limited to the medical professions.[36] This general criterion is operationalized by the applicable professional standard, which depends on the profession involved. The performance of professionals is evaluated by determining what a reasonably able and reasonably acting colleague would have done in the same circumstances. For healthcare professions, the professional standard is composed of the state of the art of medical practice, construed from relevant guidelines, protocols and scientific publications, and case law of both courts and the medical disciplinary courts, described in Section 4.4.

Claiming for compensation through adversarial procedures is difficult,[37] and claiming for compensation is especially difficult in the case of medical harm.[38] It is the injured party, in this case the patient, who carries the burden of proving both wrongdoing and causality in order to get there,[39] and in many cases neither wrongdoing nor causality are evident. Whereas traffic rules are generally unambiguous ('drive on the right', 'stop for a red light') and their violation relatively easy to determine, the professional standard of healthcare practitioners in a given situation often will not be as clearly defined. The professional standard leaves room for professional discretion considering the specific particularities of each case. Resolving the case may require one or more expert opinions, with all the delays and costs involved. Causality is often also difficult to establish, as distinguishing between the consequences of the incident and what would have been the natural progression of the patients' condition can be complex.

4.4 DISCIPLINARY LAW

The Dutch disciplinary system aims at quality improvement by correcting and, in severe cases restricting, professionals' behaviour. Disciplinary case law is published anonymously and is part of the Dutch professional standard for healthcare professionals, prescribing desired behaviour in specific circumstances in order to learn from other health care professionals' mistakes. Patients and other parties with a direct interest (the Dutch Healthcare Inspectorate, employers, or, under certain conditions, colleagues) can file a complaint with a Medical Disciplinary Board.[40] These Boards are composed of lawyers and professionals belonging to the specialisation concerning the complaint (if, for instance, the complaint concerns informed consent during labour the board will include an obstetrician). The procedure is largely dependent on patients filing complaints but patients themselves do not have a formal stake in the procedure, which means that patients cannot claim compensation before the disciplinary board or request a specific disciplinary measure. Healthcare professionals can be disciplined with (in order of gravity of the measure) a warning, a reprimand, a monetary fine, a conditional or definite suspension, withdrawal of the right to perform certain treatments or of the right to re-register (in cases where a professional voluntarily resigns from the Register of the Healthcare Professionals Act (BIG register), or removal from this register).

5. UNEXPECTED CONSEQUENCES OF LEGAL PROCEDURES IN HEALTHCARE

5.1 THE PURPOSE OF COMPENSATING FOR HARM

In the Netherlands, there is a reasonable consensus that the purpose of liability law should be restoration.[41] Dutch liability law is rooted in the theory of corrective justice: 'if, in a bilateral

34 The same criterion applies in tort law.

35 '*Redelijk handelend en redelijk bekwaam*'.

36 The norm of the 'reasonably able and reasonably acting' professional was first formulated by the Dutch Supreme Court in the *Speeckaert/Gradener* case, ECLI:NL:HR:1990:AC1103, and later laid down in Art 7:453 Dutch Civil Code (DCC).

37 R Rijnhout, *Van compensatieconflicten naar betekenisvol compenseren* (Boom Juridisch 2023).

38 J Smeehuijzen & A Akkermans, 'Medische aansprakelijkheid: over grote problemen, haalbare verbeteringen en overschatte revoluties' (2013), 13–88; Laarman & Akkermans (n 1).

39 Art. 150 Dutch Code of Civil Procedure (DCCP).

40 Art. 65 Healthcare Professionals Act (Wet BIG).

41 S Lindenberg, 'Herstel bij letsel: over juridische fundering van verplichting tot herstel' in G de Groot et al. (eds.) *Kritiek op recht- Liber Amicorum Gerrit van Maanen* (Kluwer, 2014); Akkermans (n 15).

relationship one party creates disadvantage for the other and thereby violates justice, restoration must be made in that relationship [translation BSL]'.[42] While restoration need not necessarily translate into financial compensation, other avenues of restoration generally remain out of the picture.[43] Concerns about the way medical error and medical liability are handled have led the legislature to the implementation of the previously mentioned Wkkgz, a complaint law that seeks to facilitate a response to harm in healthcare that better meets the needs of patients, thereby preventing unnecessary (legal) escalation. Another development has been the increasing attention for restorative justice as a perspective on law that broadens the scope of the needs and interests of those who seek justice after injury.[44] But first, let us see how the legal system affects patients and healthcare professionals.

5.2 LIABILITY LAW

As stated by Strasburger, '[T]here is an inherent irony in the judicial system in that individuals... must endure injury from the very process through which they seek redress'.[45] Being involved in a compensation procedure is associated with poorer outcomes for victims in terms of physical and emotional recovery.[46] Adversarialism in compensation procedures appears to play an important role. In adversarial systems the patient is expected to take the first step in order to receive compensation for their damage. In order to be eligible for compensation the patient must prove wrongdoing and causation, which will then be disputed by the opposing party. In this way, the adversarial system facilitates conflict. Research cites being the problem-owner of damage caused by someone else, the feeling of not being believed and the constant re-living of the harm-causing event as factors negatively impacting claimants.[47]

Moreover, most claims are settled through written communication by the patients' personal injury lawyer and the medical liability insurer's case manager. Consequently, the responsible party is removed from the process,[48] missing an opportunity for the non-financial needs of patients, such as apologies and acknowledgement of the harm caused, to be met. These elements of the Dutch compensation system directly contrast with the patients' desire for the professional to take responsibility, heightening the risk of perceived injustice. Perceived injustice, furthermore, is a predictor for the development of chronic pain and disability after injury.[49]

Recent research by Ruitenbeek-Bart has focused on the experiences of Dutch tortfeasors in the context of traffic incidents and medical liability. [50] While participants in that study express the view that disciplinary procedures (see section 5.3.) generally have a more profound and adverse impact than the resolution of claims, their experiences reveal the challenges inherent in liability law as well. Ruitenbeek-Bart describes professionals experiencing their role in proceedings as paradoxical; whereas professionals are accustomed to standing beside the patient, adversarial proceedings transform patients and healthcare professionals into opposing parties. Whereas

42 Rijnhout (n 37), 16.

43 Akkermans (n 15).

44 B Laarman, 'Just culture en herstelrecht in de afwikkeling van medische schade' (2019) 19 *Tijdschrift voor Vergoeding Personenschade (TVP),* no 3, DOI: 10.5553/TVP/138820662019022003001, 65–83; N. Elbers & I. Becx, *Secundaire victimisatie als probleem: herstelrecht als oplossing?: Een onderzoek naar de reikwijdte van secundaire victimisatie en herstelrecht in het straf-, civiel-en bestuursrecht in Nederland* (Boom juridisch, 2020); I Becx et al. 'Restorative Justice en Therapeutic Jurisprudence in civielrechtelijke verhoudingen: de verbreding van de focus van het letselschadeproces van schadevergoeding naar welzijn en herstel' in J Claessen & A van Hoek (eds.), *Herstelrecht in de ogen van... Reflecties op restorative justice vanuit 27 verschillende perspectieven* (Boom Criminologie, 2022), 361–380; Ruitenbeek-Bart (n 12); Rijnhout (n 37).

45 L Strasburger, 'The litigant-patient: mental health consequences of civil litigation', (1999) *Journal of the American Academy of Psychiatry and the Law Online*, 204, cited in M Tumelty, 'Exploring the emotional burdens and impact of medical negligence litigation on the plaintiff and medical practitioner: insights from Ireland (2021) 41 *Legal Studies*, 633–656 at 639.

46 L Carol, Complexities in understanding the role of compensation-related factors on recovery from whiplash-associated disorders, discussion paper 2, *Spine* (Philia Pa 1976) 2011 (36), 316–321; N Elbers et al., 'Do compensation processes impair mental health? A meta-analysis' (2013) 44 *Injury*, no. 5, DOI: https://doi.org/10.1016/j.injury.2011.11.025, 674–683.

47 I Becx et al., 'Voorspellers van chronische aspecifieke klachten na een verkeersongeluk: Een onderzoek onder schadebehandelaars en belangenbehartigers' (2023) *Tijdschrift voor Vergoeding Personenschade*, no. 2, DOI: https://doi.org/10.5553/TVP/138820662023026002001, 46–47.

48 Ruitenbeek-Bart (n 12), 279–324.

49 Becx et al. (n 47).

50 Ruitenbeek-Bart (n 12), 283–287.

some of the interviewed professionals were glad to leave legal discussions to (hospital) lawyers, others felt their lack of involvement in the proceedings conflicting with their responsibilities towards the patient. In the majority of cases, contact with the patient ceased after a claim for damages, demonstrating the divisive impact of tort law; achieving reconciliation is increasingly difficult once a claim is filed.[51]

5.3 DISCIPLINARY PROCEDURES

Research focusing on the healthcare professional is more common in the field of disciplinary law. A recurring result is the negative impact of disciplinary proceedings on the healthcare professional.[52] In a survey study amongst doctors who received a warning or a reprimand (the lightest of the disciplinary measures), respondents reported feeling attacked, powerless and angry and, consistent with findings from other studies, some respondents felt criminalized, partly due to the fact that the hearing takes place in a court building.[53] Considering the scope of disciplinary law, an impact of the procedure on professional practice might be expected or even – to some extent – desired, and it is true that the most reported changes in professional behaviour due to the disciplinary procedure (discussing improvement measures with colleagues or managers and doing more diagnostic research) are not inherently problematic. Avoiding risky patients might even be, in the words of Anthony Pemberton, a 'matter of once bitten, twice shy'.[54] Perhaps responding doctors were not doing enough diagnostic research beforehand. However, respondents themselves perceive the impact of disciplinary procedures and their consequences as predominantly negative. Recent research shows that receiving a complaint after experiencing a patient safety incident exacerbates the impact of the original incident; in this study stress related disorders were consistently more prevalent in doctors experiencing a formal complaint or a disciplinary complaint.[55]

5.4 EXPERIENCES WITH THE WKKGZ COMPLAINT PROCEDURE

The Wkkgz underwent evaluation in 2020.[56] The researchers concluded that, while significant progress had been made during the informal phase of complaint management, the potential for effective claims management has not yet been fully realized. Another noteworthy issue to mention pertains to the functioning of the dispute committees. As outlined in Section 4.2, patients have the option to submit a complaint to the dispute committee, which can also grant compensation up to €25,000. The dispute committees assess compensation requests in accordance with Dutch liability and compensation law. In practice, the dispute committees also apply procedural rules commonly seen in civil law proceedings, including the requirement that claimants must substantiate their claim and bear the burden of proof.

The dispute committees were originally intended to serve as an informal, cost-effective, and expeditious alternative to the civil procedure. Consequently, patients do not usually engage legal representation and instead submit their disputes through online forms, simply ticking a box to request compensation. As a result, a significant number of these compensation requests are denied due to insufficient substantiation. Furthermore, it appears that underlying issues are no longer being adequately addressed. Patients often perceive a shift in focus of the

51 ibid, 325.

52 F Alhafaji et al., 'Ervaringen van klagers en aangeklaagde artsen met het tuchtrecht' (2009) 13 *Nederlands-Vlaams Tijdschrift voor Mediation en Conflictmanagement*, no. 3, 18–42; L Verhoef et al., 'The disciplined healthcare professional: a qualitative interview study on the impact of the disciplinary process and imposed measures in the Netherlands' (2015) 5 *BMJ Open*, no. 11, DOI: https://doi.org/10.1136/bmjopen-2015-009275; S Witznitzer, *Defensieve dokters? Een juridisch-empirisch onderzoek naar de invloed van het medisch aansprakelijkheidsrecht op het professionele handelen van zorgverleners* (Boom juridisch, 2021).

53 B Laarman et al., 'How do doctors in the Netherlands perceive the impact of disciplinary procedures and disclosure of disciplinary measures on their professional practice, health, and career opportunities? A questionnaire among medical doctors who received a disciplinary measure' (2019) 9 *BMJ Open*, no. 3, DOI: https://doi.org/10.1136/bmjopen-2018-023576.

54 Quotation from a comment by Prof. A Pemberton on my PhD thesis.

55 G Zeeman et al., 'Prolonged mental health sequelae among doctors and nurses involved in patient safety incidents with formal complaints and lawsuits' (2020) 30 *European Journal of Public Health*, no. 4, DOI: https://doi.org/10.1093/eurpub/ckz138, 777–779.

56 R Friele et al., *Evaluatie Wet kwaliteit, klachten en geschillen zorg* (ZonMw, 2021); Ruitenbeek-Bart (n 12), para 7.3.4.2/para. 7.4.4.4 and p 413) also sheds some light on experiences of health care professionals with this procedure.

proceedings from addressing the complaint to addressing the claim. Yet, for many of them, the primary motive for filing a dispute was not the claim itself.[57] In many aspects, the dispute resolution procedure fell short of meeting patients' expectations. These include the extent to which patients believe that the dispute will prevent similar incidents from happening to others, whether the quality of care has improved as a result of the dispute, whether the supposed mistake has been acknowledged, or whether a solution to the problem has been reached.[58]

5.5 WHEN 'PROBLEMS' ARE TURNED INTO 'PROCEDURES'

The reaction to adverse events has been described as complex and 'siloed',[59] which means that procedures following patient safety incidents each address different aspects of the same issue; quality, compensation, or complaints. In order to access the right procedure and play a significant role in proceedings, patients need to be able to change (or distort) their problem, concern or issue to the shape that fits into the (narrow) legal definition of the specific procedure. Receiving an integrated response to a multifaceted problem is rare, because needs and interests that are central to one procedure are not addressed in another procedure and switching between procedures is difficult. It is highly doubtful that many patients are able to navigate their way through this maze of legal procedures, and that many of them actually do so. Organizing the response to patient safety incidents into distinct, professionalized procedures can also lead to a shift of focus on procedural correctness, instead of a focus on the problem at hand,[60] for instance when concerns about the timeliness of procedures became a focus point during the implementation of the Wkkgz.[61] Another example is the position of patients in patient safety research. The Healthcare Inspectorate increasingly values the patients' voice in quality improvement, but the patients' narrative seldom has a place in the research.[62]

5.6 LEGAL PROCEDURES AFTER HARM THROUGH THE LENS OF RESPONSIVE LAW

As we have seen, adversarial legal procedures are burdensome experiences for both patients and healthcare professionals and often seem to fall short in achieving their aims. Tort law revolves around restoration, but compensation procedures are divisive, harmful and neglectful of immaterial needs. Disciplinary procedures should contribute to quality improvement, but are negative experiences that often have an adverse impact on professional practice. The legislature's very intention was for the Wkkgz to address the problems surrounding patient safety incidents (although, as we have seen, the proper implementation still requires some work). By stimulating open disclosure and placing stricter requirements on the management of complaints and claims, the legislature sought to prevent legal conflict where possible by facilitating a response that better meets the needs of patients, and to offer a structure for expedient and informal solutions in those instances where conflicts do arise.[63] It was the explicit purpose of the legislature to decompartmentalize procedures by offering one counter for complaints, whether these constitute requests for compensation or not. In practice, the management of claims in healthcare is still distinctly adversarial.[64] In what follows, I will demonstrate that a traditional, adversarial approach to harm in healthcare might be lawful

57 R Bouwman et al., *Tweede monitor Wkkgz: Stand van zaken patiëntenperspectief en implementatie 'Effectieve en laagdrempelige klachten- en geschillenbehandeling* (Nivel, 2019), 41.

58 Friele et al. (n 56), 161–164.

59 B Laarman, De rol van het recht als er iets mis gaat in de gezondheidszorg: Over openheid in de praktijk, de manco's van het medisch tuchtrecht en een betere afwikkeling van schade, Den Haag, Boom Juridisch 2022, 273; T Gallagher et al., 'Improving Communication and Resolution Following Adverse Events Using a Patient-Created Simulation Exercise' (2016) 51 *Health Services Research*, no. 53, DOI: https://doi.org/10.1111/1475-6773.12601, 2545–2546.

60 D de Kam, *Through the Regulator's Eyes: On the Effects of Making Quality and Safety of Care Inspectable* (Erasmus University Rotterdam, 2020), 120–138.

61 P Dalhuisen & F Lijffijt, 'Eén stap vooruit en twee stappen terug?' (2019) *Tijdschrift Zorg & Recht in Praktijk*, no. 4, 15–18.

62 De Kam (n 60).

63 *Kamerstukken I* 2014/15, 32402, no. 1, 2 (NV).

64 To which can be added that this 'one counter' route only works for claims below € 25,000; in other cases, parties who do not solve the issue in the first Wkkgz phase will have to turn to regular civil (out of court) proceedings.

from an autonomous perspective on law, but is clearly in conflict with the purpose of liability law. More responsive ways of responding to harm can be found in: the principles underlying the Wkkgz; case law concerning the management of claims; and self-regulation, namely the Dutch Code of Conduct Concerning Disclosure and Settlement of Medical Liability (GOMA).[65]

6. A MORE RESPONSIVE WAY OF MANAGING CLAIMS IN HEALTHCARE

6.1 CLAIM MANAGEMENT IN THE WKKGZ, CASE LAW AND SELF-REGULATION

A central notion of the Wkkgz is that healthcare providers are required to 'carefully investigate complaints', but the Wkkgz does not define a 'complaint'. Traditionally, a complaint is understood to be 'every expression of dissatisfaction'. This means that requirements concerning the management of complaints *and* claims are in place whether the patient files a thoroughly substantiated claim for compensation (as is customary in tort law), or some kind of expression of dissatisfaction with a financial component. To be specific, this means that the healthcare provider cannot afford to wait for a patient to come forward with a thoroughly substantiated claim, but should actively approach the patient in order to reach a solution.[66] Careful reading of this provision in the Wkkgz also implies that the healthcare provider should try to resolve problems internally instead of referring the patient to the insurance company. This approach aligns with recommendations set out by Smeehuizen et al., who argue that hospitals which settle claims themselves tend to be more attentive to the broader needs and concerns of patients besides mere compensation. They are also better positioned to meet these needs. Furthermore, hospitals can be expected to be more motivated to arrive at a solution than insurance companies.[67]

A proactive response aligns with the justice perceptions of patients and the weight which they attach to accountability. Referring the patient to the insurance company can be perceived as abandonment, whereas by moving towards the patient, the healthcare provider takes responsibility, if only for the process. A proactive approach also mitigates the risks of a siloed system as described in Section 5.5; cooperation in finding a way forward prevents patients getting lost in the legal system, and it offers the opportunity to deliver tailor-made solutions that cater to the diverse needs of patients, rather than solely concentrating on legal entitlements. Proactively meeting patients' needs can also be a better way of meeting the needs of the healthcare professional(s) involved. Bearing in mind that (legal) escalation tends to exacerbate the impact of patient safety incidents on the healthcare professional as well, it may be wise for the healthcare provider to make efforts to prevent conflicts by cooperation. By meeting patients' needs proactively, an important motivation to complain or claim is taken away, thereby preventing unnecessary harm to both patient and professional.[68]

An interesting development is the publication of the renewed Code of Conduct Concerning Disclosure and Settlement of Medical Liability (GOMA). The GOMA is a well-established code of conduct signed by important organizations in healthcare, such as medical liability insurers and the professional association of doctors, the KNMG, and it is referenced by disciplinary courts and civil courts. For instance, in 2018, the court of appeal for the disciplinary committees (*Centraal Tuchtcollege*, CTG) based their decision to extend the duty of care owed to the patient to include compensation or damages explicitly on the recommendations of the GOMA:

> In this respect, the Regional Disciplinary Board rightly takes the position that communication, personal attention, empathy, caring and correct treatment are of great importance. (...) For this reason in particular, the GOMA's viewpoint is also important that the aftercare to be provided cannot, in practical terms, be limited to the consequences of the incident for the patient's health situation; *this duty of care*

65 De Letselschade Raad, 'Gedragscode Openheid medische incidenten; beter afwikkeling Medische Aansprakelijkheid' <https://deletselschaderaad.nl/wp-content/uploads/GOMA-2022_digitaal.pdf>.

66 The Wkkgz does not address the question of whether there is a right to compensation in a specific case, that question remains within the jurisdiction of tort law. The Wkkgz sets out requirements for the way in which requests for compensation are handled.

67 Smeehuijzen et al. (n 13), 175–179.

68 Vincent et al. 1990.

also extends to the settlement of damages, if there turns out to be an attributable shortcoming on the part of the care provider.

In keeping with the requirements of the Wkkgz, the GOMA advises healthcare providers to identify patients' needs and inquire whether they want or need financial compensation. In situations where harm is evident, such as when a report has been filed with the Healthcare Inspectorate, the GOMA states that it can be reasonable to provide compensation before liability is established or even before a formal claim is filed. So, if harm is evident, patients do not have to 'file a claim' at all. Instead, the harm-causing event triggers the obligation of the healthcare providers, of their own accord, to investigate and (if appropriate) offer compensation. If the healthcare provider is not aware of harm, the patient can be expected to express the need for compensation, but given the duty to investigate in the Wkkgz, the healthcare provider cannot reasonably expect the patient to provide a thoroughly substantiated claim for compensation before taking action.

6.2 THE MICHIGAN MODEL AND COMMUNICATE AND RESOLUTION PROGRAMMES

Although for legal practitioners who were raised in the adversarial paradigm, moving towards the patient instead of away might be rather new, the proposed practices are not really new at all. In several papers Boothman describes the 'Michigan Model', the approach to medical error implemented by the University of Michigan Health System (UMHS) in 2002.[69] The Michigan Model is a comprehensive approach that emphasizes open communication, impartial analysis of what happened, learning from mistakes and supporting patients and staff after something goes wrong. The Michigan Model can help to prevent unnecessary claims and streamline the management of the claims that are filed, but the model is not inherently aimed at claims regulation, moreover, it seeks to establish a culture of accountability.[70]

Variations on the Michigan Model have been adopted throughout the US as Communicate and Resolution Programmes (CRPs).[71] With regard to the response to patients who suffer from medical error, hospitals that implement a CRP commit to:[72]

(1) ensuring transparency with patients around risks and adverse events;
(2) developing and implementing action plans designed to prevent recurrences of adverse events caused by system failure or human error;
(3) supporting the emotional needs of the patient, family, and care team;
(4) proactively and promptly offering financial and nonfinancial resolution to patients when adverse events were caused by unreasonable care;
(5) educating patients or their families about their right to seek legal representation;
(6) working collaboratively with other health care organizations and professional liability insurers;
(7) assessing the program's effectiveness using accepted, validated metrics.

Two elements of CRPs are especially relevant with regard to the problems addressed in this paper. The first element I want to mention here is the integration of patient safety investigation with the assessment of medical liability, meaning that the same investigation is performed, regardless of whether the trigger is an incident report or communication that the patient is intending to sue. If care turned out to be unreasonable, compensation is offered proactively:[73]

69 R Boothman et al., 'A Better Approach To Medical Malpractice Claims? The University of Michigan Experience' (2009) 2 *Journal of Life and Health Sciences*, no. 2, 125–159; R Boothman et al., 'Nurturing a Culture of Patient Safety and Achieving Lower Malpractice Risk Through Disclosure: Lessons Learned and Future Directions' (2012) 28 *Frontiers of Health Services Management*, no. 3, DOI: http://doi.org/10.1097/01974520-201201000-00003, 13–28; W Sage et al., 'Another Medical Malpractice Crisis? Try Something Different' (2020) 324 *JAMA*, no. 14, DOI: https://doi.org/10.1001/jama.2020.16557, 1395–1396; R Boothman, 'Communication and Resolution Programs' in A Agrawal & J Bhatt (eds.), *A Case-based Innovative Playbook for Safer Care* (Springer, 2023), 369–380.

70 T Gallagher et al., 'Making communication and resolution programmes mission critical in healthcare organisations' (2020) 29 *BMJ Quality & Safety*, no. 11, DOI: https://doi.org/10.1136/bmjqs-2020-010855, 875–878.

71 Sage et al. (n 69).

72 Collaborative for accountability and improvement, 'Communication and Resolution Programmes (CRP): What Are They and What Do They Require?' <https://communicationandresolution.org/pix/Collaborative_CRP_Essentials.pdf>.

73 Boothman (n 69), 376.

> This element is a key change from traditional ways of responding to patient harm. In a deny-and-defend culture, instances of patient harm often come to light only after a claim is asserted. And at that point, the key question: "Is this case defensible?" usually translates to: "Can we find an expert to support this defense?" "Is this defensible?" is the wrong question to ask! In a CRP model, the more important questions are, "Did this care meet our expectations?" "Are we proud of this care?" and "Should we defend this care?"

A second element relates to the engagement of patients in proceedings after harm. In CRPs, healthcare providers are supposed to engage patients and their families early on, committing to 'full disclosure' in a later stage, once the investigation is finished. Early engagement offers the opportunity to learn information which only the patient knows, information that in adversarial systems is only gleaned after a claim is filed. Proactive claim management, as proposed in Section 6.1, is not 'just' a way of managing claims, it can also be beneficial in terms of patient safety.

The implementation of CRPs varies widely and, as a result, there are concerns about CRPs reaching their full potential.[74] Some hospitals remain reluctant to combine transparency with proactive offers of compensation.[75] Nevertheless, there is sufficient reason to be optimistic about CRPs. Comprehensive CRPs appear to have a positive effect on patient and healthcare professionals experiences, patient safety, and potentially even diminish defence and liability costs.[76] The positive experiences with CRPs demonstrate that a proactive approach is not only feasible but is already happening and can be highly effective.[77] The Michigan Model, CRPs, their success factors and factors impeding their success have been studied and published extensively.

6.3 RESTORATIVE JUSTICE

Engaging patients in shaping the response to patient safety incidents warrants a brief discussion of another development in healthcare: the emergent focus on 'restorative justice'.[78] Restorative justice is 'a process whereby all the parties with a stake in a particular offense come together to resolve collectively how to deal with the aftermath of the offense and its implications for the future'.[79] The aim of restorative justice is to heal the hurt that was caused by determining the needs of the involved parties in finding a way forward.[80] A restorative approach addresses the human and relational consequences of incidents by facilitating active participation, respectful dialogue, truthfulness, accountability, empowerment and equal concern for all those involved.[81] Involving the active participation of all the affected parties offers space for the narrative and the needs of the patient *and* the healthcare professional, whom, as we have seen, can be second victim. In this way, restorative justice moves beyond the win-lose perspective of adversarial law, broadening the scope of what a just solution in a given situation can be and how it should be achieved.

In the Netherlands, restorative practices are most common in the field of criminal law. Customary restorative practices are facilitated meetings between parties such as offender-victim mediation, conferencing and circles. In restorative conferences the community of stakeholders is involved in reaching and implementing an agreement. The 'community' can be

74 T Gallagher et al., 'Can Communication-And-Resolution Programs Achieve Their Potential? Five Key Questions' (2018) 37 *Health Affairs*, no. 11, DOI: http://doi.org/10.1377/hlthaff.2018.0727, 1845–1852; Gallagher et al. (n 70).

75 J Moore et al., 'Patients' Experience With Communication-and-Resolution Programs After Medical Injury' (2017) 177 *JAMA Internal Medicine*, no. 11, DOI: https://doi.org/10.1001/jamainternmed.2017.4002, 1595–1603.

76 Gallagher et al. (n 70).

77 M Mello et al., 'Outcomes In Two Massachusetts Hospital Systems Give Reason For Optimism About Communication-And-Resolution Programs' (2017) 36 *Health Affairs*, no. 10, DOI: https://doi.org/10.1377/hlthaff.2017.0320, 1795–1803.

78 J Wailling et al., 'Humanizing harm: Using a restorative approach to heal and learn from adverse events' (2022) 25 *Health Expectations*, no. 4, DOI: 10.1111/hex.13478, 1192–1199.

79 T Marshall, *Restorative Justice: An overview* (Home Office, 1999).

80 Zehr (n 21).

81 Wailling (n 78), 1195.

family, neighbours, school teachers, etc.[82] A restorative conference is facilitated by a neutral third party. Circles resemble restorative conferences, where participants sit in a circle to promote mutual respect, and an object indicating that one has the word is passed around to ensure that everyone has an opportunity to speak. However, a restorative approach need not be restricted to either of these examples. What matters is that the right people engage in dialogue and collectively resolve how to move forward.

In New Zealand, the Ministry of Health employed a restorative approach to address the needs of patients harmed by the use of surgical mesh.[83] The project consisted of three phases that centred around giving personal accounts in listening circles, individual meetings or an online database (phase 1); bringing together responsible parties to learn the outcomes of phase 1 and determining action for repair (phase 2); and reporting and evaluating (phase 3). The process was co-designed and, throughout the process, changes could be made to cater to the emergent needs of those involved. Consumers and responsible parties favoured the restorative approach over the adversarial approach that preceded the project. Whereas the first phase in particular was valued by most patients as a way to be heard and supported, patients wanted a quicker translation from outcomes into action (in phase 2). Responsible parties valued the unique perspective of patients' human experiences, as contrasted to a traditional focus on 'causation and evidence gathering'. Most patients, however, were unsure whether agencies would perform better in the future and if their individual situation would change.[84] These results offer a valuable reminder that patients not only want to be heard; acting upon their personal accounts is vital for success.

7. CONCLUSION

Looking at the way harm in healthcare is handled through a responsive lens reveals the paradoxical role of law in this context. Legal procedures such as complaints, liability, and disciplinary law should assist aggrieved patients in exercising their rights when something goes wrong. However, as soon as a problem transforms into a legal issue, the adversarial character of procedures makes both patients and healthcare professionals suffer as a consequence. The law is considered responsive when it takes into account socio-legal insights regarding user needs, the situation, and legal consequences, and integrates these insights with the underlying restorative goals of the legal system in order to adapt. An analysis of Dutch complaint law, self-regulation, and case law reveals that an adversarial response conflicts with the intentions of the legislature and prevailing views in the field regarding what constitutes a just response to harm in healthcare. Guidance for proactive responses to harm can be found in the practices of Clinical Risk Programs (CRPs) and the principles of restorative justice. I have argued from within the legal system, a system deeply entrenched in adversarial practices and rituals. It is possible that eliminating the detrimental impact of the adversarial system requires us to explore new approaches for compensating for medical harm, beyond the scope of tort law. This will be the subject of future research.

COMPETING INTERESTS

The author has no competing interests to declare.

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82 Zehr (n 21), 38; P McCold & B Wachtel, 'Community is not a place. A new look at community justice initiatives' (1998) 1 *Contemporary Justice Review*, no. 1, 71–85.

83 J Wailing et al., *Hearing and responding to the stories of survivors of surgical mesh: Ngā kōrero a ngā mārehu – he urupare.* (Ministry of Health, 2019).

84 J Wailling et al., *Healing after harm: An evaluation of a restorative approach for addressing harm from surgical mesh. Kia ora te tangata: He arotakenga i te whakahaumanu* (Ministry of Health, 2020).

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