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Thesis

"Is the current effect of Dutch disciplinary law sanctions for doctors, both medical specialist and residents, the most desirable?"

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Preface

This thesis marks the end of my life as a student. For me, writing about this subject is a perfect ending, because it enables me to combine my medical background with my newly obtained HEPL knowledge. During my time in medical school disciplinary law was a recurrent theme among the supervising attendings. I never heard them speak positively about disciplinary law and that sparked my interest about this subject.

During my research I found out that the largest part of medical doctors is not a fan of disciplinary law in its current form. The goal of disciplinary law, however, is a very noble one. This discrepancy was very interesting to see. The effects of the current disciplinary law system can be far reaching for both medical doctors and patients. Eventually a large part of society can be affected by these consequences, which has made it a very interesting subject to research.

The entire process of writing this thesis was very educational, because it enabled me to combine different skills that I gained during my seven years as a student. I came across some challenging parts, such as combining both a qualitative and a quantitative part, but in the end I feel like it contributed to the quality of this study.

I want to thank all the medical doctors who wanted to participate and gave feedback on my study. Without them this study would not have the same impact. I would also like to thank my fellow students: Savina Booi and Julian Ghobrial for their constructive feedback and the good times we had during this master. Besides them, I would like to thank my supervisor prof.dr.mr. Buijsen, for his helpful and clear feedback.
To conclude, I would like to thank my girlfriend for her critical review of my thesis and all her patience during the writing process!

I hope you will enjoy reading my thesis,

Elijah

Summary

Background

When you're not satisfied with the care provided by your medical doctor, it is possible to file a complaint. This complaint will go into what we call the "medical disciplinary law system". The goal of this system is to increase the quality of care and to protect the patients from unskilled and careless care givers. In theory this is a very humble goal to strive for, but there are more and more complaints rising on the side of medical doctors that the medical disciplinary law system fails to achieve its objective. Medical doctors are claiming that they are the "second victim" of this system.

Besides the effects of disciplinary law procedures medical doctors are also complaining about the disclosure of the ruling by the disciplinary committee. Taking the previous into account, this study aims to answer the following question: "Is the current effect of Dutch disciplinary law sanctions for doctors, both medical specialist and residents, the most desirable?"

Methods

The study started with an extensive literature research part, where the emphasis was laid on how the medical disciplinary law system is organized in the Netherlands. The search was conducted in several databases with the primary focus on PubMed and Google (scholar). The information gained from this literature research was used to compile a questionnaire. The questionnaire was in Dutch and is spread among several medical doctors. The questionnaire was made with the Qualtrics ^{XM} software from the Erasmus University of Rotterdam. The main function of the questionnaire was to gather quantifiable data to better compare different outcomes. The questionnaire had both questions which were "quantifiable" and more open-ended questions. The following inclusion criteria were defined: The respondents need to work (or have worked) as medical doctors in the Netherlands and they need to be able to read and understand Dutch, due to the language of the questionnaire. Following the opinion of the author, there was no need to obtain written consent or permission from the ethics board of the hospitals and/or Erasmus University Rotterdam.

Results

There were 269 respondents, with ages ranging from 21 to 61 years old. The group of respondents existed of Residents in Training (18.2%), Residents not in Training (16.7%), Attendings (40.5%), PhD candidates (12.3%) and others (12.3%). 52% of the group received a complaint during their career. 19.3% of these complaints ended in open court. Medical doctors often do not agree with their ruling. In the reprimand group 0% agreed with their ruling, in the warning group 16.7% agreed and from the acquitted medical doctors 88.9% agreed with their ruling. The group also scored 3 out of 5 (0 is to improve quality of care and 5 is to punish the medical doctor) regarding how they look at the goal of the disciplinary law system. Over 30% of medical doctors changed their way of treating patients after a disciplinary procedure and this often for the worse. 53% of the respondents wants to abolish the disclosure of at least one ruling.

Discussion

The most important findings in this study can be divided into two groups, namely the current view on medical disciplinary law and the disclosure of the rulings.

The current view on medical disciplinary law can be called skeptical and/or negative. The view among the respondents is that the disciplinary law leans more towards the side of punishing instead of improving the quality of patient care. The consensus among the respondents is that they think that it is more desirable and more necessary for patient safety to disclose more severe rulings. A minority of the respondents just thought that the disclosure of rulings was in place to protect patients. So, the overall conclusion is that the current effect of medical disciplinary law is not in line with the goal of increasing the quality of care and to protect the patients from unskilled and careless care givers, but mostly creates an environment where medical doctors are afraid to be indicted, which can lead to worse patient outcomes.

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Chapter 1 - The introduction –

Normally medicine and law do not collide, but in the case of medical disciplinary law these two worlds merge. Recent research showed that disciplinary law procedures can be very impactful for both the doctor and the plaintiff (most often the patient) (Alhafaji, Frederiks and Legemaate, 2009).
During these disciplinary law procedures, there are many emotions on both side of the case, varying from shame to the feeling of injustice. One of the current major claims from medical doctors is that they feel criminalized by the current disciplinary law procedures. The NIVEL *(Dutch Institute for health care/ Nederlands Instituut voor gezondheidszorg)* published several research reports that support the abovementioned claim (Roland, 2019). The claim that these procedures are emotionally challenging is confirmed by the Dutch Federation of doctors "KNMG" *(Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst)* (KNMG, 2021).

The original purpose of disciplinary law in the Netherlands for medical professionals is as follows:

"The purpose of medical disciplinary law is to ensure and to promote the quality of the individual healthcare and to protect the patients against incompetence and carelessness of the caretaker" (Centraal Tuchtcollege voor de Gezondheidszorg, 2017).

The pursuit to protect patients and to give them the highest standard of care which we are used to in the Netherlands are both important, but one can argue if this is the main result of the current disciplinary law procedures.

The Dutch disciplinary law system was characterized by a major emphasis on "informal" mediation and not in ways to punish medical doctors. During the last decade there has been a tendency to punish more and harder in medical disciplinary law (Pinto-Sietsma, 2020). One can argue that these disciplinary court rulings are experienced as punishments by several medical doctors (Dronkers, 2020).

The importance of this thesis rests on the possible effects of these changes in the perception that medical doctors have on disciplinary law. One question that arises is if this shift in perception can lead to a change in style of practicing medicine among medical doctors, both disciplined and not disciplined, to prevent themselves from being indicted. The patient care does not benefit from this shift in approach (Vento, 2018).

The abovementioned shows the importance of researching this subject. The focus of this study is to clarify and explain the current effects of disciplinary law on health care professionals in the Netherlands and if these effects are still in line with the original goals of

disciplinary law in this specialty. Besides that, it is also relevant to understand the outcome of this study for reasons of social interest. Our society will benefit from medical doctors who can function freely and keep the quality-of-care high. The cost of health care will be manageable and unnecessary costs, due to - for example - a defensive style with a lot of extra diagnostic tests, will be avoided. If there is a culture of fear among medical doctors, it will eventually have effect on all of us living in the Netherlands.
Besides the social relevance of this question, this topic also has scientific relevance. The subject of this study is an underinvestigated field in the Netherlands. There are several studies that touch upon this subject but none of these studies have the same scope as this thesis.

The research question which unfolds from this objective is as follows:

"Is the current effect of Dutch disciplinary law sanctions for doctors, both medical specialist and residents, the most desirable?"

The secondary questions that need to be answered in order to answer the main question are as follows:

1. How is medical disciplinary law organized in the Netherlands?
2. What is the original goal of the Dutch medical disciplinary law?
3. What is the current effect of disciplinary law rulings on Dutch medical doctors (both medical specialist and residents)?
4. How could the current disciplinary law system be improved according to Dutch medical doctors?
5. How do the disciplined medical doctors think about the disclosure of disciplinary measures?

In the following part of the thesis these questions will be answered.

- In chapter 2 a theoretical base will be made based on the extensive literature research on this topic. Besides that, there will be given a clear overview on the way the medical disciplinary law system currently works.
- In chapter 3 there will be a focus on the methods used to write this thesis. Besides the literature research, questionnaires will be used with both open and closed questions.
- In chapter 4 the results of the abovementioned effort will be presented in a clear and concise manner.
- In chapter 5 an interpretation of the results will be made and points of improvement of this research will be addressed. Lastly, the main question will be answered.

Chapter 2 - Background –

This chapter will give an overview of the current literature on medical disciplinary law in the Netherlands and the view medical doctors have regarding this topic.

2.1 Existing literature about the Dutch medical disciplinary Law

(KNMG, 2021; Tuchtcolleges voor de gezondheidszorg, 2021; Rechtspraak, date unknown, retrieved may 2021)

In the Netherlands medical doctors can be "convicted" in three ways, by Criminal Law, Civil Law and Disciplinary Law. In this section the medical disciplinary law will be explained.

There are also other ways on how patients can express their complaints about their treating medical doctor, like the several complaints committees of - for example - their own hospital, but this is outside the scope of this thesis.

Every year there are approximately 1600 disciplinary complaints filed in the Netherlands for personnel working in the medical field, mostly for medical doctors (69%) (KNMG, 2021). The medical disciplinary law is a special kind of law. In this kind of law, the disciplinary committee assesses if a medical doctor or another BIG-registered (*Beroepen in de Individuele Gezondheidszorg/ Professions in individual medical care)* medical professional has worked according to the professional guidelines of their profession (KNMG, 2021; CIBG, unkown, retrieved may 2021). The goal of this disciplinary procedure is to increase the quality of care and to protect the patients from unskilled and careless care givers.
There are several groups that can file a complaint with the disciplinary board:

- ⇒ Patients;
- ⇒ The next of kin of patients;
- ⇒ Parents of patients (if age < 16 y.o.);
- ⇒ The Health and Youth care Inspectorate (*Inspectie gezondheidszorg en jeugd/IGJ*);
- ⇒ Colleagues;
- ⇒ Clients of the medical doctor (e.g., a fellow medical doctor who gave you the assignment);
- ⇒ The employer;
- ⇒ And any other person who thinks that the work of the medical doctor harms him or her (KNMG, 2021; Tuchtcolleges voor de gezondheidszorg, 2021).

The complaints are allowed for situations dating back up to ten years and it can be about anything a medical doctor did or did not do (Tuchtcolleges voor de gezondheidszorg, 2021).

The Health and Youth care Inspectorate only makes claims in three situations (Leistikow, 2019):

1. To correct an individual health care provider or to protect a patient against substandard care;
2. To bring the correct course of action widely under the attention of healthcare providers;
3. To renew or improve a standard because the judgment of the disciplinary judge gives a (further) interpretation to the applicable legislation and regulations.

The Health and Youth care Inspectorate focusses mostly on the broader situation and are less focused on individual cases.
12% of the complaints against medical doctors are assessed as well-grounded and are taken into deliberation. Not all medical doctors who received a formal complaint needed to stand trial in front of a disciplinary committee. All possible options, after a complaint is assessed as well-grounded, will be discussed in the following paragraphs.

This disciplinary committee consists out of five members with different backgrounds. Normally the committee consists out of five people, which is composed as follows: two lawyers, from which the chairman is chosen and three medical doctors. Preferably the medical doctors in this committee have the same specialty as the indicted doctor, because this will enable them to understand the nuance of this specialty and have the expertise to judge the care the indicted doctor has given. There are five different regional disciplinary committees and one nationwide committee. The nationwide committee is focused on the appeal cases from the regional committees. The indicted medical doctor is always allowed to appeal the case just like the Health and Youth care Inspectorate (KNMG, 2021; Tuchtcolleges voor de gezondheidszorg, 2021). The other possible plaintiffs are only allowed to go into appeal if the complaint was ruled inadmissible or if the complaint is (partly) dismissed (KNMG, 2021; Tuchtcolleges voor de gezondheidszorg, 2021).

In the next paragraphs a step-by-step description will be given on the procedure to make a formal complaint according to the guidelines of the disciplinary committee of medical care and how the procedure looks like after the complaint is filed (Tuchtcolleges van de gezondheidszorg, 2021).

1. The first step to file a complaint is to write a letter in Dutch to the regional disciplinary committee where the medical doctor lives. The plaintiff can add possible additional “evidence” to this letter. The plaintiff needs to pay 50 euros court fee, which will be reimbursed if the complaint is founded well-grounded. Only when the court fee is paid, the procedure can start. The plaintiff is allowed to withdraw his or her complaint at any moment during this process.

2. After this the medical doctor is notified that a complaint has been made against him/her. Legal counsel is allowed for both parties, but is not compulsory. The medical doctor is allowed to send pieces of possible evidence in his/her defense to the disciplinary committee.

   After the submission of the complaint, there are several phases in the procedure.

3. The procedure starts with the preliminary investigation (*Het vooronderzoek).* During this investigation there are several moments where both the plaintiff and the indicted can respond to the complaint. First in writing and after that orally to the secretary of the committee. If a situation occurs where it is beneficiary for both parties to meet in real life, then this will be arranged. The secretary can decide if it is possible to resolve the complaints among the two parties. If that is possible the complaint can be withdrawn by the plaintiff. Even if the complaint is withdrawn, it is possible to go through with the procedure if the medical doctor wants to or if the committee thinks that it is common interest to bring this complaint to court. The new plaintiff in this situation will be the Health and Youth Care Inspectorate. If the preliminary investigation is finished the secretary has three options, namely, to refer the complaint for a final judgement to the chairman of the committee, to the council chamber (*raadkamer*) of the committee or to open court.

4. The council chamber can be made up of three or five members. The chairman is always a lawyer and there need to be at least two members (three if there are five members in total) with the same specialty as the indicted doctor. The fifth member needs to be a lawyer too. Both the plaintiff and the indicted medical doctor are not present when the case is discussed. The committee makes their judgement based on the earlier mentioned documents. The committee can make four different rulings in the council chamber:
    1. The complaint is inadmissible. This means the procedure will not continue. The reason that a complaint is inadmissible, can be that it is not clear who the indicted medical doctor is, that it is not clear what the content of the complaint is or that the medical professional is not BIG registered.
    2. The complaint is baseless. The medical doctor worked according to the guidelines and did not do anything wrong.
    3. The complaint is dismissed because there is not enough importance to it.
    4. The case needs to be treated in open court.

5. If the procedure proceeds to open court, both parties are invited to court. Normally the court is open for everybody who is interested including the press, but in some situations the court can decide to proceed with the case behind closed doors. Up to two weeks before trial new documents can be brought up by both parties and up to

one week before trial witnesses and experts can be consulted. During trial both parties are allowed to tell their side of the story and the committee will ask them relevant questions. Within two months after the court date both parties will receive the judgement of the committee with their argumentation. The Health and Youth Care Inspectorate will receive a copy of the ruling.

6. If a complaint is found well-grounded, a disciplinary committee can make several rulings and determine that some of the costs, which are made for trial on the side of the plaintiff are reimbursed. The disciplinary committee cannot impose that the medical doctor needs to pay financial compensations, this is only possible in civil court and in the independent disputes committee (Tuchtcolleges voor de gezondheidszorg, 2021). The different rulings are as follows:
    1. Warning *(waarschuwing);*
    2. Reprimand *(berisping);*
    3. Fine (*geldboete*) with a maximum of 4500 euros, to be paid to the Dutch state;
    4. (Conditional) Suspension *((Voorwaardelijke) schorsing)* of the BIG registration with a maximum of one year;
    5. (Partial) Interdiction *((Gedeeltelijke) ontzegging)* to practice their profession;
    6. (Conditional) Strike out *((Voorwaardelijke) doorhaling)* from the BIG register;
    7. Special conditions to practice medicine again;
    8. Rejection of the complaint;
    9. Well-grounded without any measure (possible with very minor offenses).

A very important and possible controversial (according to some medical doctors) next step is the disclosure of some rulings in (regional)newspapers and online. The following three rulings will be published with the name and city of residence of the “convicted” medical doctor, (conditional) suspension, (partial) interdiction and a (conditional) strike out. Before 2018 also reprimands and fines were published with the name of the medical doctor, but since the legislative change that has been made in 2018 it only gets published if the committee thinks that it is beneficial for society (de RG Bruijn-Wezeman, 2018).
Besides the disclosure of rulings which includes the name of the medical doctor, it is also possible to disclose the judgments anonymously in medical journals or trade magazines. The idea of anonymously publication is that it could be educational for other medical doctors to read the cases.

The initial process from being informed about a complaint until the judgement can take up to seven months. If there is a possible appeal it can take up to sixteen months before everything is finished (KNMG, 2021). The procedure for an appeal is mostly similar to the initial procedure, but the difference is that the nationwide disciplinary committee has three lawyers instead of two and out of this follows that there are two instead of three medical

doctors (Tuchtcollege gezondheidszorg, unknown). There is no possibility to appeal after this judgement of the nationwide committee.

2.2 Existing literature about the relationship medical doctors have with disciplinary law

A lot has been written in scientific and in popular media about the relationship between medical doctors and "their" disciplinary law. In this section an overview will be given on the current state of this relationship.
One remark that is made often, even in the popular media, is that the disciplinary law is criminalizing medical doctors (RTL Nieuws, 2017; Friele 2018). This specific news article focusses on disclosure of the earlier mentioned disciplinary law rulings in (local) newspapers and online. This open way of blaming and shaming is very harmful according to this RTL Nieuws article and 10% of the medical doctors whose ruling got published, stopped working (RTL Nieuws, 2017). Transparency in the medical world is very important, but according to René Héman (chairman KNMG) a ruling of a disciplinary committee is not a proper way to assess the overall quality of the indicted medical doctor and thus not a good method to inform patients about their possible medical doctor (RTL Nieuws, 2017). René Héman also mentions that this way of publicly shaming medical professionals can lead to a more defensive style of practicing medicine for reasons of self-protection, which is not a good development for the quality of patient care (RTL Nieuws, 2017).

The NIVEL institute also published the findings of their research in 2019 on this topic. They state that the effects of the disciplinary procedure can be very harmful, because the medical doctors felt criminalized, attacked, angry and helpless (Roland, 2019) These negative effects are only amplified due to the fact that the rulings are made public (Roland, 2019). There are also situations where the disciplinary procedure has positive effects on the way the medical doctors work, e.g., if the ruling leads to better communication and better preparation on the side of the medical doctor (Roland, 2019). However, most often this is not the case and medical doctors only experience negative effects in the way they practice medicine (Roland, 2019). This can lead to "defensive medicine" which shows in both over- and undertreatment to avoid (judicial) consequences, avoiding of difficult or complicated patients and earlier conceding of the wishes of the patients (Roland, 2019). This is in line with international studies like that of Gadjradj, Ghobrial and Harhangi where (mostly American) medical neurosurgical doctors adapted a more defensive style of practicing medicine (17.8%), referred complex patients (58.7%) and even thought about leaving the medical field after malpractice lawsuits (36.5%) (Gadjradj, 2020).

The more impact a ruling has, the more there is a negative change in practicing medicine (Roland, 2019). Next to these consequences which may lead to a lower standard of care, there are also consequences regarding the career opportunities and financial gains of medical doctors (Roland, 2019). The loss of patients occurs in 30% of the cases where a medical doctor receives a *reprimand* and in 10% of the cases where a medical doctor "just"

received a *warning.* Besides that, there is also a loss in career opportunities (reprimand 30% vs warning 8%) which is noticeable when doctors need to apply for a new job or want to have a job within the professional association (Roland, 2019). The last negative effect that is described by Roland is that insurance companies could interrogate the medical doctors about their rulings (Roland, 2019).

Friele et al found that the loss of patients could be explained as follows, he stated that almost 75% of patients think that it is important to publish the rulings and 15% of the patients are looking for information about their (future) medical doctor on the internet before their first consultation (Friele, 2018). If patients know that their general practitioner (GP) received a reprimand or a fine their reactions are divergent, namely 25% would not change anything in the relationship, another 25% said that they would discuss the ruling with the GP, the third group of almost 25% would do more research on the actions of the GP and they would be more regardful on their behavior and just 10% said that they would change their GP (Friele, 2018). One could argue that these numbers of patients who would leave their medical doctor and/or discuss the rulings with their medical doctor could be higher if there is no (long-lasting) relationship with the medical doctor, e.g. before the first consultation or with short hospital visits (Friele, 2018).

There is also a considerable part of the convicted doctors who are not content with the final judgement. There is a clear difference between medical doctors who received a reprimand or fine versus doctors who received a warning, respectively 21% versus 6% (Friele, 2018). Laarman et al. reported similar numbers in their study with 22.6% versus 4.4% (p=0.02), respectively reprimand versus waring (Laarman, 2019). This could be an issue according to Laarman, because if medical doctors do not agree with the rulings, the chances of them learning from the ruling is lower and this could result in a lower quality of care, which is not in line with the main goal of disciplinary law (Laarman, 2019).

Friele et al. also stated that the burdening on the families of the convicted medical doctors is extremely high, due to the procedure and the publishing of the rulings (Friele, 2018).

Another problem with disciplinary law according to Friele et al. is that more than 50% of the patients wants to punish the indicted medical doctor, but punishing is never the goal of the disciplinary law (Friele, 2018; Friele 2012).
The indicted doctors are aware and affected negatively by the above-mentioned intention of patients and together with the publishing of the rulings they are experiencing the disciplinary procedures as punishment (Friele, 2018). Because of this, one of the more important characteristics of medical disciplinary law, namely the fact that medical doctors need to learn from their mistakes, seems to get lost and the punishment aspect seems to have become more important (Friele, 2018). A safe environment is important if you want to learn from your mistakes, but this tendency creates an environment where medical doctors

are afraid to make mistakes, because they have felt criminalized, attacked, and helpless (Friele, 2018).

Laarman et. al also described serious effects among medical doctors in the Netherlands who received a reprimand or a warning between 2012 and 2016. There were significant differences between these two groups, medical doctors who received a reprimand gave the feeling of being under attack an 8.2/10 and the warning group scored it lower at 6.8/10 (Laarman, 2019). Also, the feelings of anger, being criminalized and feeling helpless were present in this study (Laarman, 2019). There was also a decline in perceived health shortly after the disciplinary procedure, but this effect mostly diminished over time and the differences between the two groups were not significant (Laarman, 2019). More than 70% of medical doctors who received a reprimand experienced only a negative effect of the disciplinary procedure, the warning group had a significantly lower percentage at 40.8%, just 4.4% (reprimand) and 8.5% (warning) of medical doctors perceived only positive effects after the procedure (Laarman, 2019). Reports of depressive complaints, anxiety disorders or indications of burnout are also present among the group of indicted medical doctors (Laarman, 2019).

Relevant changes in practicing medicine perceived in the study of Laarman are that the medical doctors are avoiding more complex patients, avoiding patients with complaints similar to the complaints of the patients who filed the complaint and seeing each new patient as a potential new plaintiff (Laarman, 2019).
Another fact that did not come to light in the previous mentioned studies is that when a medical doctor is convicted, colleagues refer less patients to them and do not want to work with them (Laarman, 2019).

The idea of a second victim, namely the indicted medical doctors is only growing looking at these studies.

Chapter 3 – Methods -

In this chapter a clear overview of the research processes will be provided. The reasons why specific choices are made, will be clarified and substantiated throughout. At the end of this chapter the following three terms will be discussed: validity, reliability, and generalizability.

To answer the earlier mentioned research question, both qualitative and quantitative methods have been used. The qualitative part is more relevant in order to get a better understanding, and explanation of the theory and the quantitative part is better for testing the hypothesis (Streefkerk, 2019). The study started with an extensive literature research part, where the emphasis laid on how the medical disciplinary law system is organized in the Netherlands. The search was conducted in several databases with the primary focus on PubMed and Google (scholar). The search strategy that was used is added in the appendices (2). After this initial search, the articles were assessed on whether they matched the scope of this study. First the titles were assessed, after the initial shifting the abstracts were read and after this final shift the complete articles were assessed. The same cycle repeated itself for the second search into the relationship between the researched group and medical disciplinary law.
Both international and Dutch studies were relevant for this part. The Dutch articles were relevant, because of the very specific research question regarding the situation in the Netherlands with Dutch medical doctors. The international articles helped broaden the scope and those articles created a better understanding of the feelings medical doctors endure in situations where they get accused of wrongdoing. The most important thing regarding the international literature, was that it was necessary to extrapolate it to the Dutch situation before drawing any conclusions.

The information gained from this literature research was used to compile a questionnaire. The questionnaire was in Dutch and is added both as original (1A) and as a translation (1B) to the appendix. The questionnaire was made with the Qualtrics ^{XM} software from the Erasmus University of Rotterdam. The main function of the questionnaire was to gather data and information to answer secondary question three, four and five. The goal was to gather quantifiable data to better compare the different outcomes. The questionnaire had both questions which were “quantifiable” and more open-ended questions. It was not necessary to conduct a “power-analysis” beforehand, because there was no comparison of effect size in this study done. A respondent’s rate between 75 and 100 respondents seemed satisfying also looking at the group size of previous comparable studies.

In the period of May 4th till May 27th the questionnaire was open for respondents. The respondents were reached in several ways. Firstly, the questionnaire was “promoted” on social media channels of the author (Facebook, Instagram, WhatsApp and LinkedIn (both direct messages to 200+ medical doctors and a “wall post”)) and people in his network

shared this call-up, secondly the call-up for respondents was emailed to all the medical doctors (both resident (in- and not in training) of the Leiden University Medical Centre (LUMC), GGD Hollands midden, Global Bariatric Research Collaborative (GBRC) and (a part of the medical doctors) of the Haaglanden Medical Centre (HMC), thirdly two doctor federations (VVAK, *vereniging vertrouwensartsen Kindermishandeling en huiselijk geweld*, and the NVVC, *Nederlandse vereniging voor* Cardiologie) shared the call-up in their networks. These groups were specifically chosen for the reason that there is a distribution of all kinds of medical doctors regarding age, gender, specialization, resident/attending and working in the hospital, both in an academic (LUMC) setting and in the setting of a large peripheral hospital (HMC), and not working in the hospital with the GGD and the VVAK.

The following inclusion criteria were defined: The respondents need to work (or have worked) as medical doctors in the Netherlands and they need to be able to read and understand Dutch, due to the language of the questionnaire. Experience with disciplinary law was no obligation, because otherwise you will leave out the opinion of most medical doctors, while just a small percentage of medical doctors have been in contact with disciplinary law.
The choice to incorporate all different medical specialties in The Netherlands instead of only hospital doctors was made because of two different reasons. The first reason is that a large share of medical doctors works outside of the hospital (CBS, 2021; Deuning, 2020). Therefore, it is important to incorporate their experiences with the medical disciplinary law system into this study, in order to have a thorough understanding of the view of medical doctors on this system. The second reason is that the response rate is higher when you invite more medical doctors to fill-in the questionnaire. In this research there is also no distinction between residents and attendings, because both could encounter disciplinary law and, in most literature, there is no distinction made between these groups.
The results of the questionnaire were processed anonymously, but respondents had the option to leave their contact information. If necessary, the author could contact these specific respondents for deepening questions regarding their given answers. There were no in-depth interviews conducted for this research. The analysis is done in IBM SPSS statistics version 27. The choice for SPSS instead of Microsoft Excel is made due to the nature and complexity of these results.

There was no need for contacting external professionals who could be contacted for further questions regarding their field of expertise.

Looking at this research one could conclude several things regarding the set-up of this study. Firstly, the reliability will be discussed and after that the validity, generalizability, and the effect of data triangulation, in this order (Middleton, 2019).
Some parts of this study are reliable because the questionnaire is standardized and there were no differences in the way questions were asked. This is not the case if there were

asked deepening questions after the initial questionnaire. Regarding the questionnaire there is no difference in the way the questions were asked, but there could be a difference in the way the questions were answered every time, because there is no way to influence this. The study would receive a low-medium reliability score.

The methods which are chosen to answer the research question are according to the author the most appropriate ways to retrieve the answers you need, due to the explanatory nature of the study. The claim to be 100% objective is not possible to make, so a perfect validity is impossible to accomplish due to the nature of this research. There are no completely objective ways to answer this research question in the opinion of the author. The validity is scored by the author as medium to high.

The question is if these results, conclusions, and advice are usable for a broader group than the researched group. The answer to this question is probably yes due to the nature of the work of medical doctors in the Netherlands and because the disciplinary law is the same nationwide. Doctors in the Netherlands work according to guidelines and these guidelines are the same among all doctors in the Netherlands. One could argue that there is a difference between the more urban medical doctors and the more rural medical doctors, and that this questionnaire is mostly filled-in by urban medical doctors from the “Randstad”, but these claims are beyond the scope of this article. The author has the assumption that these results, conclusions, and advice could be used nation-wide.

To make the eventual recommendations and conclusions stronger, data triangulation is used (Benders, 2020). The data is retrieved with a desktop literature search and a more empirical questionnaire. These two methods allow you to answer the main research question properly. The goals of triangulation are to get a better understanding of the problems you are facing, to get a more detailed and objective view of the situation and it could also increase the validity.
In an ideal situation more forms of triangulation would be used, but methodical, theoretical and research triangulation were not suitable for this thesis.
The ethical considerations in this study have not predominated. At the start of the questionnaire all medical doctors who participated in this research, could have read that all the data is processed anonymously and that they could ask for more information by email. The author was only aware of the identity of the respondents when they wrote down their contact details. This was completely voluntary, and the questionnaire could be completed without filling in these contact details. These contact details will be deleted after the thesis is approved by the thesis committee, not later than the 31st of August 2021. There was no need to obtain written consent or permission from the ethics board of the hospitals and/or Erasmus University Rotterdam, in the opinion of the author.
This consideration is made because this study did not include patients or other vulnerable groups. Besides that, all the respondents were well informed and there was a possibility to

ask questions by email. There is no explicit permission needed to use this data, besides of the (implicit) description of the questionnaire. This was sufficient to proceed, without further consultation of the earlier mentioned ethics boards. Both the supervisor and the reading committee did not foresee any ethical objections. The study protocol is in line with the WMA declaration of Helsinki – ethical principles for medical research involving human subjects (The World Medical Association, 1964).

Chapter 4 – Results -

In this section a clear and concise representation of the results will be given. 269 respondents completed the questionnaire. In table 1 a description is given of the main characteristics of the respondents.

Table 1 Respondent characteristics

Number of respondents	269 (100%)		
Medical doctor	**Yes**	**No**	
	269 (100%)	0 (0%)	
Sex	**Male**	**Female**	**Different**
	109 (±40.5%)	158 (±58.7%)	2 (±0.7%)
Age group	**21-25 Y/o**	**26-30 Y/o**	**31-35 Y/0**
	17 (±6.3%)	67 (±24.9%)	50 (±18.6%)
	36-40 Y/o	**41-45 Y/o**	**46-50 Y/o**
	29 (±10.8%)	22 (±8.2%)	21 (±7.8%)
	51-55 Y/o	**56-60 Y/o**	**61+ Y/o**
	17 (±6.3%)	18 (±6.7%)	28 (±10.4%
Current occupation	**Resident not in training (ANIOS)**	**Resident in training (AIOS)**	**Attending**
	45 (±16.7%)	49 (±18.2%)	109 (±40.5%)
	PhD candidate	**Other**	
	33 (±12.3%)	33 (±12.3%)	
Place of work	**Intramural (Hospital)**	**Extramural (Outside of the hospital)**	
	192 (±71.4%)	77 (±28.6%)	

4.1 Descriptive statistics

The average response time was approximately 70 minutes, and the median was 4 minutes and ±47 seconds. Table *2* gives an overview of the specialties that were represented. The respondents represented 31 different specialties.

Table 2: List of specialties with complaint rate		*Complaint rate*	*Appearance in disciplinary court rate***
Anesthesiology	15	66.7%	20%
Cardio-thoracic surgery	4	25%	100%
Cardiology	19	52.6%	20%
Dermatology	3	66.7%	0%
Emergency medicine	3	66.7%	0%
Gastroenterology	8	75%	16.7%
General Physician	21	47.6%	30%
Geriatrics	3	33.3%	0%
Gynecology	16	43.8%	14.3%
Insurance medicine	1	0%	-
Intellectual disability physician	1	0%	-
Internal medicine	35	37.1%	7.7%
Maxillofacial surgeon	2	50%	0%
Military medicine	1	0%	-
Neurology	8	62.5%	20%
Nuclear medicine	1	100%	0%
Occupational medicine	2	100%	100%
Ophthalmology	3	33.3%	100%
Orthopedic surgery	7	57.1%	25%
*Other**	32	46.9%	13.3%
Otolaryngology	5	60%	33.3%
Pediatrics	14	50%	28.6%
Plastic and reconstructive surgery	3	66.7%	0%
Psychiatry	8	75%	0%
Public health doctor	29	58.6%	23.5%
Pulmonary medicine	6	66.7%	50%
Radiology	3	66.7%	0%
Radiotherapy	1	0%	-
Rheumatology	4	0%	-
Surgery	7	71.4%	0%
Urology	4	75%	0%

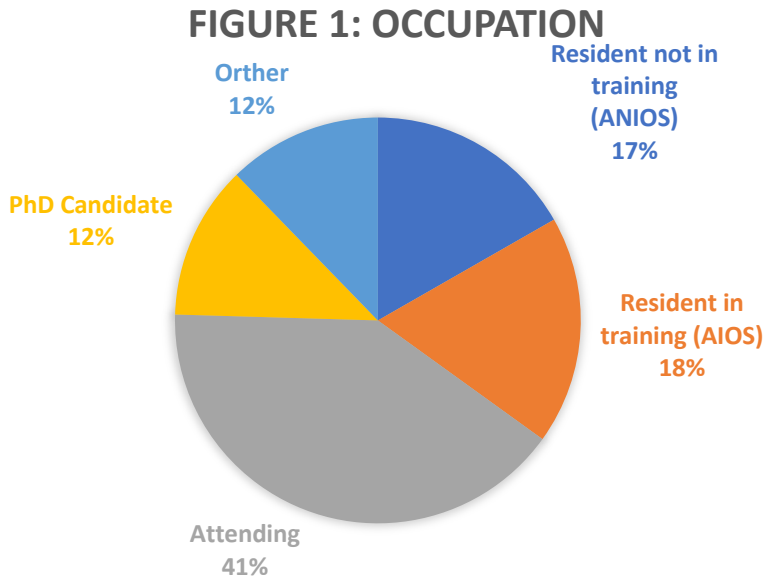
*The following specialties were mentioned: Intensive care medicine, Hospital medicine, Transplantation surgery, Cosmetic surgery and Child abuse medicine.
** As percentage of the doctors who received a formal complaint

Among the respondents 52% received a formal complaint during their career**.** The distribution of these complaints was as follows:

- 4 (±2.9%) complaints were originated in a situation where the doctor worked both intramural as extramural;
- 33 (±23.6%) complaints concerned an extramural situation;
- 103 (±73.5%) complaints regarded an intramural situation**.**

There was no significant difference between the number of complaints between the sexes, 51.4% vs 47.9%, respectively male and female. There is a clear difference in complaint rate between the different “occupations”. See table 3

Table 3: complaint rate per occupations	% of the total complaints	% of people in the group who received a complaint
Attending	60.7%	78.0%
Resident in training	18.6%	53.1%
Resident not in training	5.0%	15.6%
PhD candidate	5.7%	24.2%
“Others”	10%	42.4%



27 (±19.3%) of the 140 complaints ended in front of a disciplinary court. Again, there are no significant differences between males and females, respectively 51.9% vs 44.4%. Of these 27 cases that appeared in open court, 70.4% concerned an attending, the resident in training was represented in 14.8% of the cases and the PhD candidate and the resident not in

training were both represented in 3.7% of the cases. Two third of the complaints in this study were for medical doctors working intramural and one third concerned medical doctors who worked extramural.

In these 27 cases the disciplinary court ruled as follows:

- 18 (66.7%) times the medical doctor was acquitted;
- 6 (22.2%) times the medical doctor received a warning;
- 3 (11.1%) cases the medical doctors received a reprimand.

4.2 What is the current view on the disciplinary law?

There is a variation in the way of thinking about the fairness of the rulings for the respondents who went to court. None of the medical doctors who received a reprimand agreed with the ruling (0/3), 16.7% (1/6) of medical doctors who received a warning agreed with their ruling and of the acquitted medical doctors 88.9% (16 out of 18) agreed with the "ruling" they received.

When asked what the respondents thought about the primary goal of the disciplinary law in their specific case several answers were given. A score of 0 means that the goal is to maintain and/or improve the quality of care and a score of 5 means that the primary goal is to punish the indicted medical doctor. The mean score was 3.0±1.5 (20% scored it a 5, 20% a 4, 28% a 3, 8% a 2, 20% a 1 and 4% a 0).
Dividing this into subgroups according to the given rulings the following is seen:
In the *Warning group* the mean is 3.67±1.5 (33.3% scored it a 5, 33.3% scored it a 4 and both 3 and 1 had 16.67%).
In the *Reprimand group* the mean is 3.33± 2.1 (5, 4 and 1 all scored 33.3%).
In the *Acquitted group* the mean is 2.6±1.5 (11.8% scored it a 5 and the same amount scored it a 4, 35.3% scored it a 3, 11.8% scored it a 2, 23.5% scored it a 1 and 5.9% scored it a 0).

How the indicted medical doctors are treated during their procedure, in their own opinion, is also measured on a 0-5 scale. 0 means they felt that they were treated like a criminal and 5 means that they felt they were treated as an equal. The mean score was 2.5±1.6 (15.4% scored it a 5, 15.4% scored it a 4, 19.2% scored it a 3, 15.4% scored it a 2, 26.9% scored it a 1 and 7.7% scored it a 0).
Dividing this into subgroups according to the given rulings the following is seen:
In the *Warning group* the mean is 2.7±1.4 (16.7% scored it a 5, 33.3% scored it a 3, 33.3% scored it a 2 and 16.7 scored it a 1).
In the *Reprimand group* the mean is 0.7±1.2 (33.3% scored it a 2 and 66.7% scored it a 0).
In the *Acquitted group* the mean is 2.8±1.6 (16.7% scored it a 5, 22.2% scored it a 4, 16.7% scored it a 3, 11.1% scored it a 2 and 33.3% scored it a 1).

A part of the respondents changed their way of treating patients after the procedure. Both in the *Warning group* as in the *Reprimand group* 33.3% changed their way of treating patients. In the *Acquitted group* 44.4% changed their way of treating patients.
The following answers were given when asked what they changed in their treating behavior:

- "Making more notes in the patient files and becoming more risk averse"
- "Practicing medicine in a more defensive style and more consultation with legal counsel"
- "More defensive notes in the patient files"

- “For the time of almost one year I did not have any conversation with families of immigrant patients”
- “More time and patience for the patient and his/her dissatisfaction or uncertainties”
- “Better documentation because that is the main point in a disciplinary law procedure. More defensive behavior in practicing medicine. This led to more unnecessary diagnostic tools and more unnecessary monitoring”
- “Writing more in the patient file, though it was already complete in my opinion. I turned way more defensive”
- “Being more patience”
- “Being more careful. My own “safety” is becoming an issue, when treating patients”
- “More careful in things you say, it was very hard to do”

70% of these medical doctors stated that the above-mentioned change is perceived as negative relative to the situation before the complaint. The other 30% perceived the change as something positive regarding the quality of care.
Some of the positive effects that were seen as beneficial were as follows (these quotes are translated from the Dutch answers given in the questionnaire):

- “More defensive and more careful medicine”
- “It’s better for patients to have as little ambiguity as possible during their treatment”

The negative effects were more about the “fear” that was created after the procedure:

- “Loss of work joy and motivation”
- “Afraid of everything you write down, because it could be made public. More careful in all forms of communication.”
- “Distrust between caregiver and patients is growing. The entire procedure creates a lot of stress and I felt like a victim, despite the fact that I was acquitted”
- “Disciplinary law is not doing what it should do! My procedure took a lot of years (including appeal) and I did not learn anything from it, besides writing more in the patient files. It only took time and energy and yielded just satisfaction for the plaintiff.”
- “I turned more reserved, without even receiving a ruling”

In this cohort there is also a group of respondents who mentioned changes in the environment at home due to the procedure. 18.8% of the respondents experienced changes at home and 20% of these changes were characterized as positive, 60% as negative and the last 20% did not experience it as either positive or negative.

4.3 Is the goal still the goal?

The earlier mentioned definition of medical disciplinary law was presented to the respondents. 69% of the respondents were familiar with the complete definition, 27.4% knew the definition partly and 3.5% did not knew the definition at all.
Of the indicted medical doctors 59.1% thought that the earlier mentioned definition was not in line with the goal of their procedure. When all the respondents were asked if the current system functions properly (0= the system does not function properly and 5= the system functions properly), the mean was 3.03 and 26.1% scored 2 or less (0=0.9%, 1=6.6%, 2=18.6%, 3=39.4%, 4=30.5% and 5=4%).
When asked if the disciplinary law system needs to change (1= completely agree and 5= completely disagree) the mean was 2.52 (1=11.1%, 2=42.9%, 3=31.4%, 4=12.4% and 5=2.2%).
Additionally, the respondents were asked what they would change in the current medical disciplinary law system (one could choose more than one option). The answer options were based on the earlier mentioned literature. See table four for the answers.

Table 4: Possible changes in the current disciplinary law system	Number of respondents who chose the answer option
Gravity of the rulings	13
Way the medical doctor is treated during the procedure	98
Disclosure of the rulings	48
The procedure	41
Raise the threshold to make a complaint	69
Drop the threshold to make a complaint	4
Better guidance for the indicted medical doctor	140
The composition of the committee	26
Other options mentioned by the respondents, e.g. ○ Better evidence before conviction ○ Medical doctors in the committee need to have the same specialty ○ Maximum of 1 lawyer in the committee ○ Mediation instead of punishment ○ Wider view than just the legal view ○ Length of the procedure ○ More focus on hindsight bias	45

Change nothing	22

The disclosure of (some of) the rulings was the subject of the last part of the questionnaire. The following questions were asked to all respondents:

- Is it necessary for patient safety to disclose the ruling (0=not necessary and 5=necessary)?
- Is it desirable for patient safety to disclose the ruling (0=not desirable and 5=desirable)?
- The results are shown in table 5.

Table 5 Level of necessity and desirability of disclosure of rulings

Ruling	Mean necessary score± standard deviation	Mean desirable score± standard deviation
Warning	1.36±1.38	1.44±1.46
Reprimand	1.89±1.59	1.85±1.62
Fine	1.58±1.48	1.69±1.54
(Conditional) Suspension of the BIG registration with a maximum of one year	3.27±1.60	3.34±1.59
(Partial) Interdiction to practice their profession	3.65±1.57	3.65±1.60
(Conditional) Strike out from the BIG register	4.00±1.54	4.00±1.51
Acquittal	2.35±2.06	2.54±2.10

The following answers were given, when asked to the function of disclosure:

- 37.5% answered among other things to protect patients
- 34.6% mentioned that it is to inform patients
- 10.8% answered that the disclosure is to punish medical doctors
- 20.8% thought that the disclosure helps with establishing or gaining social control of medical doctors in the same specialty
- 58% said that it is to create transparency in the medical world

- 6.7% had other ideas about the function of disclosure and some of these ideas were as follows:
  - "To humiliate the medical doctors"
  - "Protect the title of a medical doctor if acquitted"
  - "To prevent recurrence of the incidents"
  - "It has no function"

More than half of the respondents (53.5%) wants to abolish the disclosure of at least one ruling. 42.4% of the respondents want to abolish the disclosure of the warning, 32.3% wants to abolish the disclosure of the reprimand, 31.6% wants to abolish the disclosure of a fine, 10.8% wants to abolish the disclosure of the (conditional) suspension of the BIG registration, 7.8% wants to abolish the disclosure of the (partial) interdiction and 5.2% wants to abolish the disclosure of the (conditional) strike out from the BIG register.
The majority of the respondents does not think that the disclosure of rulings has a positive effect on patient safety (44.2% is negative and 21.9% is neutral). Some of the reasons they gave are stated below:

- *"A punished doctor will be more defensive in the future and the focus will be more on safety, so disclosure won't help with this."*
- *"A culture of fear is created among doctors"*
- *"Only the most impactful rulings need to be disclosed" (several variants of this remark)*
- *"If a doctor can't practice anymore, because he/she is not able to give proper care, he/she needs to get stroked out of the BIG register. If that is not the case disclosure is just reputation damage."*
- *"The consequences of disclosure are major for the doctor. Doctors are not willingly hurting patients. Things go wrong, but that is a part of the job. Colleagues need to talk to each other if things do not go like they are supposed to. Currently, good doctors could get a ruling and if this ruling is disclosed, their career options are limited."*
- *"It is more important to educate the doctors on these subjects."*
- *"The balance between the privacy of the doctor (prevention of a pillory) versus the small benefit in patient safety."*
- *"The doctor is already punished."*
- *"A disciplinary law trial often has a constructive character which could help the doctor to learn from his/her mistakes, but often patients see the ruling as irreparable incompetence."*
- *"The cases are often unique, so it does not say much about the competence of the doctor in toto."*
- *"Murderers are not placed in newspapers with their full name, why do doctors need to be exposed for smaller "faults". And besides this, the rulings often have a very high "Captain Hindsight" level."*

Chapter 5 – Discussion & Conclusion -

5.1 Main findings

The most important findings in this study can be divided into two groups, namely the current view on medical disciplinary law and the disclosure of the rulings.
The current view of the respondents on medical disciplinary law can be viewed as skeptical and/or negative looking at the literature in chapter two and the results in chapter four. The view among the respondents is that the disciplinary law is leaning to the side of punishing instead of improving the quality of patient care. The same tendency is seen in the literature. The experience of being punished is more present when a medical doctor received a ruling in comparison to medical doctors who are acquitted and/or non-indicted colleagues. How medical doctors are treated in their own opinion during the process is also ambivalent. The mean score was in the middle of the two answer options, but there was a difference between the groups with and without a ruling.
An evident group of doctors who were indicted changed their way of treating patients. The acquitted group showed the most change. The changes are often focused on a more defensive style of practicing medicine, distrust for the patient and taking more time for patients. The largest part of changes is defined as negative in the eyes of respondents. Besides changes at work, some of the indicted medical doctors, also experienced changes at home, which are most often perceived as negative. This is completely in line with the findings from the literature.

Not all respondents were aware of the current definition of medical disciplinary law and a large part of the indicted doctors thought that this definition was not in line with the focus of their disciplinary procedure. A very small part of the respondents thought that the current system functions properly, the majority scored it a 3 out of 5. There also seems no consensus in the group of respondents whether the system needs to change looking at the answers they gave in the questionnaire. The two most important things that they would change are two points that are focused on the well-being of medical doctors, namely:

- The way the medical doctor is treated during the procedure;
- Better guidance for the indicted medical doctor.

The disclosure of the rulings is still a hot topic, looking at all the answers that were given. The consensus among the respondents is that they think that it is more desirable and more necessary for patient safety to disclose more severe rulings. There were no significant differences between the desirability and necessary scores. A minority of respondents just thought that the disclosure of rulings was in place to protect patients. A majority thought that it was to create transparency in the medical world.
More than half of the respondents wants to abolish the disclosure of one or more rulings. The rulings that are mentioned most are the warning, reprimand and fine. Due to change of

law in 2018 all three of these rulings are not disclosed, except if the disciplinary committee thinks that it is beneficial for society (de RG Bruijn-Wezeman,2018).
Positive effects of disclosure are still unclear for respondents, since the majority only experiences the negative effects, like the growing fear among medical doctors, which could lead to worse patient outcomes.

5.2 Strengths and limitations

In the following two paragraphs the strengths and limitations of this study will be discussed.

5.2.1 Strengths

This study has several strengths which will be addressed in this paragraph. First and foremost, the number of respondents in comparison to similar studies is relatively high. Due to this high number of respondents, there is a higher change that you can include medical doctors who are indicted in the researched group. This high number of respondents also indicates that this subject is relevant for the group that is researched.

Next to the number of respondents, there is also a relatively wide array of specialties present in this study group (30+). This helps to broaden the view of this study and the chances to extrapolate it to the complete group of Dutch medical doctors.

Another possible strength of this study is that it (tries to) incorporate(s) both quantitative as qualitative data on this subject. Because of that, this study gives a more complete view on the current state of medical disciplinary law and this also gave the respondents the possibility to mention several things that the author did not think of when making the questionnaire.

The last strength of this study is that it focusses on an understudied field in the current literature. This studied field has so much impact on both the plaintiffs and doctors, so it is important that this study also focusses on the emotional and psychological effects of medical doctors specifically.

5.2.2. Limitations

Just like any other study this study has limitations. One of the biggest limitations is the descriptive nature of this study. The study does not really go into depth on some of the subjects, which is necessary to make specific claims and recommendations.

Another limitation is the lack of in-depth interviews with some of the respondents, which could have helped clarifying their initial answers. These interviews were not performed, due to several reasons. The first reason is that there was a limited time to conduct these interviews. Besides that, the answers of the questionnaire were received shortly before the due date of the thesis. This made it very hard to incorporate these interviews in this study. The next reason was that the author and most of the respondents were working more than normally due to the corona pandemic. Therefore, it was not possible to make arrangements for interviews.

A third limitation was that the group of respondents was primarily from the “Randstad” and this could give a distorted image. One of the reasons behind this, is that the network of the author is primarily in this area. Even with all the respondents from the two doctor federations, the majority is still from the same area as the author.

The division in occupation is also skewed to the side of the attendings. This could give a more negative view on the disciplinary law because they are practicing medicine longer than the residents, so the chances that they were indicted are higher. From the results, we’ve seen that the indicted groups are often more negative on this subject.

The sample size is not small for similar studies, but the sample size is still (too) small if you want to do quantitative analyses in e.g. SPSS. The initial goal of this study was not to search for causal inference, but for explanatory answers. This could be a limitation also.
To make the sample size bigger and to incorporate more indicted medical doctors, it is necessary to send the questionnaire to more hospitals, GGD’s, doctors federations and directly to indicted doctors (their names could be found in the BIG register). It is also desirable to extend the period that the questionnaire is open for respondents.

Some remarks were made by a small number of respondents that some questions of the questionnaire could be interpreted in several ways. To avoid this, it is important to test the questionnaire by sending it beforehand to a small part of your target audience. The remarks were about the definition of a complaint because it could be an unofficial complaint, a complaint within a hospital or an official complaint, where this study is about. Another remark was about the unclarity of the question “*if someone appeared in front of a disciplinary committee*”, because a complaint can also be handled in the council chamber and this question caused confusion by at least one respondent.

5.3 Answers to research questions

In this paragraph the research question and the five sub questions will be answered. These five sub questions were used to answer the main question.

1. **How is medical disciplinary law organized in the Netherlands?**

   See appendix three for a graphical representation of disciplinary law in the Netherlands.

2. **What is the original goal of the Dutch medical disciplinary law?**

   The original (main) goal of Dutch medical disciplinary law can be reduced to just one sentence: *The goal of the disciplinary law is to increase the quality of care and to protect patients from unskilled and careless care givers.*

3. **What is the current effect of disciplinary law sanctions on Dutch medical doctors (both medical specialist and residents)?**

   The current effect is not in line with the original goal. Currently the sanctions often have the effect to create fear among the indicted doctors and this creates an atmosphere of defensive medicine. This would not be beneficial for patient safety and the quality of care. The sanctions are often experienced as punishment, while this is not the initial goal.
   There is also a negative effect noticeable in the private life of the indicted doctors.

4. **How could the current disciplinary law system be improved according to Dutch medical doctors?**

   There are several points of improvement possible in the eyes of medical doctors. In their opinion, the focus must be more on the well-being of medical doctors because they are often forgotten as a second victim. The way the medical doctor is treated during the procedure needs to be improved, according to the respondents. Besides that, there is a request for better guidance of the indicted medical doctor. Lastly, there is also a call for less or no disclosure of rulings.

5. **How do the disciplined medical doctors think about the disclosure of disciplinary measures?**

   The largest part of medical doctors in this study does not think that the disclosure of rulings has a positive effect on patient safety, however it has an enormous negative

effect on the wellbeing and practice of medical doctors. More than half of the respondents wants to abolish the disclosure of at least one ruling. The necessity and desirability to disclose rulings was the highest in the case of more severe rulings, like a strike out from the BIG register, and the lowest in the less severe rulings, like a warning.

"Is the current effect of Dutch disciplinary law sanctions for doctors, both medical specialist and residents, the most desirable?"

After gathering data from the literature study and from the questionnaire, there is sufficient data to answer the research question. If the most desirable effect possible is in line with the original goal from sub question two, one can argue that the current effect is not or not completely in line with this goal. The current effect of disciplinary law has more of a punishing and “frightening” character for medical doctors, which can lead to a more defensive style of practicing medicine, which is not beneficial for the patients. The answer to the research question is no, because the current effect deviates too much from the original goal.

5.4 Recommendations

As discussed earlier, this study is more of a descriptive and explanatory nature, so further research is necessary in order to dive deeper into this subject. In further research it is important to include a wide array of medical doctors from different specialties, both intra- as extramural, different ages and different places from the Netherlands.

It is also important to choose a direction for further research, because this study was a combination from both quantitative and qualitative research. This was a good choice for the explanatory nature of this study, but for more specific research it is better to do or quantitative or qualitative research.

Some aspects of this study became clear and could be tackled by doctor federations and/or the disciplinary committee and the government.
The most important finding was that the current effect is not in line with the original goal. It is the task of the government and the disciplinary committee to tackle this problem. It may be possible to create a taskforce with several representatives from different BIG registered specialties to discuss the current state of the disciplinary law system and ways of improvement. It is important to do this quickly, because from this research (and earlier research) one could learn that defensive medicine is not beneficial for the patients.

The doctor federations can play a big role in providing medical doctors with more guidance during trial and in the way they are treated during trial. The first point is a point which can be tackled by the doctor federations, because they can create a better system to guide their members during a procedure. This could be by providing better knowledge about the procedure, assisting with finding proper legal counsel or just facilitate sessions where more experienced (with the disciplinary law) medical doctors can help and talk to the indicted medical doctors.
Regarding the way in which medical doctors are treated, it is important to inform the disciplinary committee about the way doctors experience trial. This can raise awareness in the disciplinary committee and may lead to the disciplinary committee adapting their procedures to make sure these procedures are (more) in line with the original goal.

Another possibility is to make a change in the group of people who are able to file a complaint. According to Caressa Bol, there is a need for a change in the medical disciplinary law and in this change, there could be a bigger role for The Health and Youth care Inspectorate (Bol, 2021). In general, they make less complaints than the patients, but when they do the complaints are often for more severe cases and more often their complaints are found grounded. Maybe in further research one could investigate if it is possible that The Health and Youth care Inspectorate functions as a selection committee, where the complaint can be assessed, before going to the disciplinary committee. This might improve the quality

of the complaints and make the number of complaints lower. According to Bol, this could reduce burdening of the medical doctors (Bol, 2021).

The last recommendation is that it can be beneficial for both patients as medical doctors to know what the reasons are that patients file complaints. If this is known, medical doctors can choose to incorporate this from the beginning in their ways of practicing medicine. It is necessary to do more research into this and maybe incorporate these results in medical training.

5.5 Conclusion

This study gives an overview of the current state of the medical disciplinary law in the Netherlands. The results show that there is a deviation from the initial goal and that this created a culture of fear among medical doctors. The fear to be indicted, results in a more defensive style of practicing medicine and this can lead to worse patient outcomes. Another aspect that is not contributing to a better and safer environment according to the respondents, is the disclosure of disciplinary committee rulings. These disclosures only have negative effects on the medical doctors, according to the respondents. So, the overall conclusion is that the current effect of medical disciplinary law is not in line with the goal to increase the quality of care and to protect the patients from unskilled and careless care givers, but mostly creates an environment where medical doctors are afraid to be indicted, which can lead to worse patient outcomes.

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1A. Questionnaire in Dutch

Master scriptie: Tuchtrecht onder Nederlandse artsen

Enquêteflow

Block: Default Question Block (34 Vragen)

Pagina-einde

Start van blok: Default Question Block

Q39 In deze vragenlijst zult u gevraagd worden naar uw ervaringen en kennis van het medisch tuchtrecht. Deze resultaten zullen geanonimiseerd verwerkt worden in de masterscriptie van Elijah Sanches in het kader van de studie Health Economics Policy and Law aan de Erasmus Universiteit. Als we contact met u mogen opnemen voor verdiepende vragen, kunt u uw e-mailadres invullen bij de laatste vraag. Als u nog vragen heeft voor ons kunt u een mail sturen naar het volgende email adres 587795es@student.eur.nl .

Invultijd 5-7 minuten.

Q3 Werk u momenteel als arts?

- ○ Ja (1)
- ○ Nee (3)

Q1 Wat is uw geslacht?

- ○ Man (1)
- ○ Vrouw (2)
- ○ Anders (3)

Q2 In welke leeftijdscategorie valt u?

- ○ 21-25 jaar (1)
- ○ 26-30 jaar (2)
- ○ 31-35 jaar (3)
- ○ 36-40 jaar (4)
- ○ 41-45 jaar (5)
- ○ 46-50 jaar (6)
- ○ 51-55 jaar (7)
- ○ 56-60 jaar (8)
- ○ 61+ jaar (9)

Q8 Kunt u aangeven wat op u van toepassing is?

- ○ ANIOS (1)
- ○ AIOS (2)
- ○ Specialist (3)
- ○ Promovendus (7)
- ○ Overig (5) _____

Q9 Kunt u aangeven onder welk specialisme u valt?

- ○ Algemeen militair arts (1)
- ○ Anethesiologie (2)
- ○ Arts verstandelijke gehandicapten (3)
- ○ Bedrijfsgeneeskunde (4)
- ○ Cardiologie (5)
- ○ Cardio-thoracale chirurgie (6)
- ○ Chirurgie (7)
- ○ Dermatologie (8)
- ○ Gynaecologie (9)
- ○ Huisartsengeneeskunde (10)
- ○ Interne geneeskunde (11)
- ○ Kaakchirurgie (12)
- ○ Keel-neus-oorheelkunde (KNO) (13)
- ○ Kindergeneeskunde (15)
- ○ Klinische genetica (16)
- ○ Klinische geriatrie (17)
- ○ Longgeneeskunde (18)
- ○ Maag-darm-leverzieken (MDL) (19)
- ○ Maatschappij en Gezondheid (20)
- ○ Medische microbiologie (21)
- ○ Neurochirurgie (22)
- ○ Neurologie (23)

- Nucleaire geneeskunde (24)
- Oogheelkunde (25)
- Orthopedische chirurgie (26)
- Ouderengeneeskunde (27)
- Pathologie (28)
- Plastische chirurgie (29)
- Psychiatrie (30)
- Radiologie (31)
- Radiotherapie (32)
- Reumatologie (33)
- Revalidatiegeneeskunde (34)
- Spoedeisende Hulp (35)
- Sportgeneeskunde (36)
- Tropengeneeskunde (37)
- Urologie (38)
- Verzekeringsgeneeskunde (39)
- Overig (40) _____

Q4 Kunt u aangeven waar u werkt of het grootste gedeelte van uw carriere heeft gewerkt?

- In het ziekenhuis (intramuraal) (1)
- Buiten het ziekenhuis (extramuraal) (2)

Q5 Heeft u ooit een klacht van een patiënt ontvangen?

- ○ Ja (1)
- ○ Nee (2)

Deze vraag weergeven:

If Heeft u ooit een klacht van een patiënt ontvangen? = Ja

Q26 Had de klacht betrekking op uw werkzaamheden...

- ○ In het ziekenhuis (intramuraal) (1)
- ○ Buiten het ziekenhuis (extramuraal) (2)
- ○ Beiden (3)

Deze vraag weergeven:

If Heeft u ooit een klacht van een patiënt ontvangen? = Ja

Q6 Bent u ooit verschenen voor een tuchtrechter?

- ○ Ja (1)
- ○ Nee (2)

Ga naar: Q28 Als Bent u ooit verschenen voor een tuchtrechter? = Nee

Deze vraag weergeven:

If Bent u ooit verschenen voor een tuchtrechter? = Ja

Q7 Kunt u hier aangeven welke maatregel u opgelegd heeft gekregen indien u voor een tuchtrechter bent verschenen? (meerdere antwoorden zijn mogelijk)

- ☐ Waarschuwing (1)
- ☐ Berisping (2)
- ☐ Geldboete (3)
- ☐ Voorwaardelijke schorsing van de inschrijving van de zorgverlener in het BIG-register (maximaal een jaar) (4)
- ☐ Gedeeltelijke ontzegging het beroep uit te oefenen (5)
- ☐ Doorhaling van de inschrijving in het BIG-register (6)
- ☐ Vrijgesproken (7)

Deze vraag weergeven:

If Bent u ooit verschenen voor een tuchtrechter? = Ja

Q10 Vond u dat deze maatregel terecht was?

- ○ Ja (1)
- ○ Nee (2)

Deze vraag weergeven:

If Bent u ooit verschenen voor een tuchtrechter? = Ja

Q11 Wat was het primaire doel van de tuchtrecht procedure in uw ogen?
0= De kwaliteit van zorg behouden/verbeteren
5= De arts te straffen

	0	1	2	3	4	5
Wat was het primaire doel van de tuchtrecht procedure? ()						

Deze vraag weergeven:

If Bent u ooit verschenen voor een tuchtrechter? = Ja

Q13 Kunt u aangeven hoe u vond dat u behandeld werd tijdens en rondom de zitting?
0= Als een verdachte
5= Als een gelijke

	0	1	2	3	4	5
Hoe werd u behandeld? ()						

Deze vraag weergeven:

If Bent u ooit verschenen voor een tuchtrechter? = Ja

Q14 Bent u uw patiënten anders gaan behandelen na de tuchtrecht zaak?

- Ja (1)
- Nee (2)

Ga naar: Q18 Als Bent u uw patiënten anders gaan behandelen na de tuchtrecht zaak? = Nee

Deze vraag weergeven:

If Bent u uw patiënten anders gaan behandelen na de tuchtrecht zaak? = Ja

Q15 Kunt u hieronder aangeven wat u anders bent gaan doen na de opgelegde maatregel?

_____

_____

_____

_____

_____

Deze vraag weergeven:

If Bent u uw patiënten anders gaan behandelen na de tuchtrecht zaak? = Ja

Q17 Heeft u het idee dat de bovenstaande verandering in uw "behandelstijl" een positief effect heeft op de kwaliteit van zorg?

- ○ Ja (1)
- ○ Nee (2)

Deze vraag weergeven:

If Heeft u het idee dat de bovenstaande verandering in uw "behandelstijl" een positief effect heeft... = Ja

Or Heeft u het idee dat de bovenstaande verandering in uw "behandelstijl" een positief effect heeft... = Nee

Q40 Kunt u uw antwoord op de vorige vraag hieronder kort toelichten?

_____

_____

_____

_____

_____

Deze vraag weergeven:

If Bent u ooit verschenen voor een tuchtrechter? = Ja

Q18 Zijn er zaken in uw thuissituatie veranderd door de opgelegde maatregel?

- ○ Ja (1)
- ○ Nee (2)

Deze vraag weergeven:

If Zijn er zaken in uw thuissituatie veranderd door de opgelegde maatregel? = Ja

Q35 Hoe zou u deze verandering in de thuis situatie typeren?

- Positief (1)
- Negatief (2)
- Neutraal (3)

Q28 Bent u bekend met de volgende definitie van het tuchtrecht?

-Het tuchtrecht voor de gezondheidszorg heeft als doel de kwaliteit van de individuele gezondheidszorg te bewaken en te bevorderen en de patiënt te beschermen tegen ondeskundig en onzorgvuldig handelen van een zorgverlener. Het gaat om een algemeen belang.-

- Ja (1)
- Nee (2)
- Deels (3)

Deze vraag weergeven:

If Bent u ooit verschenen voor een tuchtrechter? = Ja

Q30 Vindt u dat de bovenstaande definitie als doel werd gesteld tijdens uw eigen "tuchtrecht zaak" ?

- Ja (1)
- Nee (2)

Q21 Hoe functioneert het tuchtrecht systeem in uw ogen?
0=Het systeem functioneert niet
5=Het systeem functioneert optimaal

	0	1	2	3	4	5
Hoe functioneert het tuchtrecht systeem in uw ogen? ()						

Q27 Wat vind u van de volgende stelling: **Het tuchtrecht systeem moet anders.**

- ○ Volledig mee eens (4)
- ○ Deels mee eens (5)
- ○ Neutraal (6)
- ○ Deel mee oneens (7)
- ○ Volledig mee oneens (8)

Q22 Als u wat kon veranderen aan het huidige tuchtrecht systeem, wat zou dat zijn?

- ☐ Zwaarte van maatregelen (7)
- ☐ Wijze waarop een arts wordt behandeld tijdens de procedure (4)
- ☐ Openbaring van de maatregelen (5)
- ☐ Procedureel (6)
- ☐ Drempel verhogen om een klacht in te kunnen dienen (8)
- ☐ Drempel verlagen om een klacht in te kunnen dienen (9)
- ☐ Betere begeleiding voor de arts (10)
- ☐ Samenstelling tuchtcollege (drie leden-beroepsgenoten en twee juristen (waarvan één voorzitter)) (11)
- ☐ Overig (12) _____
- ☐ Ik zou niets veranderen (13)

Q29 Is het in uw ogen **noodzakelijk in het kader van de patiëntveiligheid** dat de opgelegde maatregelen of vrijspraak openbaar gemaakt worden voor het algemene publiek?

Niet noodzakelijk Geen mening Noodzakelijk

0 1 2 3 4 5

Waarschuwing ()	
Berisping ()	
Geldboete ()	
Voorwaardelijke schorsing van de inschrijving van de zorgverlener in het BIG-register (maximaal een jaar) ()	
Gedeeltelijke ontzegging het beroep uit te oefenen ()	
Doorhaling van de inschrijving in het BIG-register ()	
Vrijspraak ()	

Q41 Is het in uw ogen wenselijk in het kader van de patiëntveiligheid dat de opgelegde maatregelen of vrijspraak openbaar gemaakt worden voor het algemene publiek?

Niet Wenselijk Geen mening Wenselijk

0 1 2 3 4 5

Waarschuwing ()	
Berisping ()	
Geldboete ()	
Voorwaardelijke schorsing van de inschrijving van de zorgverlener in het BIG-register (maximaal een jaar) ()	
Gedeeltelijke ontzegging het beroep uit te oefenen ()	
Doorhaling van de inschrijving in het BIG-register ()	
Vrijspraak ()	

Q24 Wat is in uw ogen de functie van het openbaar maken van de tuchtrecht maatregelen?

- ☐ Beschermen van de patiënt (4)
- ☐ Informeren van de patiënt (5)
- ☐ Straffen van de artsen (6)
- ☐ Sociale controle vanuit de vakgroep (8)
- ☐ Transparantie creëren vanuit de medische wereld (10)
- ☐ Overig (9) _____

Q25
Zou u het openbaar maken van één of meerdere tuchtrecht maatregelen afschaffen als u de kans kreeg?

- Ja (1)
- Nee (2)

Deze vraag weergeven:

If Zou u het openbaar maken van één of meerdere tuchtrecht maatregelen afschaffen als u de kans kree... = Ja

Q38 Welke uitspraken van het tuchtrecht college zou u niet openbaren voor het algemene publiek?

- [ ] Waarschuwing (1)
- [ ] Berisping (2)
- [ ] Geldboete (3)
- [ ] Voorwaardelijke schorsing van de inschrijving van de zorgverlener in het BIG-register (maximaal een jaar) (4)
- [ ] Gedeeltelijke ontzegging het beroep uit te oefenen (5)
- [ ] Doorhaling van de inschrijving in het BIG-register (6)
- [ ] Vrijspraak (7)

Q32 Denkt u dat het openbaar maken van de tuchtrecht maatregelen een toegevoegde waarde heeft voor de patiëntenveiligheid?

- Ja (1)
- Nee (2)
- Neutaal (3)

Q43 Zou u uw antwoord op de vorige vraag hieronder kunnen toelichten?

_____

Q36 Mogen we contact met u opnemen over eventuele vervolgvragen?

- ○ Ja (1)
- ○ Nee (2)

Deze vraag weergeven:

If Mogen we contact met u opnemen over eventuele vervolgvragen? = Ja

Q37 Vul hier uw e-mailadres in voor verder contact.

_____

Einde blok: Default Question Block

1B. Questionnaire in English

Simplified questionnaire translated from Dutch (the workflow of the questionnaire is left out, but could be found in the Dutch version)

Master thesis: Disciplinary law among Dutch medical doctors

In this questionnaire you will be asked about your experiences and knowledge of the medical disciplinary law. These results will be processed anonymously in the master thesis of Elijah Sanches as part of the study Health Economics Policy and Law at Erasmus University. If we may contact, you for in-depth questions, you can enter your e-mail address in the last question. If you have any questions for us, you can send an email to the following email address 587795es@student.eur.nl.

Questionnaire time 5-7 minutes.

1. Are you currently working as a medical doctor?
    1) Yes
    2) No
2. What is your gender?
    1) Male
    2) Female
    3) Other
3. What is your age category?
    1) 21-25 y/o
    2) 26-30 y/o
    3) 31-35 y/o
    4) 36-40 y/o
    5) 41-45 y/o
    6) 46-50 y/o
    7) 51-55 y/o
    8) 56-60 y/o
    9) 61+ y/o
4. Choose your current occupation from below
    1) Resident not in training
    2) Resident in training
    3) Attending
    4) PhD student
    5) Other
5. Choose your current specialty from below
    1) Anesthesiology
    2) Cardio thoracic surgery
    3) Cardiology
    4) Clinical geneticin
    5) Dermatology
    6) Emergency medicine

7) Gastroenterology
8) General military medicine
9) General practitioner
10) Geriatrics
11) Gynecology
12) Insurance medicine
13) Intellectual disability physician
14) Internal medicine
15) Maxillofacial surgery
16) Medical microbiology
17) Medical rehabilitation
18) Neurology
19) Neurosurgery
20) Nuclear medicine
21) Occupational medicine
22) Ophthalmology
23) Orthopedic surgery
24) Other
25) Otolaryngology
26) Pathology
27) Pediatrics
28) Plastic and reconstructive surgery
29) Psychiatry
30) Public health
31) Pulmonology
32) Radiology
33) Radiotherapy
34) Rheumatology
35) Sports medicine
36) Surgery
37) Tropical medicine
38) Urology

6. Choose where you have worked the longest period of your medical career
    1) Intramural (inside of the hospital)
    2) Extramural (outside of the hospital)
7. Did you ever receive a complaint from a patient?
    1) Yes
    2) No
8. Was the complaint related to your work in the following setting:
    1) Intramural
    2) Extramural
    3) Both
9. Did you ever stand trial Infront of the disciplinary committee?
    1) Yes
    2) No
10. Could you choose which ruling the committee sanctioned in your case?
    1) Warning

2) Reprimand
3) Fine
4) (Conditional) suspension of the BIG registration with a maximum of one year
5) (Partial) interdiction to practice
6) (Conditional) strike out from the big register
7) Acquittal

11. Did you think that you deserved this ruling?
    1) Yes
    2) No
12. What was the primary goal of the disciplinary law procedure in your case? Choose a number between 0 and 5.
    1) 0= To protect and improve the quality of care
    2) 5= To punish the medical doctor
13. Could you indicate how you were treated during the procedure? Choose a number between 0 and 5.
    1) 0= Like a suspect
    2) 5= Like an equal
14. Did you change your way of treating patients after the procedure?
    1) Yes
    2) No
15. Explain your answer to question 14
16. Has the above-mentioned change in your way of treating patients a positive effect on the quality of care?
    1) Yes
    2) No
17. Explain your answer to question 16
18. Were there changes noticeable in your private life after the ruling?
    1) Yes
    2) No
19. How would you call the change in question 18?
    1) Positive
    2) Negative
    3) Neutral
20. Are you familiar with the following definition: "*The purpose of the medical disciplinary law is to ensure and to promote the quality of the individual healthcare and to protect the patients against incompetence and carelessness of the caretaker"?*
    1) Yes
    2) No
    3) Partly
21. Do you think that the definition of question 20 was the main goal in your own procedure?
    1) Yes
    2) No
22. How does the disciplinary law system functions in your opinion? Choose a number between 0 and 5.
    1) 0= The system does not function
    2) 5= The system functions perfectly

23. What do you think of the following: The disciplinary system needs to change!
    1) Completely agree
    2) Agree
    3) Neutral
    4) Disagree
    5) Completely disagree
24. If you were able to change anything in the disciplinary law system, what would it be?
    1) Severity of the rulings
    2) The way a medical doctor got treated
    3) Disclosure of the rulings
    4) Procedural
    5) Higher threshold to file a complaint
    6) Lower threshold to file a complaint
    7) Better counseling for medical doctors
    8) Change in composition of the disciplinary committee
    9) Other
    10) I Would not change anything
25. Is it necessary to disclose the rulings for patient safety? Choose a number between 0 and 5. 0= not necessary and 5= necessary
    1) Warning
    2) Reprimand
    3) Fine
    4) (Conditional) suspension of the BIG registration with a maximum of one year
    5) (Partial) interdiction to practice
    6) (Conditional) strike out from the big register
    7) Acquittal
26. Is it desirable to disclose the rulings for patient safety? Choose a number between 0 and 5. 0= not necessary and 5= necessary
    1) Warning
    2) Reprimand
    3) Fine
    4) (Conditional) suspension of the BIG registration with a maximum of one year
    5) (Partial) interdiction to practice
    6) (Conditional) strike out from the big register
    7) Acquittal
27. What is the function of the disclosure of rulings?
    1) To protect the patient
    2) To inform the patient
    3) To punish the medical doctor
    4) Social control from colleagues
    5) A more transparent medical world
    6) Other
28. Would you abolish the disclosure of one or more rulings?
    1) Yes
    2) No
29. Which ruling you would not disclose?
    1) Warning

2) Reprimand
3) Fine
4) (Conditional) suspension of the BIG registration with a maximum of one year
5) (Partial) interdiction to practice
6) (Conditional) strike out from the big register
7) Acquittal

30. Do you think that the disclosure of rulings has a positive effect on the patient safety?
    1) Yes
    2) No
    3) Neutral
31. Could you explain your answer to the last question?
32. Could we contact you for further question regarding your answer?
    1) Yes
    2) No
33. Fill in your email address for further contact.

Thank you for your time!

1C. Questionnaire: example of the invitation e-mail

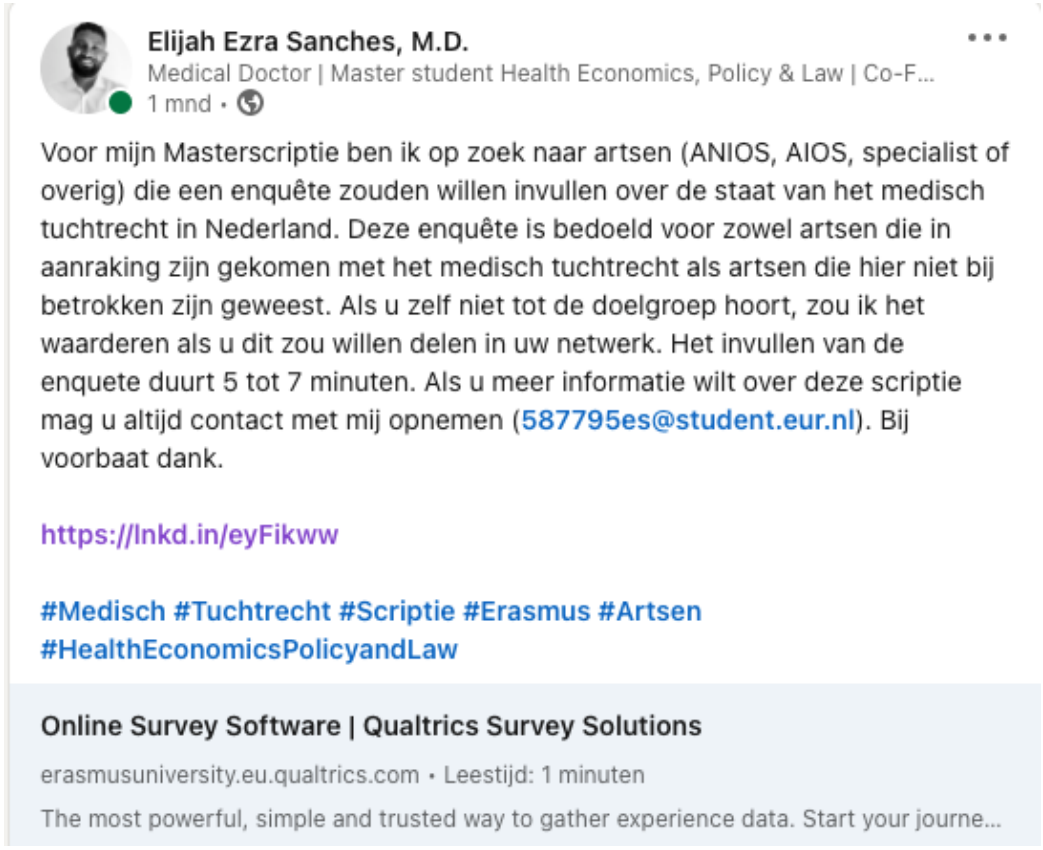
Geachte artsen,

Voor mijn Masterscriptie ben ik op zoek naar artsen (Promovendus, ANIOS, AIOS, specialist of overig) die een enquête zouden willen invullen over de staat van het medisch tuchtrecht in Nederland. Deze enquête is bedoeld voor zowel artsen die in aanraking zijn gekomen met het medisch tuchtrecht als artsen die hier niet bij betrokken zijn geweest. Als u zelf niet tot de doelgroep hoort, zou ik het waarderen als u dit zou willen delen in uw netwerk. Het invullen van de enquête duurt 5 tot 7 minuten.

https://lnkd.in/eyFikww

Met vriendelijke groet,
Elijah Sanches
Co-assistent LUMC s1329103

1D. Questionnaire: example LinkedIn post



Elijah Ezra Sanches, M.D.
Medical Doctor | Master student Health Economics, Policy & Law | Co-F...
1 mnd •

Voor mijn Masterscriptie ben ik op zoek naar artsen (ANIOS, AIOS, specialist of overig) die een enquête zouden willen invullen over de staat van het medisch tuchtrecht in Nederland. Deze enquête is bedoeld voor zowel artsen die in aanraking zijn gekomen met het medisch tuchtrecht als artsen die hier niet bij betrokken zijn geweest. Als u zelf niet tot de doelgroep hoort, zou ik het waarderen als u dit zou willen delen in uw netwerk. Het invullen van de enquete duurt 5 tot 7 minuten. Als u meer informatie wilt over deze scriptie mag u altijd contact met mij opnemen (587795es@student.eur.nl). Bij voorbaat dank.

https://lnkd.in/eyFikww

#Medisch #Tuchtrecht #Scriptie #Erasmus #Artsen
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2. Search strategy

(Dutch[Title/Abstract]) AND (Disciplinary Law[Title/Abstract]) in Pubmed

((Disciplinary law) AND (Medical)) AND (Experience) in Pubmed

“Medical disciplinary law” in Google Scholar

“Dutch medical disciplinary law” in Google Scholar

“Dutch experience medical disciplinary jurisprudence” in Google scholar

“Medisch tuchtrecht” in Google search engine

“Staat van het medisch tuchtrecht” in Google search engine

3. Graphical presentation of the disciplinary law in the Netherlands

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