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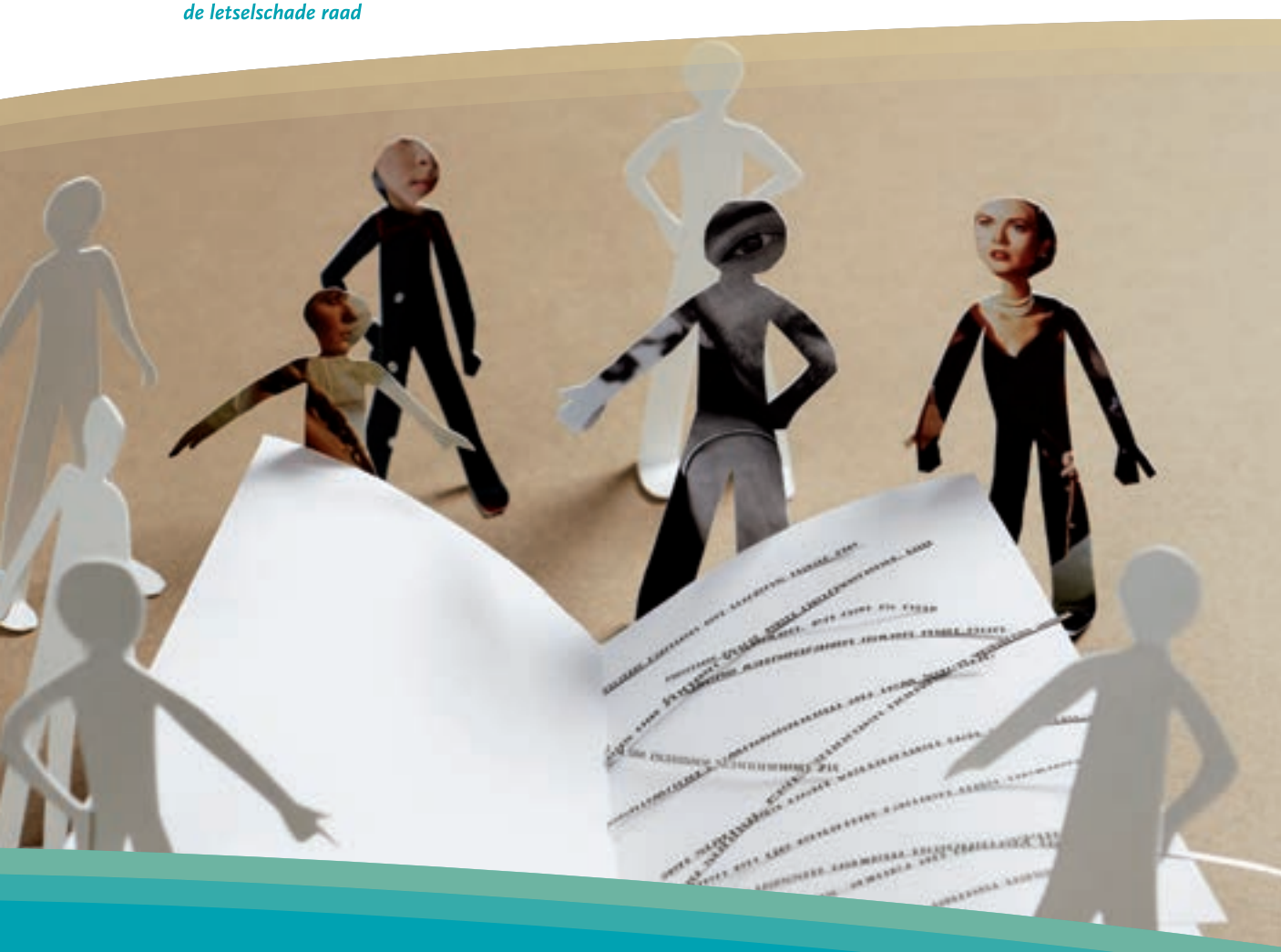

Code of Conduct for Handling Personal Injury Claims (GBL)

2012

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The Personal Injury Council (De Letselschade Raad) aims to increase the harmony and clarity in handling personal injury claims. It strives for a better and more personal treatment of the victim, as well as an improvement in the technical aspects of claims settlement.

Who drafted the GBL 2012?

The first version of the Code of Conduct for Handling Personal Injury Claims (GBL) was published in 2006 (see Sources) and forms the basis for the GBL 2012. Coordinated by the Personal Injury Council, between 2010 and 2012, the first Code of Conduct was updated and improved by the members of the broadly composed Working Group on Revision of the Code of Conduct. In doing so, they were inspired by the experiences and insights gained within their own and related professional groups. Annex 2 lists the participating organizations and their representatives. Annex 3 lists the names of all participants in the consultation rounds held by the Working Group.

Main adaptations

The GBL 2012 has been revised in its entirety. The main changes are:

- The division into 'principles' from the first version has been abandoned in favour of a more refined division into rules of conduct that have been derived from the moral values, standards and responsibilities inherent to the professional handling of a personal injury case.
- The code is organized according to the chronological order of the handling of personal injury claims.
- Good practices and references to case law have been added to the rules of conduct.

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The Medical Paragraph is part of the Code of Conduct for Handling Personal Injury Claims. It can be found on the website of the Personal Injury Council (De Letselschade Raad): www.deletselschaderaad.nl/MedischeParagraaf

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Preface

Fortunately, most personal injury claims are handled satisfactorily. The Personal Injury Council gladly publicizes practices showing that a responsible handling of personal injury claims is quite possible. The good practices serve as an example for everyone involved in personal injury claims. In the Code of Conduct for Handling Personal Injury Claims (Gedragscode Behandeling Letselschade, GBL), these examples have been converted into generally applicable rules. In applying the Code of Conduct, the interests of the injured party can justify departure from the rules at all times: if the particular of personal injury case requires customization of the rules.

Thanks to the introduction of the GBL in 2006, the handling of personal injury cases has improved. Self-regulation by professionals involved in personal injury cases has led to many improvements in the handling of personal injury claims. Many professionals in the sector are enormously involved and willing to contribute to making improvements. They deserve sincere appreciation for their input. Nevertheless, some of the cases, an estimated 5 to 10%, were not properly handled. Consequently, the need arose to bring the Code of Conduct more closely in line with the complexity of handling personal injury cases. In 2008, the Personal Injury Council assumed the task of further streamlining the GBL.

The Personal Injury Council is pleased with the publication of the GBL 2012. In the ten rules of conduct of this code, the focus is always on the victim's interests. Compliance with the rules of conduct helps to professionalize the handling of claims. The handling of claims will then run properly and smoothly, and that is important to the injured party, but also to all other parties. A speedy procedure keeps the costs down, enhances the good reputation of the parties and will generate positive attention, which will increase social support for the personal injury practice.

In the run-up to the GBL 2012, the market called for clarity regarding the status of the GBL. Because: what happens if a party does not comply with the GBL? After good consultation, it was decided in 2012 to link quality requirements to registration in the GBL Register of the Personal Injury Council. Registration is open to professional practitioners who are involved in the handling of personal injury claims. This is on condition that they endorse the GBL and commit themselves to comply with it. Henceforth, the parties in the Register will be reviewed annually by way of a self-assessment and every three years by way of a file search and on-site audit.

The Personal Injury Council also has an early warning function. If parties are dissatisfied with the handling of personal injury cases, they can contact the Dispute Resolution Desk of the Personal Injury Council. An attempt is made there to get the settlement back on track. In the Platformoverleg (the Council's Board of Participants) interest groups and umbrella organizations of victims and insurers discuss signals of bad practices. These bad practices are dealt with in the project group Integral Approach to Bad Practices and corrected as far as possible, for example by filing a complaint with the Financial Services Disciplinary Board or with an umbrella organization.
In the coming years, the Personal Injury Council will continue to make efforts to promote compliance with the GBL.

Also on behalf of the Board of Management of the Personal Injury Council, I thank everyone who has contributed to the new version of the GBL. In particular, I mention the members of the Working Group on Revision of the Code of Conduct who rewrote the GBL, and the organizations of the Platformoverleg (the Council's Board of Participants) who appointed the members of the Working Group thereby making staff and knowledge available. I also thank the participants in the consultation rounds: all the professionals from the sector, the directors and board members, academics and representatives of the judiciary. Their comments and constructive criticism of the draft versions of the Code of Conduct were of great value and contributed to this fine result: the GBL 2012.

Deborah Lauria,
Director of the Personal Injury Council

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1 Introduction

Aim and context of the code

An accident can suddenly turn the life of a victim (hereinafter: 'injured party') upside down. If the person responsible is liable, his or her liability insurer (hereinafter: 'insurer') will usually compensate the damage or loss. The insurer and injured party, often assisted by a representative, then examine together the extent of the damage. The insurer often engages an internal or external loss adjuster for this purpose. The parties consult with one another to determine the compensation for the injured party or reach a different, appropriate solution.
Handling personal injury claims can be complicated and often takes a long time, while the injured party needs to focus mainly on physical recovery and coping with emotions. If the consultations with the insurer run with difficulty, the injured party almost always experiences this as an additional burden. The Code of Conduct for Handling Personal Injury Claims (GBL) provides a solution for this and describes how the handling of claims can run as smoothly as possible.

What is in the GBL?

The GBL describes which moral values and responsibilities are central to the handling of personal injury claims and which moral standards result from them. The GBL formulates those standards as rules of conduct for all parties involved. The rules are accompanied by an explanation and good practices.

For whom?

The GBL is intended for everyone professionally involved in handling personal injury cases, such as insurers, representatives, loss adjusters, medical advisers, occupational consultants and agencies that make personal injury calculations.
The injured party takes a central place. The GBL gives the injured party insight into the course of the handling of the claim. The GBL is a guideline for professional organizations in organizing their work processes and monitoring their quality and effectiveness. Individual professional practitioners will find guidance in the code to make choices as carefully as possible so that they are able to substantiate them.

When does the GBL apply?

In the settling of personal injury claims, the Personal Injury Council makes a distinction between minor and serious injury. In case of minor injury the starting point for handling claims is the Personal Injury Guideline for Slight Injury; the GBL applies to serious injury claims. However, claims with slight injury should of course be handled in the spirit of the GBL.

Although the GBL was originally drafted for settling traffic accidents, the Code of Conduct now applies to personal injury cases regardless of the cause of the injury. It is nevertheless not always possible to apply the GBL. In case of a workplace accident, the establishment of liability is often much more complex than in the case of a traffic accident. In the event of injury after a medical incident, the Code of Conduct for Disclosure of Medical Incidents; better settlement of

Medical Liability (Gedragscode Openheid medische incidenten; betere Afwikkeling Medische Aansprakelijkheid, GOMA) applies. In the event of personal injury claims after a workplace accident or a medical error, the GBL therefore applies fully only as soon as cover exists under the insurance policy and liability has been established wholly or partially. As long as there is no clarity in this regard, the insurer does, however, see to it that it pursues an active (claim settlement) policy and acts in the spirit of the GBL. The Dutch Association of Insurers (Verbond van Verzekeraars, VvV) has declared the GBL binding on all its members.[1]

Representation

Injured parties have a choice between drafting the notice of liability and settling the claim themselves or engaging a representative. In the first case, the injured party will communicate directly with the insurer of the person or organisation. In the second case, communication between the injured party and the insurer of the person or organisation responsible runs by way of the representative. The rules of conduct apply in both situations.

The relationship between injured parties and their representatives is first of all governed by an agreement. The representatives must ensure that they act according to the standards of their own professional group in performing the agreement. In doing so, they weigh the standards from the GBL against the prevailing standards in their relationships with the injured parties as clients. In this regard, the GBL can specify open standards.

Professional relationships and quality requirements

Most personal injury claims are settled satisfactorily. This often happens consciously or unconsciously in the spirit of the GBL. The Personal Injury Council contributes actively to conscious choices in settling personal injury claims. The associated organizations in the Platformoverleg (the Council's Board of Participants) consider it a matter of course that the injured party takes a central place in a proper personal injury claim settlement. They consider it logical that the parties will act accordingly and commit themselves to the GBL.

The GBL enjoys broad support in Dutch society. It is therefore defensible that professionals should observe the GBL in settling personal injury claims. All this does not affect the fact that a representative can, or perhaps even must, depart from the GBL in certain individual cases, but must indeed be able to give arguments for doing so.

All professionals who are involved in settling personal injury claims must ensure that they maintain and further their own expertise. They must at least meet the registration requirements for their professional groups and attend courses and meetings that are relevant to the practice of their professions. Membership of a professional organization in the area of personal injury is desirable to support the professionalization process.

1 The decision to declare the GBL binding was taken in December 2007 by the General Membership Meeting (ALV). See also http://verzekeraars.nl/Dossiers/Letselschade.aspx.

Reader's guide

The GBL comprises seven sections. After this introduction, the second section will deal with the moral values, standards and responsibilities which are inherent to the careful handling of a personal injury case. These matters are explored further in Annex 1. When we place the moral standards in the specific context of personal injury practice, we call them rules of conduct. Some rules of conduct deal with attitude and others with procedures. The exact formulation of the rules is dealt with in the next sections.

Sections 3 to 6 deal with the customary phases of the handling of a personal injury claim. In the Netherlands, in principle, everyone bears their own losses unless someone else is liable. So the injured party can claim compensation only if it has been established that the party he or she holds responsible for the damage or injury is actually liable.
Once liability has been established, the parties map out the damage or injury. Usually the injured party has to provide a lot of information, such as proof of material damage, for example to a car or clothing. In cases of personal injury, medical proof will often be necessary as well. The parties have to make a comparison between the actual situation and the hypothetical situation without an accident. They take good and bad chances into consideration and determine which future developments can reasonably be expected.
Particularly the disabilities resulting from the accident form the basis for all personal injury claims. Those disabilities have to be determined. Sometimes the injured party already had symptoms before the accident. Further investigation can indicate whether these have influence on the injury. This whole process is explained in Section 5. The sixth section goes more deeply into the medical assessment process.

In practice, no clear distinction is usually made between the investigation of medical matters and loss adjustment. On the contrary: both processes usually coincide. The GBL does however make a clear distinction. Aspects that deserve separate attention are therefore described separately. This provides more clarity.

The GBL is based on a harmony model: the parties work together and are not against each other. It is their joint responsibility to reach a settlement of the claim as soon as possible. This responsibility holds for all steps in the procedure: from the establishment of liability and the extent of the damage up to and including solving any problems. Despite striving for harmony, it sometimes happens that the parties do not reach agreement. For that situation, the seventh section, on Dispute Resolution, contains various examples of how the claim settlement – whether or not under the direction of a third party – can nonetheless be brought to a good end.

Rules of conduct

Rule of conduct 1: Provide information about representation

Representatives who are approached for assistance in settling personal injury claims explain to the injured parties under what conditions they can provide their services. In doing so, they are guided by the interests of the injured parties. The representatives provide the injured parties with the correspondence between them and the insurer.

Rule of conduct 2: Confirm receipt

Two weeks at the latest after receipt of the notice of liability, the insurer confirms receipt in writing to the injured party and the latter's representative.

Rule of conduct 3: Start an investigation

The insurer acts alertly and carefully by starting an investigation into the liability of its insured immediately following receipt of the notice of liability.

Rule of conduct 4: Take a position

The insurer takes a substantiated position on liability within three months of receipt of the notice of liability.

Rule of conduct 5: Exploration and contact

The parties strive for appropriate solutions in the personal and work environment of the injured party by exploring in depth the latter's personal circumstances, ambitions and potential. Requests for additional information are proportional. The insurer takes account of the fact that the injured party may have to make efforts to obtain the information.

The insurer has personal contact with the injured party at least once a year in order to inform itself of the latter's injury and situation, even if the injured party is assisted. This requirement does not apply if the injured party states that he or she does not appreciate such contact.

Rule of conduct 6: Draw up a damage report

In consultation with the injured party, the representative provides for a substantiated report of the damage. The insurer states with reasons which damages it acknowledges and what in its opinion still needs further investigation. If relevant, it will also make its position known on reimbursement of the costs of extrajudicial legal assistance and a possible expert investigation.

Rule of conduct 7: Pay within 14 days

The insurer pays the injured party the damages that have become evident and which it has acknowledged, or which have been definitively assessed between the parties. This is done within 14 days after acknowledgement or the definitive assessment.

Rule of conduct 8: More than two years: evaluate

If handling of the claim lasts more than two years from the damage report, the parties – at the insurer's initiative – will find out what has caused this. The parties will agree specifically on the measures needed to conclude the handling of the claim as soon as possible and on the party that will implement them.

Rule of conduct 9: Seek a solution

If the claim settlement reaches a deadlock, the parties will map out exactly what is keeping them divided. They will seek a solution together as soon as possible.

Rule of conduct 10: Engage a third party

If the parties do not succeed in reaching a solution jointly, they will contact a third party to bring about a final solution. The parties will preferably take this decision together.

2 Ethical starting points

The moral values, standards and responsibilities that are appropriate for a professional personal injury practice are stated concisely below. They constitute the starting points for the above-mentioned rules of conduct.

Principles

Professionals involved in personal injury claims have a moral duty to honour the human dignity of the injured party, in particular the values self-determination, equality, reciprocity and respect. To this effect, the professional must provide the injured party with all necessary information and have decisions in the claim handling process taken on the basis of reasonableness and fairness.
These principles are part of *the responsibility to approach*. Professionals have their own responsibility to enter into and remain, as long as necessary, in discussion with the injured party and the other professionals in a reasonable manner.

Consequences

Professionals involved in personal injury claims have to substantiate the basis of their choices and why they disregarded other choices. When asked, a professional should be able to demonstrate an explicit weighing of the identified interests. This weighing of consequences is part of *the handling responsibility*. Professionals have their own responsibility to examine the consequences of all options for handling, to weigh them and to form an independent judgment on that basis.

Virtues

It is a virtue of justice for professionals involved in personal injury claims to compensate the impaired health of the injured party in an appropriate manner. The values fairness and sincerity are therefore first and foremost. It is a virtue of care for professionals to deal carefully and confidentially with the provision of information as well as the professional procedures to be gone through, and to respect the privacy of the injured party. It is also a virtue of care for professionals to develop their competencies further and to conduct themselves according to the criteria of professional practice that prevail in their professional group. Lastly, it is a virtue of self-education to develop self-knowledge and courageously adhere to these ethical starting points. These virtues are part of *the responsibility to develop*. Professionals have their own responsibility to develop self-knowledge and competencies. Precisely this contributes to a careful and confidential approach to the injured party and an honest and fair compensation of the loss.

Values in the GBL

For the GBL, human dignity is the central, overarching value. The table below contains a definition of human dignity with the four moral values it enshrines. These are intrinsic values. That means they have a value in themselves that is worth striving for.

Table: Human dignity and intrinsic values

Definition of human dignity	*Intrinsic values*
Human beings are intrinsically sensitive creatures who are conscious of themselves and can (learn to) think and act independently by developing themselves as they see fit in interaction with others specifically by:	1. Self-determination
putting oneself in the other person's position	2. Reciprocity
treating him or her as an equal,	3. Equality
and respecting the other person's individuality.	4. Respect

To achieve the application of this value in the GBL five other values deserve attention. These are health, privacy, sincerity, trust and courage. These values function as means to achieve the central value. They are therefore also called instrumental values.

1. Health

Human beings need health to actualize their talents and achieve their ambitions and potential. In the event of personal injury claims, injured parties lack health to a greater or lesser extent. This impairs the intrinsic value of self-determination (or autonomy). It is relevant to recognize this fact in the personal injury claim settlement.

2. Privacy

Anyone who is injured and claims compensation will be faced with procedures and assessments, will end up in files and will be the subject of discussion among professionals. This is unavoidable. It does, however, give rise to the need for discretion in the use of personal data. Those involved must respect the injured party's privacy and right of self-determination.

3. Sincerity of the parties towards one another

Sincerity is an important instrumental value for all parties involved in handling personal injury claims. Each party should not just be honest and open on his or her own about relevant matters, but should also approach the other party honestly and openly. Sincerity facilitates an equal and respectful settlement of the personal injury claim.

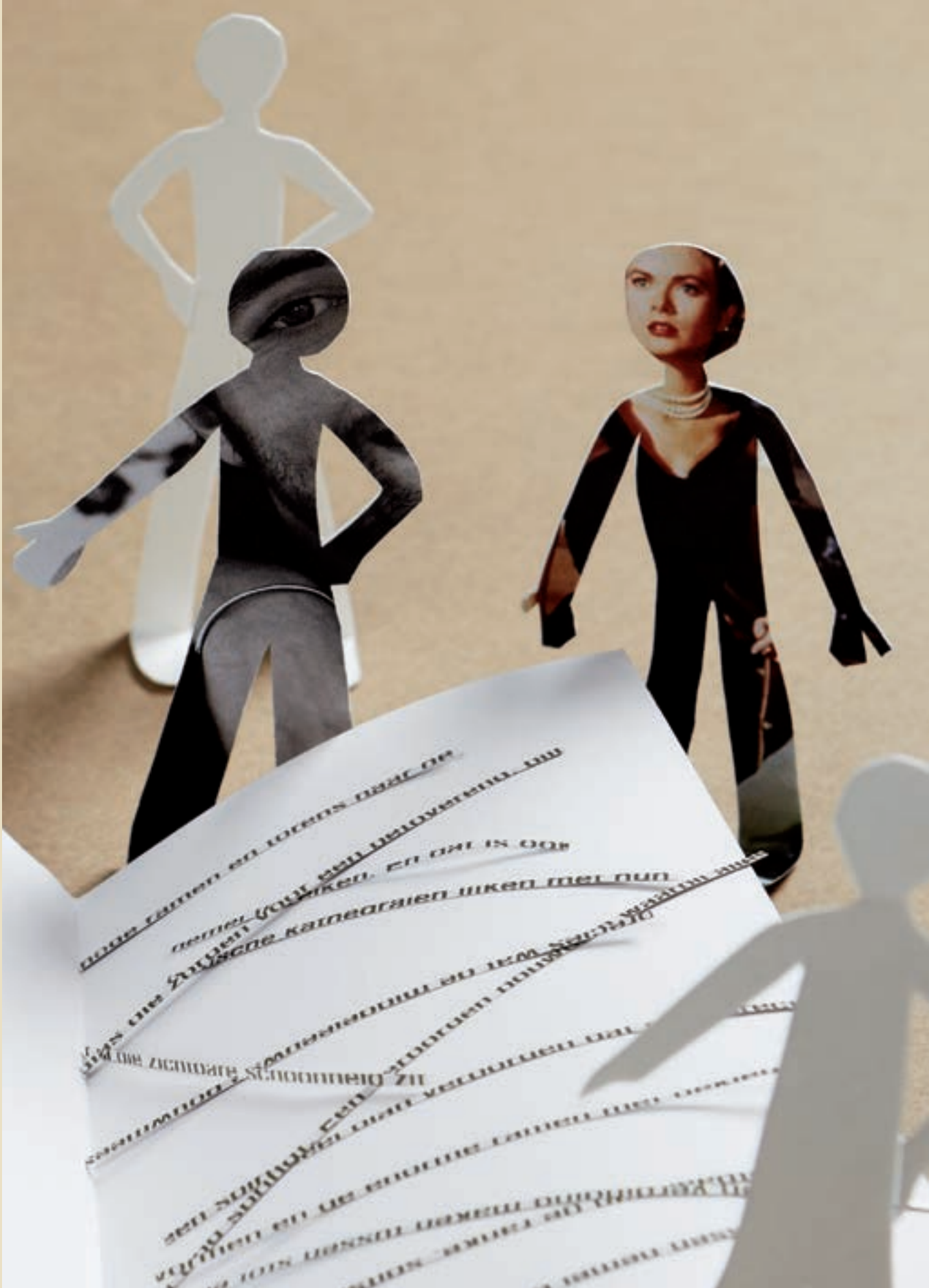
4. Trust

Trust is at least the expectation that the other party will take a predictable attitude and behave predictably. Representatives do of course primarily focus on the interests of the injured party, their own client. Based on their good reputation, professional representatives take extra care in their relationship with other parties involved, such as the insurer. Such care is reciprocal. Trust serves the target values respect and reciprocity.

5. Courage

Courage stands exactly between cowardice and overconfidence. Professionals with courage willingly dare to take risks in order to stand up for the professional values referred to in the ethical starting points of the code, even if this means moderation of other values and, for example has financial consequences.

The first paragraph of Annex 1 contains an explanation of the above-mentioned moral values and standards and their relationship to the rules of conduct. In the second section, there is an outline of the three perspectives: principles, consequences and virtues and their connection with the three responsibilities.



3 Representation

Rule of conduct 1: Provide information about representation

Representatives who are approached for assistance in settling personal injury claims explain to the injured parties under what conditions they can provide their services. In doing so, they are guided by the interests of the injured parties. The representatives provide the injured parties with the correspondence between them and the insurer.

Explanation

a. The costs of representation and flows of money

Representatives provide clarity to the injured party regarding the conditions under which they can provide their services and regarding any choices made in that respect. Such clarity is required before the representative and the injured party enter into an agreement. The representative gears his or her offer to the interests of the injured party. The representative gives the injured party a written explanation of the reason for the different types of rate agreements and states that the injured party has a free choice.

A *no cure no pay* agreement is as a rule only meaningful to the injured party if it is plausible that liability will be a source of debate with the insurer.[2] For instance, in the case of a head-tail collision, liability is well-nigh a fact. In that case, the representative must explain clearly why the choice of *no cure no pay* is nevertheless logical.

It is unethical and unacceptable for a representative to claim double, for example by charging the injured party a percentage of the compensation and at the same time invoicing the insurer for a fee.

The costs of representation in a claim settlement are also called 'extrajudicial costs'.[3] It is legally regulated that these costs are part of the damages of the injured party (Section 6:96 of the Netherlands Civil Code (BW)). If liability has been determined, the injured party can recover these costs from the liable party, provided the costs are reasonable. On the one hand, it must be reasonable that the injured party has engaged a representative and, on the other, the amount of the costs must be reasonable. What is reasonable depends on many factors, such as the hourly rate, the gravity of the injury, the complexity of the case and the amount of the claim in proportion to the time the representative spends on handling it.

2 As information for injured parties, the Personal Injury Council has published the guide 'Grip op uw letselschade' (Grip on your personal injury) containing inter alia various financial arrangements.

3 This applies in contrast to the costs of the representative's fee in case of a court action. Injured parties must in principle pay these costs themselves.

b. Correspondence

If injured parties have representatives, they will receive copies from their representatives of the notices to and from the insurer. The insurer will therefore send only substantive notices to the injured party if the latter does not have a representative. For the rest, the insurer is at liberty to inform the injured party about the progress of the claim settling process, even if the latter does have a representative.[4]

4 Cf. point 5 of Company Regulation 15 'Provision of information in cases of personal injury', applicable since 1 July 2012.

4 Establishment of liability and initial contact

Good practice

The injured party can hold the person responsible liable. For assistance in settling the personal injury claim, the injured party can contact a representative.

If liability is established, injured parties can then recover the damage and/or loss they are suffering or have suffered from the person responsible. The person responsible often has liability insurance, for example the compulsory motor liability insurance for motor vehicles. In that case, the insurer acts on behalf of the person responsible. In the handling of the personal injury claim, in most cases the injured party therefore has to deal with the insurer or with a loss adjuster engaged by the insurer.

In establishing liability, values such as sincerity, reciprocity, trust and equality play a part. The insurer needs to communicate understandably and constructively so that the injured party will be well able to follow the answer to the question of liability.

A respectful approach makes the personal injury claim process more comprehensible for injured parties. The injured party will then notice that the insurer takes them seriously, which gives trust that their case will be handled carefully. Respect and trust contribute to mutual understanding. Recognition is important. That is the central conclusion of the study 'Slachtoffers en aansprakelijkheid' (Victims and liability) (2008). Empathy is also very important. Injured parties who feel that they are listened to, have more confidence that the insurer takes them seriously.[5]

Rule of conduct 2: Confirm receipt

Two weeks at the latest after receipt of the notice of liability, the insurer confirms receipt in writing to the injured party and the latter's representative.

Explanation

Two weeks at the latest after receipt of the notice of liability, by confirming receipt thereof, the insurer makes itself known to the injured party and - if applicable - to his or her representative.[6] The

5 For a case in which empathy was lacking, see the decision of the Insurance Companies Supervisory Board ('RvT') (2004/18). The complainant's daughter died in an accident on 11 January 2002. The insurer was informed immediately. After the insurer was subsequently held liable for the consequences of the accident on 8 May 2002, it disputed being fully liable (only) on 29 October 2002 and stated that the matter had been presented to its counsel. Following the latter's advice, the insurer persisted in its position in a letter of 26 November 2002. The complainant reproached the insurer for never having expressed its sympathy. The RvT found the complaint well-founded. The insurer defended itself by pointing to the substantial amount of time between the accident and the notice of liability, and to the circumstance that correspondence was not with the complainant himself, but with his counsel. The RvT found that this did not demonstrate an understanding and sympathetic attitude that was appropriate and called for in the incident.

6 Cf. Recommendation 13 of the Code of Conduct for Medical Incidents; better settlement of Medical Liability (GOMA)

person responsible may not yet have reported the loss to the insurer. In that case, the insurer will request the person responsible (its own insured) to report the damage immediately. For a smooth handling of the claim, telephone or digital communication is preferable.

After the injury has been reported, the insurer will contact the injured party. If the injured party has a representative, the insurer will contact that representative. The contact should preferably run by way of a fast means of communication such as telephone or e-mail.
If the injured party gets in touch him/herself, the insurer will make time for this communication. If a discussion is not actually possible at that moment, the insurer will make an appointment for a discussion as soon as possible. If the injured party has a representative, the insurer coordinates with that representative how it can demonstrate its interest to the injured party.

The insurer will tell the injured party who is handling his or her case and therefore acts as contact person. During the initial contact the insurer:
- inquires after the welfare of the injured party and shows sympathy and understanding;
- inquires about the consequences of the accident;
- states the information under which the claim is known to it, such as the file reference and the name and telephone number of the handler;
- sends a confirmation by e-mail or letter if the injured party so desires;
- explains what the injured party can expect of the claim settling process.

The insurer sends a brochure, letter or e-mail or refers to a website with more detailed information.

If the injured party is assisted by a representative, the insurer sends the injured party the above-mentioned brochure, letter, e-mail or link to the website and informs the representative to that effect.

In this way, the insurer provides information at any rate about:
1. assessment of liability;
2. the GBL;
3. the personal injury Guidelines;
4. the claim settling process;
5. representation and reimbursement of extrajudicial costs;
6. the medical process; and
7. the possibility that the injured party will be approached in connection with a satisfaction survey.

Rule of conduct 3: Start an investigation

The insurer acts alertly and carefully by starting an investigation into the liability of its insured immediately following receipt the notice of liability.

Explanation

The substantive contacts about liability and the injury are held between the insurer and the representative. They make agreements together on the steps to be taken in settling the claim.

The insurer starts from a completed and signed damage form in order to determine involvement and fault. If necessary to establish liability, the insurer writes directly to witnesses. Sometimes the insurer requests official police report(s). In all cases, in addition the insurer requests only that information that is actually needed in order to establish liability.

Generally, the insurer usually needs answers to the following questions:
- What exactly happened?
- Which injured party/parties are involved?
- Whom does the injured party hold responsible for the injury and for what reason(s)?

To establish liability, the insurer does not necessarily need a completed and signed claim form. In its decision of 16 April 2007 (VR 2008/128) further to a complaint, the Insurance Companies Supervisory Board ('RvT') found it defensible that the insurer drew conclusions about liability on the basis of a letter in which the insured gave his version of the accident, a witness statement and the police report. According to the RvT, the insurer rightly took the position that these documents were sufficient to assess liability. Consequently, the insurer did not need to require a completed claim form (still) to be sent, according to the RvT.

Rule of conduct 4: Take a position

The insurer takes a substantiated position on liability within three months of receipt of the notice of liability.

Explanation

a. Introduction

According to rule of conduct 4, the insurer has to take a position on liability within three months following receipt of the notice of liability. This period is laid down by law for vehicle insurers in Section 4:70 subsection 6 of the Financial Supervision Act (*Wft*).[7]
This section also provides that within the period of three months, the insurer will:

a. make a reasoned proposal for compensation, if liability is not disputed and the extent of the damages has been determined; or
b. give a reasoned answer on all points of the request for compensation if liability is disputed or if the extent of the damages has not yet been fully determined.

By doing so, the insurer sees to it that the injured party does not needlessly remain uncertain for too long a time. Injured parties need certitude quickly and want to know as soon as possible if their injury will be compensated. This enables the injured parties to represent their interests.

The insurer must explain its position clearly, certainly if it rejects liability wholly or in part. Friendly, open, understanding and understandable communication is important. If the insurer disputes liability, it must send the injured party a reasoned answer on all points of his or her request for compensation, providing with evidence justifying why the insurer disputes liability.

Sometimes the insurer still waits for information from other organizations. Think for example of an official report from the police. In that case the insurer may take a provisional decision by acknowledging liability 'subject to reservations'. The insurer must state on the basis of exactly what missing information it might still change its decision.

A judgment of 10 June 2003 of the Arnhem Court of Appeal (VR 2004/45) is relevant, even though the exact passage of time in this judgment is not completely clear. In the course of the years, a motor liability insurer had expeditiously tackled the settlement and reintegration of a claim and had also made substantial advance payments. When the injured party started interim relief proceedings, the insurer disputed for the first time that it was liable. The Court of Appeal dismissed that. The Court of Appeal referred to the period of 3 months after the accident and ruled that the insurer should have realized that precisely its cooperation without reservations in limiting the loss and substantial advance payments had aroused the injured party´s justified trust that liability was no longer at issue.

7 This period is also in line with Recommendation 15 of the 'Code of Conduct for Disclosure of medical incidents; better settlement of Medical Liability' (GOMA) which also stipulates a period of three months for claims in medical liability cases.

b. Not against better judgement

The insurer rejects liability only if this is reasonably defensible. Rejecting liability against better judgement is contrary to reciprocity, sincerity (of the professional involved in the personal injury claim) and trust (in a professional organization).[8]

c. Own fault

It is the injured party's own fault if the injury is (partly) to blame on him or herself. It follows from the law (Section 6:101 subsection 1 of the Netherlands Civil Code) that in that case, the obligation to compensate is reduced partially, in other words by a certain percentage. Sometimes the compensation even lapses completely. If the insurer considers relying on the injured party's own fault, it must (in principle) prove that assertion. In considering this, it will see whether it will be able to furnish such proof. Moreover, it should take account of the interests of the injured party and realize how that assertion can come across to the injured party. The (legal) assertion 'own fault' can actually come across as emotionally loaded to someone who has had an accident and is usually not a lawyer. Reliance on own fault requires careful handling. The insurer should therefore substantiate its position in an understandable and respectful manner. During a following debate over (the extent of) own fault, the handling of the claim will proceed.

d Acknowledged is acknowledged

If the insurer has acknowledged liability (in part), it can in principle no longer change this to the disadvantage of the injured party. The Netherlands Supreme Court (Hoge Raad) so ruled in its judgment of 19 September 2003, NJ (Dutch Law Reports) 2003, 619. From the viewpoint of certainty, the injured party may in principle hold the insurer to the statements it made (or were made on its behalf). Supposing that the insurer writes to the injured party that it acknowledges liability for the consequences, it will then be bound by this. The injured party should, after all, be able to trust that the insurer as a professional party deals carefully with liability issues.

8 Cf. in a broader context: N. van Tiggele-van der Velde (2009) and J.L. Smeehuizen (2009).

5 Determination and compensation of losses

Good practice

Insurers actively gather the financial, medical, occupational and any other information that is needed to settle the personal injury claim. The underlying idea of this attitude is that insurers take care that injured parties return to the position before the accident as soon as possible – at any rate in a financial sense. A quick settlement shortens the period of breach of their self-determination or autonomy and freedom, and gives them social and economic security. Cooperation is expected of the representative and the injured party. In consultation with their clients, representatives provide for a reasoned overview of the damages. This enables insurers to handle the claim as properly, effectively and efficiently as possible, which promotes transparency and expeditiousness.

The obligation to pursue an active claims settlement policy is not new. Company Regulation 15 from 1992 of the Motor Vehicles Department of the Dutch Association of Insurers stipulated for example that the insurer must take an active attitude in settling claims.[9] The insurer should demonstrate concern for the material and immaterial needs of the injured party, acknowledge them and act accordingly. It should find out what the injured party considers important. By doing so, it acknowledges and shows respect to the injured party.

Personal injury settlements are based on cooperation. In harmony, on the basis of respect and reciprocity, the parties form a picture of the injured party's situation. Injured parties should cooperate in settling the claim. Sincere cooperation will arouse trust in the injured parties that they are taken seriously. It is obvious then that the injured party takes a central place. The handling of a claim is usually unknown territory for injured parties. Professional parties take this into account. They talk to injured parties in plain language and avoid jargon. If they nevertheless have to use professional terms, they explain to the injured parties exactly what they mean.

The parties work together, but if they nevertheless cannot reach agreement on the amount of a certain loss item, the insurer must then at least pay the part it acknowledges. They both give their reasoned opinions on the part on which there is no agreement. If possible, they present alternatives. If they still do not succeed in reaching agreement, they discuss alternative solutions aimed at reaching agreement. Conceivable solutions are discussed in the 'Dispute Resolution' Section.

9 Company Regulation 15 'Provision of Information in Personal Injury Cases' has applied since 1 July 2012.

Rule of conduct 5: Exploration and contact

The parties strive for appropriate solutions in the personal and work environment of the injured party by exploring in depth the latter's personal situation, ambitions and potential. Requests for additional information are proportional. The insurer takes account of the fact that the injured party may have to make efforts to obtain the information. The insurer has personal contact with the injured party at least once a year to inform itself of the latter's injury and situation, even if the injured party is assisted. This requirement does not apply if the injured party states that he or she does not appreciate such contact.

Explanation

a. Contact with the injured party

About two months after the accident, the parties will check again how things are going with the injured party.[10] The lack of an upward trend might indicate stagnation in the recovery process. In that case the parties will consult on whether interventions could be appropriate and if so, which. Engagement of a reintegration agency or occupational consultant or other expert is conceivable. It is up to the insurer to facilitate this. Moreover, by doing so, the insurer shows the injured party interest and empathy.

If the injured party has not recovered completely from the accident within three months,[11] the insurer must:

- actively continue to gather the financial, medical, occupational and any other information that is relevant to settling the claim; and
- in the interim regularly compensate the damage and/or injury suffered which it acknowledges by making timely advance payments to the injured party.

Engaging an occupational consultant or other expert

If the injured party is not or not fully able to return to work within three months, the insurer will discuss whether engaging an occupational consultant or other expert could speed up his or her return.[12] Sometimes the injury is so permanent that, as a result of the accident, the injured party can no longer function (wholly or partially) on the labour market without assistance. It can also happen that, due to the accident, the injured party can no longer perform household chores independently. In such cases, the parties will discuss whether the engagement of an occupational consultant or other expert could help to increase the (remaining) possibilities of the injured party.

10 Cf. 'Procesgang licht letsel' (Procedure for slight injury), which stipulates that the provider of legal assistance must indicate the loss by (inter alia) assessing whether occupational disability of less than 4 weeks and/or recovery of the injured party within 6 months after the accident can be expected. The 'Company Regulation on Provision of Information in Cases of Personal Injury' stipulates in this context that the insurer must visit the injured party as soon as possible if the injury is expected to last more than six months.

11 This period is in line with the period of the 'Personal Injury Guideline for Slight Injury' which stipulates that with expected recovery within three months, it is not generally necessary to request medical information.

12 This period runs parallel to that of the 'Personal Injury Guideline for Slight Injury'.

If they expect this to be the case, they will then make specific agreements to that effect.
It is important for the injured party to strive for reduction of the disabilities. Health is an important value in human existence. The liable party has little or no direct influence on recovery of the state of health. It is nevertheless indeed possible to make a direct connection to what the insurer can do for injured parties and their health. Take a loss item such as 'household help': by assessing the extent of the need for help and then providing for it (financially or in kind), the insurer contributes to recovery to the original state of health. Help with the housekeeping compensates the disability, which enables injured parties to regain their freedom and (a certain extent of) autonomy. In this way, the insurer therefore helps them to live life with dignity.

Appropriate solutions

The claim settlement is aimed at the future. Appropriate solutions for injured parties in their personal and work environment are first and foremost. What is appropriate differs from individual to individual. Think for example of the nature and gravity of the disabilities, or the background, education and experience of an injured party. Possible solutions are facilities in the home, training, education or advice on choosing a profession. With the aim of contributing to recovery, the insurer helps the injured party to find and use appropriate integration possibilities. With that, the insurer builds trust and helps the injured party to return as far as possible to the situation as it was before the incident for which liability exists.

Final settlement of the claim

Once it has been established that a stabilized medical condition has been reached, the parties will consult as soon as possible on a final settlement of the claim. They agree amongst them on who will formulate a settlement proposal. Sometimes it is not yet possible to formulate a proposal, for example because sufficient information is not yet available. In that case, the parties make specific agreements. They determine what information is required to draft the proposal as soon as possible and who will request that information. After receiving the additional information, the party which according to the agreement must draft the proposal does so immediately. It sends a copy of the information obtained to the other party.

The foregoing does not affect the fact that the parties are at liberty to try to reach a final settlement of the claim earlier. It is not an absolute necessity to wait until a stabilized medical condition has been reached. Whether the final settlement of the claim is possible or desirable at an earlier stage depends on the facts and background of the specific case, such as the nature and gravity of the injury and/or the injured party's wish to settle the claim, even though no stabilized medical condition has been determined.

b. No 'fishing expeditions'

Insurers take into account that it will cost the injured party time and effort to obtain the requested information. That is why requests from the insurer for information, as worked out in more detail in the Medical Paragraph, are proportional. Furthermore it is necessary for insurers to think in advance whether certain information is really necessary to assess the loss. The insurer might perhaps explain for what reasons it does (or does not) request certain information. According to the harmony model,

this is precisely how the insurer can involve the injured party in the claim settlement and show respect. 'Fishing expeditions' are not allowed.

The insurer must explain what consequences it attaches if the injured party does not cooperate with it and does not provide the information. It must give the injured party the possibility to decide whether or not to cooperate, thus providing him or her with autonomy. It is conceivable that the injured party will refuse to provide the requested information or to cooperate in gathering it. In that case, the injured party may be required to substantiate why in his or her opinion the insurer may not require him/her to provide the desired information.

c. Tripartite meeting

A tripartite meeting is a meeting between the injured party, his or her representative and the insurer (or the loss adjuster engaged by the insurer). In principle, there are three appropriate times for a tripartite meeting, namely:

- at the start of the settlement of the personal injury claim;
- while coordinating the measures to be taken in relation to the two-year period of Rule of Conduct 7; and
- at the end of the settlement of the personal injury claim, if one or more of the parties feels a need to do so.

The purpose of a tripartite meeting can be very diverse. For example, the discussion partners aim to get acquainted, bring about mutual understanding, give injured parties the opportunity to tell their story and express their concerns, wishes and needs, to explain the claim and coordinate the handling of the claim. In addition, the parties can exchange information during the tripartite meeting and consult about the state of affairs. Lastly, they can use a tripartite meeting to discuss a final settlement.

The representative and the insurer see to it that injured parties know beforehand what the purpose is of the tripartite meeting. They ensure that injured parties know what to expect so they can prepare for the tripartite meeting and are therefore able to have their interests represented. By providing good information they show respect for injured parties, whom it is all about.

If injured parties do not have representatives, the insurer points out the possibility of engaging a representative prior to the first tripartite meeting. If injured parties state that they want to have their interests represented, the insurer will wait until the injured party has arranged this before making an appointment for a tripartite meeting.

A report is made of the tripartite meeting. The parties agree on who makes the report. The report contains at least the action points and agreements made. The parties will receive a copy of the report.

Please note: during the meeting with an injured party who has no representative, the insurer does not pressurize the injured party to decide on its proposals, but allows him/her a two-week period for reflection. This enables the injured party to deliberate and, if desired, obtain expert advice, for

example by engaging a representative or consulting a general practitioner or occupational physician. The injured party has the right during the reflection period to request an extension.

d. Mandate

Insurers often engage an internal or external loss adjuster to settle the claims. During their contacts, the parties talk about all kinds of matters and make agreements with each other. Making agreements implies that the discussion partners on behalf of the insurer have a sufficient mandate ('are authorized') to deliberate fully with injured parties. This means they are authorized to make statements on behalf of the insurer to which injured parties can hold them. The law also assumes this – as the main rule (Section 3:35 of the Netherlands Civil Code). Moreover, it is a logical aspect of professional conduct.

Injured parties may in any case expect their discussion partners to be clear about any limitations of their authority. This enables injured parties to know what to expect and can gear their choices accordingly. This enables them to decide freely and autonomously.

The binding opinion of Teeuwissen and Bouman[13] is relevant in this context. As a starting point they consider it undesirable for insurers to go against from the advice of the loss adjuster. They argued that an insurer would not need to follow positive advice from an external loss adjuster only if the content or formation of the advice is so contrary to reasonableness and fairness that it would be in conflict with good faith to bind the insurer by it.[14]

Rule of conduct 6: Draw up a damage report

In consultation with the injured party, the representative provides for a substantiated report of the damage. The insurer states with reasons which damages it acknowledges and which in its opinion still need further investigation. If relevant, it will also make its position known on reimbursement of the costs of extrajudicial legal assistance and a possible expert investigation.

Explanation

a. Introduction

The starting point is that the injured party receives full compensation of the damage for which someone else is liable. But how should the damage be calculated? Damage is determined in the way most in line with its nature. It is not always possible to determine the specific extent of damage. In that case the damage is estimated (Section 6:97 of the Netherlands Civil Code).
The insurer must gain substantial in-depth knowledge of the injured party in order to determine the amount of the damages. As a professional it has this responsibility to the injured party. Exactly

13 4 May 1998, VR (Motor Vehicle Regulations) 1999, 14
14 Cf. HR 18 June 1993, Dutch Law Reports (NJ) 1993, 615

which aspects play a part in determining damages depends on the specific situation, ambitions and the original and remaining potential of the injured party.

The main rule is that injured parties prove the amount of their losses. Sometimes this can be done by submitting invoices, but they are not always available. Moreover, some loss items are not calculated concretely, but abstractly. For the loss item 'household help' for instance, the injured party does not actually have to engage a helper. It concerns compensation of the injured party's 'need for help' (Cf. HR 5 December 2008, NJ 2009, 387). There are also situations in which the amount of the loss cannot or can no longer be determined with certainty. In that case, the insurer has to accept that only limited certainty exists about the exact amount of the loss. Such acceptance is important, because it shows that the insurer trusts the injured party. Furthermore, it shows respect.

Problems with proof also occur in relation to future losses. In determining the losses, the point is ultimately to make a comparison between the actual situation and the hypothetical situation without an accident. This comes down to a reasonable expectation of future developments, in which both good and bad chances are taken into consideration. Think for example of a career that stagnates or is slowed down due to the accident. The law has separate provisions on future losses. For example, Section 6:105 subsection 1 of the Netherlands Civil Code provides that the court can assess such losses in advance after weighing the good against the bad chances. The court may also wholly or partially postpone the assessment of losses that have not yet occurred.

b. Requirements for the standardization of proof

The requirements the insurer sets for proof, and therefore for the information it requires, should do justice to the fact that future developments are often difficult to make plausible. In that case, the insurer has to be satisfied with a reasonable expectation of future developments, whereby account is taken of good and bad chances. The Netherlands Supreme Court (HR) does not set very high requirements for such proof (HR 15 May 1998, NJ 1998, 624 (*Vehof/Helvetia*), but there are limits. In the *Sas/Interpolis* judgment (14 January 2000, NJ 2000, 437), the Netherlands Supreme Court ruled that in assessing the circumstances, the court, as much as possible to the advantage of the injured party, can take account of the loss of the possibility to make choices. According to the Supreme Court, however, the possibility of a teacher to continue working until the age of 65 did not have to be assumed, unless reasons were found in her personal circumstances to assume the contrary.

The Personal Injury Guidelines

The Personal Injury Council has set out guidelines for many loss items. They can be consulted on www.deletselschaderaad.nl. The guidelines are not binding and the parties may depart from the monetary amounts. They nevertheless are an important aid in determining the amount of the damages, thus contributing to a smoother settlement of personal injury claims.

In 2012, the guidelines 'Household help', 'Kilometre allowance', 'Slight injury including general damages', 'Delay in studies', 'Self-sufficiency', 'Reimbursement of hospital and revalidation day fees' and 'Definition of increased economic vulnerability' are applicable.

The importance of the guidelines is obvious. In the short term, they provide the injured parties with a certain degree of certitude, because they obtain clarity relatively quickly regarding specific loss items.

The guidelines have meanwhile acquired authority at law as well, as judicial institutions are regularly inspired by the guidelines (see for example: District Court (Rb.) of Den Bosch 27 June 2012, National Case-Law Number (LJN): BW 9260 (delay in studies); District Court of Breda 11 June 2012, National Case-Law Number: BW 8563 (self-sufficiency); District Court of Arnhem 6 June 2012, National Case-Law Number: BW 9358 (household help); District Court of Arnhem 21 September 2011, National Case-law Number: BT 7190 (self-sufficiency); District Court of The Hague 5 October 2011, National Case-Law Number: BU 3901 (self-sufficiency); District Court of Amsterdam 29 June 2011, National Case-Law Number: BR 6183 (household help); District Court of Rotterdam 20 April 2011, National Case-Law Number: BQ 6208 (delay in studies). The foregoing is merely a selection of the court decisions. Much more case law, classified according to guideline, can be found on the site of The Personal Injury Council (De Letselschade Raad).

c. Record of assessed damages

It is preferable for the parties to keep a record of assessed damages in which all loss items are included that are relevant to the personal injury claim. The record of assessed damages must be clear and understandable to the injured party. This enables injured parties to map out the losses so that they can have an overview of what financial interests are involved. A good record of assessed damages helps to promote the clarity of the claim settlement as a whole.

d. Handling plan

The record of assessed damages can form part of a so-called 'handling plan'. The parties record in the handling plan the points on which they agree and make working agreements: who does what and when? They mention differences of opinion and make specific agreements to resolve them, which enables them to recognize bottlenecks quickly. The parties agree with each other on what information is necessary and record these agreements. Besides this, they plan the medical process together, as well as the further determination of losses. In this way, the handling plan makes visible what still has to be done and what the parties agree or do not agree on. All parties involved, including the injured party, then know what is required of them.

The handling plan is not tied to a certain form. The parties themselves decide on the content of the plan. The point is the idea behind the handling plan. It is essential that the handling plan gives insight into the state of affairs, so that the injured party is able to follow the handling of the claim closely. The same holds for other parties involved, such as medical advisers, experts and judicial experts. A digital version of the handling plan accessible to all parties is preferable.

The handling plan is a living document: during the handling of the personal injury claim, the parties continually update the contents. The joint analysis compels the parties to keep searching for specific solutions. They do so expeditiously by identifying differences of opinion early.

Rule of conduct 7: Pay within 14 days

The insurer pays the injured party the damages that have become evident and which it has acknowledged, or which have been definitively assessed between the parties. This is done within 14 days after acknowledgment or the definitive assessment.

Explanation

On the one hand, the insurer shows the injured party respect by paying the compensation within 14 days. On the other, it has a duty to enable the injured party to participate in life autonomously (again). This gives human dignity back to the injured party. No matter what, the insurer should prevent the injured party from pre-financing the damage. This explicitly concerns advance payment and not 'subsequent payment'.[15] As long as there is a debate between the parties over the exact amount of the damages, the insurer will make an advance payment available which it considers reasonable, and is at any rate willing to pay to the injured party. The advance may be less than an amount offered in any amicable settlement.

The liable party's obligation to compensate the injured party for the loss may not be made subject to preconditions. This is logical, because otherwise the consultations would have characteristics of a power struggle and that is precisely not the intention of the GBL, which is based on a harmony model.

The insurer must make the payment in relation to the personal injury directly to the injured party, even if the injured party is assisted by a representative. The injured party may, however, authorize the insurer in writing to transfer the payment to the representative's clients' account. In that case the insurer informs the injured party of the (advance) payments it made to the representative.

If the representative has received money on the injured party's behalf, he or she must transfer it to the injured party as soon as possible. Setoff - for example against the representative's fee - may take place only if this was explicitly agreed with the injured party, in advance and in writing.[16]

At the final settlement, the insurer informs the injured party of the total amount it has paid in compensation. In doing so, it indicates separately what amount it has paid in extrajudicial costs. The insurer will be at liberty to inform the injured party in the interim about extrajudicial costs it is paying to the representative.[17]

15 By providing late and inadequate advance payments, the insurer damaged the reputation of the insurance sector (RvT 2001/19 Mo.). According to the Insurance Companies Supervisory Board ('RvT'), insurers must see to it that income that is acknowledged and lost by the injured party is compensated in a timely manner. RvT 2005/052 (Med.) is relevant in this context. In the opinion of the RvT – as the insurer argued – there was sufficient doubt as to the causal connection and the complainant himself had not asked for advance payments for three years either. The complaint was declared unfounded.

16 Cf. District Court of Den Bosch 18 April 2012, National Case-Law Number BW2959, which considered setoff of the fee with no right or basis to be automatically unlawful.

17 See in the same sense the Company Regulation on Provision of Information in Personal Injury Claims.

Rule of conduct 8: More than two years: evaluate

If handling of the claim lasts more than two years from the damage report, the parties - at the insurer's initiative - will find out what has caused this. The parties will agree specifically on the measures needed to conclude the handling of the claim as soon as possible and on the party that will implement them.

Explanation

The parties should always conclude each part of the claim settlement expeditiously. They need to take each step promptly, use short response times and if necessary hold each other accountable for breaking agreements made. This ensues from the need to provide certainty to injured parties and from the moral duty to return injured parties to their original condition as soon as possible. Expeditious handling is therefore ultimately based on respect for human dignity.[18]

Sometimes a certain deadline is not feasible. The party in question then makes clear to the other party why it is not feasible and also indicates when he or she indeed expects the action to be taken. By demonstrating openness and clarity, that party shows the other party respect and allows the other party to trust that he/she takes them seriously, even though the deadline was not met.

Direct contact

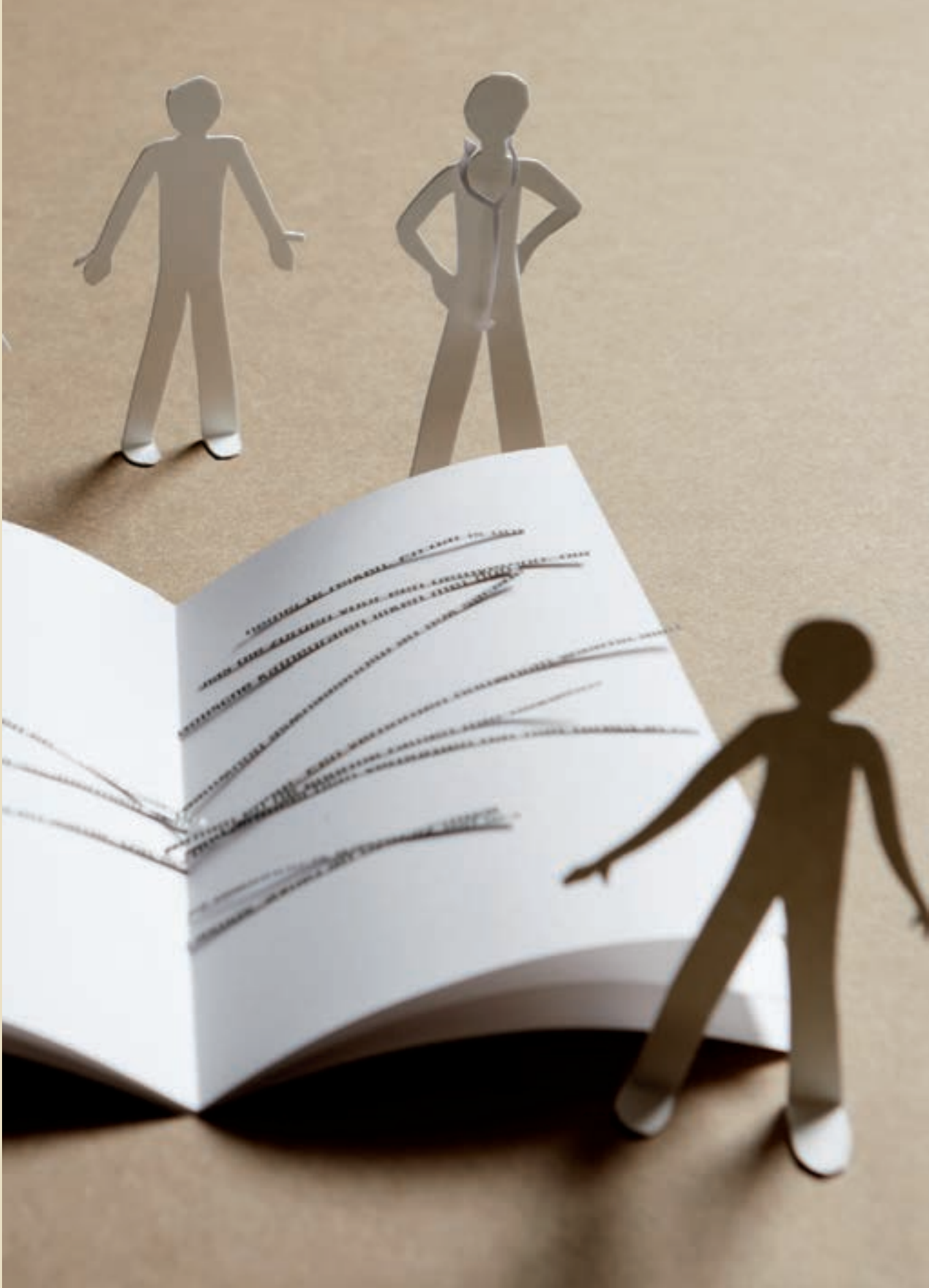
Sometimes the handling of a personal injury claim stagnates because the representative does not respond within the agreed time. In that case, the insurer will be at liberty to contact the injured party directly. The insurer must then explain to the injured party what information was requested from the representative and why it has contacted him/her directly.[19] The insurer only contacts the injured party directly after it has informed the representative of its intention and allowed him/her a period of four weeks to respond.

Most personal injury claims are settled within about two years after the notice of claim. If the handling lasts longer, the parties consult on which specific measures are needed to reach a speedy settlement. The insurer takes the initiative for this. If the injured party has a representative, the insurer then has contact with the representative, but also makes efforts to involve the injured party as well. The parties discuss why it is taking so long and - if necessary - make agreements on what to do next. By doing so, the insurer acknowledges the injured party. This arouses trust, even if the settlement is taking a long time. There can be valid reasons for long proceedings in themselves, but the injured party should be aware of them.

18 In the case that led to the (well-founded) complaint to the Financial Services Disputes Committee no. 16 van 23 March 2009 (to be found via www.kifid.nl), the insurer acknowledged that the loss adjustor it had engaged had not acted expeditiously and had taken an unreasonably long time to settle a claim. The complaint against the insurer that it had failed to settle a claim promptly was also well-founded (RvT 2004/64 Mo.). According to the RvT, expeditious and careful handling may be expected of insurers. Many more examples can be found that deal with this problem: J.L. Smeehuizen (2009) and A.J. Verheij (2002).

19 Cf. point 4 of Company Regulation 15 'Provision of Information in personal injury claims'.

A recommendation made by the Dutch Association of Insurers to its members in July 2012 is worth mentioning. According to the Association, the insurer should have its relevant claims handling department request a second opinion after two years have passed. Should the handling of a personal injury claim last longer than three years, and the injured party is not satisfied with the insurer's approach, the injured party will be entitled to independent dispute resolution, such as mediation, according to the Association's recommendation.



6 The medical assessment process

Introduction

In cases of personal injury to some extent, medical information usually plays a significant role. The representative usually consults a medical adviser in such cases.[20] The 'Medical Paragraph' forms part of the GBL as a separate publication in which the procedure is described for gathering medical information and the issue of advice by medical advisers, who are usually engaged by the parties. The 'Medical Paragraph' contains rules and good practices for the medical assessment process in determining personal injury. Various working documents in the 'Medical Paragraph' afford the good practices substance. They translate the good practices into actual working methods. An example of a successful working document is de 'IWMD Vraagstelling causaal verband bij ongeval'. (IWMD Questionnaire Concerning Causal Connection in Accidents). This working document is included in Section 5 of the 'Medical Paragraph' that deals with the medical expert's examination.

This section contains a brief description of the medical assessment process and several starting points and good practices from the 'Medical Paragraph'. For a complete statement of rules, good practices and working documents, please refer to the 'Medical Paragraph' ('*Medische paragraaf*') itself (www.deletselschaderaad.nl/medischeparagraaf). Should there be any differences in interpretation between the GBL and the 'Medical Paragraph' concerning the rules and good practices in the medical assessment process, the text of the 'Medical Paragraph' will prevail.

After medical information has been collected, it must as a rule be determined if, and if so which (medical) disabilities the injured party has due to the incident for which liability exists. A proper description of them is indispensable for a claim settlement. After all, particularly the disabilities constitute the basis of the claim. A medical specialist (for example a neurologist or orthopaedist) usually makes a diagnosis and determines whether the injured party has a disorder that leads to disabilities, after which an insurance physician or a medical adviser determines the exact disabilities. An occupational consultant then calculates the specific impediments on the basis of those disabilities. The assignment of the occupational consultant often consists of several parts, for example determination of the loss of ability to work (also called earning potential) and loss of the ability to perform household chores or loss of self-sufficiency (another word for maintenance of the house and garden). Sometimes the occupational consultant assists in making provisions to increase the injured party's fitness for work or attempts to improve the injured party's reintegration. In addition, the occupational consultant can advise on adjusting the job or place of work to increase the injured party's ability to work.

20 Cf. a judgment of 5 September 2009 of the Leeuwarden Court of Appeal (National Case-Law Number: BB 3156).

To do so, he or she checks:[21]

1. what activities are performed for the tasks;
2. how much time the separate tasks take; and
3. the extent to which performance of these separate tasks is restricted by the aforementioned disabilities.

Once again: it is in particular because of the inability to perform tasks for which liability is acknowledged that an injured party is entitled to compensation.

a. Proportionality, transparency, objectivity and independence

The main criteria in the medical assessment process are proportionality, transparency, objectivity and independence. Proportionality is without a doubt the most important criterion and applies to:

- the (medical) examination;
- the (medical) information requested;
- discussion of the information, disabilities and claim; and
- the performance of medical experts' examinations.

Furthermore, no more time should pass than is necessary in the specific case. Only a proportional breach of the confidentiality of medical information can be justified. 'Proportional' means that the insurer has to weigh its interests in having access to the medical information against the legitimate interests of injured parties, including respect for their privacy. The potential relevance of the requested medical information is especially important. An example: an injured party asserts that since the accident, he or she has had certain symptoms, but these symptoms had already played a part earlier in their life. In that case it is easier to justify requesting access to the medical history than if it has been established that the injured party had no symptoms at all before the accident. The 'Medical Paragraph' lists a number of proportionality criteria (such as relevant medical history). These criteria are helpful in substantiating and assessing a request for access to medical information (§ 3.3.1 of the 'Medical Paragraph').

Proportionality considerations actually run as a thread through the entire medical assessment process in:

1. Requesting medical advice: What questions are posed to the medical adviser?
2. Collecting and dealing with medical information: to which medical information may the insurer request access and which persons may inspect this information?
3. Advice by the medical adviser: Which medical information do medical advisers consider in issuing their advice?
4. Any questions regarding a medical expert's examination: Is the examination really necessary or would consultation among medical advisers perhaps help to further the case as well?

21 Interim relief judge of the Utrecht District Court 21 May 2008, National Case-Law Number: BD 2391.

The proportionality considerations are connected with values which form an integral part of the medical process, such as trust, respect, independence, sincerity and equality. Transparency is also important. Transparency in handling the claim is essential in order to further mutual trust between (representatives of) injured parties and insurers. Transparency is essential, especially in the medical assessment process. Insurers need to give clear reasons why the injured party has to make medical information available. In turn, injured parties need to be transparent towards the insurer about the (medical) developments and (medical) information that may be important in settling the claim. Transparency is required in medical advice as well. Transparency increases verifiability and does justice to values such as sincerity and equality.

Lastly, objectivity and independence are important. The medical adviser's position is by no means simple. On the one hand, he or she as a professional must be autonomous, objective and independent. On the other, he or she is engaged to advise only one of the two parties. This inevitably entails a certain one-sided perspective. The 'Medical Paragraph' deals extensively with this.

b. Requesting medical advice

Section 2 of the 'Medical Paragraph' contains a format for requesting advice from a medical adviser (Working Document 2). The medical adviser needs to receive enough background information, for example about the circumstances of the harmful event, the medical, social and occupational aspects of the injured party's life, the nature and amount of the main damages and any points of dispute between the parties. The parties need to ask the medical adviser specific questions relevant to the case. The working document contains suggestions for the request. The working method set out in Section 2 of the 'Medical Paragraph' allows injured parties to trust that the parties will deal carefully and respectfully with their claims. They know exactly what to expect, feel safe and acquire trust in the advice to be given and with that also in the handling of the claim as a whole.

c. Collecting and handling medical information

Insurers need information from injured parties, but injured parties are entitled to protection of their privacy. Access to medical information pre-eminently affects personal life. Insurers must therefore inform injured parties in good time of the need to request medical information. In doing so, insurers must state who will be able to inspect the information, under which rules and good practices the breach of their privacy is limited to what is necessary and what the possibilities are to monitor compliance with them. Section 3 of the 'Medical Paragraph' contains a 'Consent form for the provision of medical information'. Insurers can use this working document to inform injured parties, so that injured parties can give informed consent to collect and handle their medical information in accordance with the rules and good practices from the 'Medical Paragraph ' (Working document 3-I). The idea behind this is once again that injured parties should feel safe and should be able to trust that their medical information will be handled with due care.

An important point is that the medical advisers of both parties exchange all relevant information. In principle, they should be able to have the same medical information available. This does justice to the value 'equality'.

d. Medical advice

Section 4 of the 'Medical Paragraph' deals with the medical advice itself. Medical advisors strive for the highest possible degree of objectivity and independence. In doing so, they observe the rules and regulations of the professional code applicable to them. They should not allow themselves to be guided by the client's interests. They are critical, do not take any preconceived position and have a respectful attitude. In their advice, a distinction is made between facts, allegations and personal opinions, and they monitor the limits of their competency and expertise. Their advice contains only medical information that is (potentially) relevant to handling the claim and answering the questions asked.

§ 4.3 of the 'Medical Paragraph 'contains the requirements medical advice has to meet (see also the ruling of the Central Medical Disciplinary Tribunal of 1 September 2011 (C2010.302)):

1. The adviser explains clearly and consistently the grounds on which the conclusion is based.
2. The grounds explained are sufficiently and demonstrably supported by the facts, circumstances and findings of the report.
3. Said grounds justify the conclusion drawn from them.
4. The content of the report is limited to the expertise of the medical adviser.
5. The investigation method is sound and results in answering the question, and the medical adviser does not go beyond the limits of reasonableness and fairness.

Besides the substantive requirements, the highest disciplinary tribunal has called for standardization of the way in which medical advisers issue their advice (CTG 19 July 2007, 2006.026). This resulted in the development of Working Document 4. This section of the 'Medical Paragraph' helps medical advisers to produce uniform and structured reports.

An important good practice is that the medical advice and the way in which it originates is transparent and verifiable. The medical advice should therefore first of all contain a list of all requested and consulted medical information and the questions asked. A medical adviser preferably gives advice in writing. The parties must make the medical advice on which they rely available to each other. An explanation of these rules and good practices can be found in §4 of the 'Medical Paragraph '.

e. The medical expert's examination

Medical experts' examinations are in principle limited to the following three situations:

1. The medical advisers themselves do not have enough medical knowledge to assess the problems presented.
2. There is not enough detailed medical information available (from examinations) to assess the problems presented. This occurs, for example if a lot of time has already passed since the medical treatment and there is a need for current medical information from examinations of the injured party.
3. The medical advisers continue to have substantiated differences of opinion on certain points, for example on the question of which disabilities ensued from the accident. Before a medical expert is engaged for an examination, it is advisable to see whether direct consultation between the medical advisers can help to further the case. If this succeeds, an expert's medical examination may not be necessary.

Sometimes an expert's medical examination is needed nevertheless. In that case, it is preferable to have the expert's medical examination conducted at the request of both parties. A joint expert's medical examination has virtually the same value (and evidential value in any proceedings) as an expert's medical examination by order of the court. In that sense, a joint expert's medical examination is more valuable than an expert's medical examination conducted after a one-sided request (Cf. Amsterdam Court of Appeal 16 March 2010, National Case-Law Number: BM 9228).

If the parties decide on a joint expert's medical examination, they consult with each other on the expert to be appointed, the specific questions to be submitted and the medical information they will present to the expert. In accordance with the case law of the Netherlands Supreme Court on this point (HR 22 February 2008, National Case-Law Numbers: BB 3676 and BB 5626, Red (case law of the week) 2008, 256 and 261) the report on the expert's medical examination, conducted on a joint request, must in principle be available to both parties, therefore also to the insurer's loss adjuster. This principle, too, is based on values such as equality, sincerity and trust.

In formulating the questions to ask the expert, it is advisable for the parties to be in line with the questionnaire of the IWMD, the so-called Questionnaire Concerning Causal Connection in Accidents, drawn up by the Interdisciplinary Working Group of Medical Experts (IWMD) of the VU University in Amsterdam (www.rechten.vu.nl/iwmd). This questionnaire was drafted specially for the assessment of causal connection in accidents. Judges also use this questionnaire in thinking up questions for experts.

7 Dispute resolution

Good practice

Despite the harmony model based on cooperation, it sometimes happens - unfortunately - that a claim settlement reaches a deadlock. In that case, the parties will discuss exactly what is keeping them divided. Once that has become clear, they seek a solution. If they do not succeed, they contact a neutral third party. This decision is taken jointly, or if that does not succeed either, by one of the two parties.

Seeking a solution together ensues from the moral values of acknowledgment and mutual respect. Even though the parties have a dispute, they assume their responsibility and remain in discussion with each other, because escalation (usually) does not solve the problem. This enables the claim settlement process to take place on the basis of equality of the parties.

Rule of conduct 9: Seek a solution

If the claim settlement reaches a deadlock, the parties will map out exactly what is keeping them divided. They will seek a solution together as soon as possible.

Explanation

Seeking solutions starts with a precise description of the problem. The party with the problem involves the other party in it and together they attempt to solve the problem. The underlying idea is that injured parties should be able to decide in all freedom, i.e. autonomously, what they would want to or could do about the problem. Moreover, injured parties will have the feeling that they 'take a central place'. Parties who seriously attempt to solve a problem together also feel safe. They will actually find that the other party respects their existence and performance. Here, too, human dignity plays a significant role.

The parties should explain as accurately as possible in writing what exactly the problem is that is keeping them divided. While mapping out the problem, they should also indicate the points on which they do agree. In this way they define the dispute as well as possible. This gives them certainty, because it will be clear what has been keeping them divided.

Rule of conduct 10: Engage a third party

If the parties do not succeed in reaching a solution together, they contact a third party to bring about a final solution. The parties preferably take this decision together.

Explanation

Solutions often seem to be far away, but are sometimes nearer by than we think. The advice of a colleague or third party can give a very different view of the matter. This allows the parties to check their opinions. They demonstrate respect by having an open mind for the other person's viewpoint and make the effort to pay serious attention to him or her. The parties can decide together to engage a neutral third party, but one of the two parties can also make this choice. This needs to be done constructively and within a short time. The neutral third party can, for example, be a mediator or arbitrator, a binding adviser, an expert in the field of loss calculation, a medical specialist, an insurance physician, a technical expert or an occupational consultant.

In 2011, the plan was conceived to give the mediator's profession a legal framework. In a private member's bill, it was suggested to include in the law that the parties to a dispute must inform the court why mediation has not been tried – or if it has indeed been tried – why the parties did not succeed in reaching agreement.[22]

Parties can also engage the Dispute Resolution Desk of the Personal Injury Council. Each party can contact the Dispute Resolution Desk to ask a question, about a difference of opinion or to present a dispute. The lawyer of the Dispute Resolution Desk analyses the matter, hears everyone involved and gives advice on the most appropriate solution of the conflict. The Dispute Resolution Desk can also help to determine what exactly is keeping the parties divided if they cannot do so themselves.

Injured parties in motor vehicle liability cases have the additional option to contact the Financial Services Complaints Tribunal (KiFiD). They can file a complaint with the KiFiD or with the Ombudsman, possibly followed by the Financial Services Disputes Committee. The Ombudsman will attempt to resolve the matter through mediation. In a decision, the Disputes Committee will issue an opinion, usually binding, on the dispute presented. Both the Ombudsman and the Disputes Committee can refer the case to the Financial Services Disciplinary Tribunal (Insurance) for a fundamental test of the insurer's behaviour, for example against the rules of conduct applicable in the sector. This concerns self-regulation that is binding on the members of the Association of Insurers.

'Acting in the spirit of the GBL' means that the parties actually make efforts to reach a solution. If they ultimately fail to do so nevertheless, they can involve the courts in their dispute in various ways. They can, for example start interim relief proceedings or submit an application to order 'subproceedings'. These proceedings have existed since 1 July 2010 and provide the possibility to bring part of the claim settlement before the court with the intention of getting the claim settlement back on track. Personal injury practice has meanwhile made frequent use of this possibility.

22 Cf. in this context also the oration by Barendrecht (2011).

In the spirit of the GBL, it is preferable to submit a joint application for subproceedings. Possible subjects of subproceedings are the question of liability, the extent of own fault, determination of the value of an adjustment report in the claim settlement or the amount of certain damages. An additional advantage of these proceedings for the injured party is reimbursement of extrajudicial costs. In principle, the court must assess the extrajudicial costs, even if it ultimately dismisses the application. These proceedings can therefore usually be started against relatively predictable costs for the injured party.

Another possibility to involve the court is to submit an application to order a preliminary expert's report or an examination of witnesses. The court allows such application in principle, which thus obliges the other party to cooperate, for example in an examination to determine the disabilities resulting from an accident. The court's ruling will then put an end to (often protracted) debates over the question whether the examination is actually necessary and the court will appoint an expert for this purpose.

The GBL is intended to keep the settlement of personal injury claims out of court, but this does not always succeed. After bringing the case to the court of law, the parties are still required to 'act in the spirit of the GBL'. Before the court as well, the parties do, after all, have to make efforts to try and reach a solution together. In law there are many times at which the parties, whether or not the court has given them the opportunity to do so, can attempt to get together to resolve the difference of opinion. The harmony model does, after all, also apply at law. In no respect does it impair the conduct of a proper defence on behalf of the client. What is more, the old adage 'hard on the case, but easy on the individual' applies fully to professionals involved in personal injury cases.

Annex 1:

Explanation of the ethical starting points

Ethics is thinking systematically and critically about applying moral values and standards in a practice. In this case: personal injury practice. How can a professional act with moral responsibility in this practice? This Annex has two parts. The first part deals with the three basic moral concepts behind the rules of conduct of the GBL 2012: moral values, standards and rules.

The second part discusses the background of the responsibility to approach, handling responsibility and development responsibility. Behind each of these responsibilities there is a classical perspective from ethics: the perspective of principles, consequences or virtues.

Moral values, standards and rules

Moral values, standards and rules are logically interrelated. You go down the stairs, as it were, from abstract moral values to specific rules. And once that is clear, you can also go up the stairs again from specific rules to the moral values they serve.

Table 1. Values, standards and rules

Values ↓	Abstract and descriptive
Standards ↓	Generally prescriptive
Rules	Prescriptive in a specific context, for example personal injury practice

Moral values

We find values everywhere in our personal lives and work. Everyone acts to a greater or lesser degree according to specific values. We often do so without realizing it. A value is 'a collective opinion or representation of what is good' (Van Es, 2011). It is a shared conviction of what is good for humans. Human dignity is such a value. What is more, it is a prominent, overarching value, enshrining four other important values (see Table 2). Human dignity therefore deserves a special place in thinking about personal injury.

Intrinsic values

Human dignity as the overarching existential value is defined in the first column of Table 2. The second column contains the four moral values it enshrines. These are intrinsic values. i.e., they have value in themselves worth striving for.

Table 2. Human dignity and intrinsic values

Definition of human dignity	*Intrinsic values*
Human beings are intrinsically sensitive creatures who are conscious of themselves and can (learn to) think and act independently by developing themselves as they see fit in interaction with others specifically by:	1. Self-determination
putting oneself in the other person's position	2. Reciprocity
treating him or her as an equal,	3. Equality
and respecting the other person's individuality.	4. Respect

Human rights

Human dignity is mentioned regularly in the Universal Declaration of Human Rights (Charter of the United Nations, 1945). Human dignity is a key term in this Charter, as an indication of for example the basis of human rights, a qualitative level of life that is protected by respect from others and human life in which the basic facilities are guaranteed.

The Netherlands Supreme Court (Hoge Raad)

Closer to home, human dignity plays an essential role in personal injury claims. This is evident from various judgments of the Netherlands Supreme Court, such as the Baby Kelly judgment (HR 18 March 2005, Dutch Law Reports (NJ) 2006, 606) in which it ruled that the court does not deny the human dignity of a child born disabled by assessing the loss in the way most in line with its nature. In the judgment of 20 September 2002, NJ 2004, 112, the Netherlands Supreme Court considered reliance on human dignity well founded in the sense that a person in a coma resulting from an injury may not be denied damages on that ground alone.

Instrumental values

Human dignity is the central value for the GBL. To actually monitor and achieve application of this value in the GBL, five other values also deserve attention. These are health, privacy, sincerity, trust and courage. These values act as a means to achieve the central value. That is why they are also called instrumental values.

1. Health

People need health to actualize their talents and achieve ambitions and potential. In personal injury claims, injured parties lack health to a greater or lesser extent. This impairs the intrinsic value of self-determination (or autonomy). It is relevant to recognize this fact in the personal injury claim settlement.

2. Privacy

Anyone who has an injury and claims compensation is faced with procedures and assessments, ends up in files and becomes the subject of discussion among professionals. This is unavoidable. It does however give rise to the need for discretion in the use of personal information. The parties involved must show respect for the injured party's privacy and right of self-determination.

3. Sincerity of the parties towards one another

Sincerity is an important instrumental value for everyone involved in handling personal injury claims. Each party should not only be honest and open in a self reflective manner about relevant matters, but should also approach the other party honestly and openly. Sincerity facilitates an equal and respectful handling of the personal injury claim.

4. Trust

Trust is at the least the expectation that the party will behave and act predictably. Of course representatives primarily have the interests of the injured party, their own client, in mind. Based on their reputation, professional representatives will take extra care in their relationship with other parties involved, such as insurers. This care is reciprocal. Trust serves the target values respect and reciprocity.

5. Courage

Courage is to be found exactly between cowardice and overconfidence. Professionals who have courage willingly dare to take risks and to stand up for the professional values referred to above in the ethical starting points of the code, even if this would mean moderation of other values and, for example, have financial consequences.

Professional values

In addition to the above-mentioned values, in their jobs, thus also in personal injury claims, a professional acts on the basis of values that are typical of truly acting professionally, such as self-knowledge, carefulness, reasonableness and awareness of interests (Van Es, 2011).

> Values — Values are collective opinions or representations of what is good, requiring conviction about what is good for a human being. The nine central values in the GBL are given in Table 3.

Table 3. The nine values of the GBL

Intrinsic values	Human dignity, a combination of: 1. Self-determination 2. Reciprocity 3. Equality 4. Respect
Instrumental values	Means to achieve human dignity: 1. Health 2. Privacy 3. Sincerity 4. Trust 5. Courage

Moral standards

Standards are derived from values. Standards are instructions for actions. With that, standards are less abstract, better applicable and also more verifiable in practice. An example of a standard is: 'The insurer makes clear to the injured party on what basis it arrives at a decision on his or her situation.' This shows sincerity: the insurer states why it took a certain decision. Moreover, the insurer enables the injured party to trust that he or she is appreciated. It also takes injured parties seriously by soundly substantiating its decision. By making the decision clear, it gives them the opportunity to represent their interests properly. This enables injured parties to achieve self-determination; they are able to tell whether they are satisfied with the decision or not. If necessary, they can decide what kind of action to take in order to take the law into their own hands. Without such clarity, injured parties would have to guess why a certain decision was taken. That would prevent them from representing their interests properly. For example, they would not know why they are denied what they claim.

Seek information about the other person's needs if you want to help them. In this case: find out what injured parties need to put them in the position from before the accident. This way the insurer shows that it has an eye for (the problems concerning) the injured party's health. This enables injured parties to trust that the insurer respects them. Because the insurer puts itself in their position, it expresses reciprocity.

Standards — Standards are instructions for actions that are derived from moral values, for example: Seek information about the other person's needs if you want to help them.

Moral rules

If we place standards in a specific context, we then call them rules. Rules are specific standards in the field of personal injury practice. Because they specifically pertain to regulating conduct, we henceforth refer to them as rules of conduct. Rules of conduct can be divided into rules on attitude and rules on procedure.

Rules on attitude relate to the manner of communication and treatment of one another in the field of personal injury claims. For example:
- deal respectfully with one another;
- argue clearly and understandably;
- consult harmoniously;
- act carefully; and
- display escalation-avoiding behaviour.

Typical rules of conduct on attitude are rules of conduct 1, 3, 5 and 9.

Rules on procedure prescribe who must do what within what period, so that the injured party can be assisted respectfully. For example:
- send confirmation of receipt within two weeks; and
- establish liability within three months.

Typical rules of conduct on procedure are rules of conduct 2, 7 and 8.

Rules of conduct 4 and 10 combine aspects of attitude with aspects of procedure.

Rules — Rules are standards that apply specifically in the context of personal injury practice. They can be divided into rules on attitude (such as 'Deal respectfully with one another') and rules on procedure (such as 'Adhere to the agreed time limits'). This code focuses particularly on regulating conduct. That is why the GBL 2012 uses the term rules of conduct.

Moral responsibilities and ethics

Within ethical starting points, three moral responsibilities are discussed: approach, handling and development. Behind each responsibility there is a classical perspective from the doctrine of ethics. These three perspectives are explained below in a brief historical survey (Van Es, 2011).

> Responsibility to approach — Professionals have their own responsibility to enter into and remain, as long as necessary, in discussion with injured parties and with the other professionals in a reasonable manner.
>
> *The responsibility to approach originates in the perspective of principles.*

The perspective of principles asks as central questions:
- Which principles are relevant to this moral issue?
- Which rights and obligations therefore play a part?

A principle is an axiom or conviction that needs no further substantiation. Practical actions should be assessed as to whether they are sufficiently in line with prescribed behaviour. The accent therefore does not lie on the content of the action, but on its form and justification. The perspective of principles can be considered a form of legal thought about morality. This is also expressed in derivations from principles: duties and rights.

Moral law

Duties are derived from principles that are considered universally applicable. Deontos means duty or obligation; that is why we call this deontology: the study of the nature of duty or obligation. Such a universally applicable principle functions as a moral law. This is the perspective of Immanuel Kant (1788): 'We find the basis of morality in that which all rational persons have in common, Reason'. This moral law is unconditional: it is a 'categorical imperative'.
Kant used different formulations for his imperative, but two of them are especially known and influential.

The first formulation reads:
Always recognize that human individuals are ends, and do not use them as means to your ends.

Or: treat the other person with respect, as a person with his or her own will and desires.

The second formulation reads:
Only act according to the principle that might safely be made a universal principle.

The rules of behaviour a person uses towards other persons should also be the rules of behaviour that other persons may use towards that person. The rule holds for everyone else in similar situations. This formulation by Kant resembles the golden rule that appears in Christianity, Islam and the doctrine of Confucius. The exact formulation varies from one doctrine to another, but the core comes down

to the familiar saying: 'Do to others as you would have them do to you'. In this form, the golden rule is passive and even somewhat fearfully formulated. The undertone is: 'Watch out!' Kant's categorical imperative is formulated as a purposeful activity. The undertone is: 'Show it!' In all formulations, the point is that one person places him or herself in another person's position.

Rights and obligations

The common element in the two formulations of the categorical imperative can be seen in the obligations derived from them. Such obligations always demonstrate a striving for **reciprocity**. Treat another person as you yourself would want to be treated. Act according to rules that others can also use. Kant strove for a rational ethics of obligations. This also includes the obligation to show respect for the rights of others.

The basic idea behind rights is that individuals have interests that are worth protecting. Rights are aimed at the independence of the individual. If we say that someone has the right to do something, we mean that it would be wrong for us to interfere with it. So there must be special reasons to intervene. For those reasons, rights are sometimes referred to as trumps in contacts between an individual and the government.

Anyone who takes rights seriously relies on one of the two underlying ideas or principles. The first idea is that of **human dignity**. All people can act and decide freely in a moral respect, and have intrinsic value; value in itself. People should therefore respect one another. The second idea is that of political equality. The weak in society are less healthy, have less self-confidence, knowledge or money, but they are entitled to the same care and respect from the government as the strong.

Reasoning in terms of rights is often about entitlements that have not yet been actualized. In that case, rights are desires formulated as a claim. The scope of these claims can be regional or universal. In regional rights, one relies on principles that are recognized within a region or culture. In universal rights, one relies on principals that would have worldwide recognition and are of all ages, for example human rights.

> Taking responsibility — Professionals have their own responsibility to examine the consequences of all options for handling, to weigh them and to reach an independent opinion on that basis.
>
> *Taking responsibility originates in the perspective of consequences.*

The perspective of consequences asks as the basic question: What are the positive and negative consequences of this (possible) action?

A consequence is the result of an act or deliberate omission of that act. Not all results are intended as such, because not all effects of actions can be viewed or predicted. People nevertheless have to consider as thoroughly as possible which positive and negative consequences an action has or will presumably have. A professionals conduct of a personal injury claim should preferably be conduct that brings about the most good or the least harm.

In managing responsibility, the accent is therefore not on the form but on the content. The perspective of consequences can be considered an economic style of thinking about morality. Telos stands for purpose and teleology as the doctrine of purpose is part of that perspective. The main question is: 'What will the advantages and disadvantages be?'

Wise enjoyment

The question of advantages and disadvantages played an important role as early as in the thoughts of Epicurus (300 BC). He viewed happiness as the beginning and end of a blessed life. To him happiness did not mean enjoying as much as possible (hedonism), but rather enjoying as wisely as possible (epicurism). Some pleasurable experiences are within reach only if one relinquishes other pleasures. The ultimate purpose was to achieve mental rest. Epicurus judged actions by the extent to which they resulted in pleasure and avoided pain, in the short and long term. His main moral criterion was therefore weighing the advantages against the disadvantages.

Costs and benefits

Consequences or results are often expressed in terms of costs and benefit or usefulness. This is also called utilitarianism. Usefulness or 'utility' was the unit in which Jeremy Bentham (1798) aimed to express the pleasure and pain of an action. 'Nature has placed mankind under the governance of two sovereign masters: pleasure and pain.' Utility means: useful in stimulating pleasure or happiness and avoiding pain. In his opinion, differences in quality did not play a part: pulp is just as good as poetry, as long as it results in just as much utility. As 'everyone counts as one, no one as more than one', equality is guaranteed, but also a certain indifference. The aim is to maximize utility; whose utility is not relevant. Society should strive for 'the greatest happiness of the greatest number'.

Quality and freedom

John Stuart Mill (1861) adjusted two aspects of this calculating utilitarianism. First of all, he brought back the difference in quality: 'some forms of pleasure are more desirable and worthwhile than others'. A hierarchy of pleasure or benefit can therefore be made. The right people to make this hierarchy are 'competent judges' who are aware of the higher and lower forms of pleasure. They are able to express a well-considered preference. The second application is safeguarding individual freedom. The greatest happiness of the greatest number may never lead to 'the terror of the majority'.

> Responsibility to develop —Professionals have their own responsibility to develop self-knowledge and competencies, so that careful and confidential accommodation of injured parties and honest and fair compensation of the loss is achieved.
>
> *The responsibility to develop originates in the perspective of virtues.*

The perspective of virtues asks as its main questions: 'How should I live?' and 'Who do I want to be?' In this perspective, the point is primarily character: ethos. A virtue, virtus, is a well-considered 'good' way to live one's life. With a view to this, the virtue perspective asks the question: 'Is what I do appropriate in this context?'

The right means

According to Aristotle (340 BC), virtues are in the middle between extreme positions, each of which is a vice in itself. Between vices such as rashness and cowardice, courage is a moral virtue. Between bluffing and silence, this is truthfulness, and between servility and gruffness this is friendliness. Other moral virtues are moderation, justice and independence.

Time and time again, the moral virtue is in the middle between two extremes. Anyone who sits on a bench between two others has a chance of hearing the popular joke: "...and virtue in the middle!" This saying is only partly correct. Moral virtues may well lie in the middle between extremes, but this is not exactly the arithmetical middle between two vices. The point is to find the golden mean. The golden mean sometimes lies closer to one and sometimes closer to another vice, but never coincides with one of the two vices. The choice of the golden mean actually means acting as you should act, in accordance with a rule in keeping with the practice at that time. The context of the act is therefore important in finding the golden mean.

Christian virtues

Thomas of Aquinas (1273) added some Christian virtues to his interpretation of Aristotle and placed a stronger accent on habit formation. Some virtues have already been passed on at birth. These are the Christian or theological virtues that make the concept of God possible: faith, hope and love. Other virtues are aimed at human society. People may well be driven by desires, but these can be controlled by way of moral virtues. The four main moral or cardinal virtues are: prudence, justice, temperance and courage. Moral virtues are formed by custom or habit. Acting virtuously therefore requires becoming accustomed to doing so and practice.

Contemporary virtues

According to Steutel (1992), we can divide contemporary virtues into two types: virtues of justice and virtues of care. In addition, following Michel Foucault (1984), we can also distinguish virtues of self-determination.

Virtues of justice are about general moral conduct. The three main virtues of justice are fairness (or impartiality), honesty (or sincerity), and trust (or loyalty). The leitmotif here is neutrality.

Virtues of care are about the happiness and well-being of one's fellow human beings. Examples of such virtues are caring (structurally maintaining someone), willingness to help (occasionally helping someone out), generosity or altruism, and charity (giving without wanting anything in return). The leitmotif here is solidarity.

Virtues of self-determination are about development of one's own personality. The three remaining cardinal virtues of Aquinas are found here with new names: prudence is now often understood to mean carefulness, while courage means mental courage and willingness to learn, and temperance means self-discipline. The leitmotif in the virtues of self-determination is personal responsibility.

Professionalism

Several of the foregoing elements - context-relatedness, habit forming, intrinsic motivation - appear together in a special way in the work of Alasdair MacIntyre (1981 and 1988). He views virtue as an acquired human quality that enables people to achieve what is good within 'a practice'.

A practice is a form of cooperation that produces something specific that can only be fully recognized and understood by participants in the practice. People take part in such a practice because of its intrinsic value. It is the delight of playing in a string quartet or on a football team, or playing chess, communicating, advising or settling claims in itself that motivates. One participates in the practice carefully: each practice has rules and standards of excellence. Delight lies in the correct exercise of that practice and in meeting the standards of excellence as far as possible.

MacIntyre's conception of virtues as practices of intrinsic value strongly resembles the term professionalism. The professional practice of a trade requires insight into its intrinsic values. Formulated differently: professionalism can be conceived as the practice of virtuousness.

Annex 2

List of terms in the rules of conduct

Case law: legal precedents.

Causal connection: connection between cause and effect, for example between the accident and the injury.

Claim for compensation: claim of the injured party for compensation of the loss he or she has incurred and/or the material or immaterial damage to be suffered in the future.

Claims handler: file handler at or on behalf of the insurer.

Court proceedings: proceedings at a District Court, Court of Appeal or the Netherlands Supreme Court (Hoge Raad).

Damage report form (or agreed statement of facts on a motor vehicle accident claim form (SAF): form on which the parties involved state the factual situation of a motor vehicle accident.

General damages: damages for pain, grief, inconvenience and impairment of enjoyment of life. A collection of case law on general damages is included, for example in the ANWB 'Smartengeldboek' (www.smartengeld.nl).

GOMA: Gedragscode Openheid medische incidenten; betere afwikkeling Medische Aansprakelijkheid (Code of Conduct for Disclosure of Medical Incidents and Better Settlement of Medical Liability).

Handling plan: document, preferably digital and accessible to everyone involved, in which the parties record working agreements, state differences of opinion and make specific agreements to resolve differences of opinion, owing to which the claim can easily be followed.

Injured party: the person who suffers injury as the result of an accident.

IWMD Questionnaire: questionnaire specially developed for experts' medical examinations in cases of accidents by the Interdisciplinary Working Group of Medical Experts of the VU University in Amsterdam (www.rechten.vu.nl).

KiFiD: Financial Services Complaints Tribunal (www.kifid.nl).

Liability: legal obligation to compensate someone else's losses. In order to be liable, fault is not necessarily required. An obligation to compensate can also arise because a certain fact is at someone's risk. Think for example of a collision between a weaker traffic participant (such as a cycler or pedestrian) and a motor vehicle. In principle, the driver of the motor vehicle is liable, even if he or she was not to blame for the occurrence of the accident. Exceptions to this are nevertheless possible.

Liability insurer: the insurer with which the person responsible for the accident is insured against liability and the resulting claims for compensation of the injured party/parties and/or surviving dependants. Where 'the insurer' is mentioned in the text, this means the liability insurer, unless explicitly stated otherwise.

Loss adjuster: a person who, on behalf of the insurer, discusses, gathers, assesses, partially helps define the strategy for and settles the personal injury claim in personal contact with the injured party and/or the latter's representative.

Mediation: an alternative method to resolve disputes without going to court. A third party (mediator) accepted by both parties helps to resolve the dispute in an acceptable and satisfactory manner or to make it manageable.

Medical adviser: physician who provides a party with medical advice.

Medical expert: specialist who performs an expert's medical examination.

Notice of liability: a notice in which the injured party or someone on his or her behalf, holds the person responsible liable for a certain incident, informs him or her of the consequences and claims compensation of the loss.

Occupational consultant: consultant in the field of occupations and employment. He or she is also (for example) competent to map out the physical stress a certain task entails for the injured party and compare it to the disabilities of the injured party.

Professional: a specialized professional practitioner who continually keeps up the level of his or her professional knowledge and competency. He or she acts according to the rules and standards of his or her professional group and is accountable for his or her actions.

Re-integration: resumption of one's own or a different job in such a way that the injured party is able to work again in spite of disabilities.

Representative: natural or legal person that, on behalf of the injured party, sends the notice of liability and/or files a claim, thereby representing the interests of the injured party. This natural or legal person may be a lawyer, a legal assistance insurer, a personal injury firm or a self-employed personal injury specialist.

Stabilized medical condition: situation in which someone has completely recovered or in which no essential changes (improvement or worsening) in recovery are expected any longer.

Statement of assessed damages: list of the various loss items and the related amounts which the injured party claims.

Stichting Bevordering Kwaliteit Personenschadeberekening (BKP): foundation with the aim of developing, formulating and monitoring quality standards to be met by a personal injury calculation expert.

Annex 3

Working Group on Revision of the Code of Conduct

The Working Group on Revision of the Code of Conduct was formed by the Personal Injury Council. Between January 2010 and September 2012, the members of the Working Group updated and improved the Code of Conduct from 2006 on the basis of the experience and insight gained within their own and related professional groups.

The following persons were members of the Working Group:

From the Personal Injury Council

Caroline Blom
Sandre Douma
Ivanka Dijkstra
Deborah Lauria

Professionals from the organizations involved

Karen Bruins	- ANWB
Bas van der Lijn	- ANWB
Rachel Dielen	- Stichting Personenschade Instituut van Verzekeraars (PIV)
Anton Elskamp	- ARAG Rechtsbijstand
Marloes Faasen	- Centramed
Peter Hoogenberg	- SRK Rechtsbijstand
Lisanne Polak	- Victim Support Netherlands (Slachtofferhulp Nederland)
Jelle Smits	- Dutch Motor Traffic Guarantee Fund (Waarborgfonds Motorverkeer)

External experts

Rob van Es	- Ethicist
Erik-Jan Wervelman	- Lawyer

Annex 4

Participants in the Consultation Rounds

The Working Group on Revision of the Code of Conduct held a series of consultation meetings in the first half of 2012 on the draft version of the new code. During the meetings about a hundred people gave input, from representatives to personal injury loss adjusters, and from directors and board members to academic researchers and judges. The names of the participants are listed in this Annex.

A separate discussion was held with a delegation from the Executive Board of the Association of Personal Injury Lawyers (LSA). The delegation consisted of LSA Chairman Joost Wildeboer and Vice-Chairman Oswald Nunes.

Erwin Audenaerde (Stichting Register Arbeidsdeskundigen), Marianne Audenaerde (NIVRE), Arno Akkermans (VU University Amsterdam), Arie Jan Baanen (Nationale Nederlanden), A.R. van Beek (Arag), Peter van den Bedem (Achmea Claims Organisatie), Ferda van Benthem (Asselbergs en Klinkhamer Advocaten), Michiel van Berckel Smit (ANWB), Astrid Blaauw (GAV), Franc van der Blom (Waarborgfonds Motorverkeer), Henk Boersma (GAV), Henny Bom (ANWB), Hanneke Comans- Diesfeldt (Diesfeldt Advocaten), Harry Crielaars (Slachtofferhulp Nederland), Ivo Croonen (ANWB), Evert Jan Dennekamp (Dennekamp Letselschade), Jochem Docter (ZLM Verzekeringen), Vanessa van der Does (Delta Lloyd), Leon Dols (Stichting Univé Rechtshulp), Renate Dozy (Gerechtshof Arnhem), R. van Dijk (Das), Jasper van Eekelen (Das), Gijs Fenenga (GC Fenenga), Ivo Giesen (Universiteit Utrecht), H.T.A.G. Hartog (Das), Bert de Hek (Gerechtshof Leeuwarden), Harry Henschen (MediRisk), Arl Hoffmans (Achmea Claims Organisatie), P.F.G.T. Hofmeijer-Rutten (Rechtbank Rotterdam), Elisabeth Huijsmans (Gerechtshof Den Bosch), M.S. Immink-Aykaz (Letsel.nl), Victor Jammers (Slachtofferhulp Nederland), G. Jansonius (Achmea rechtsbijstand), Sander Kernkamp (Nationale Nederlanden), Stephanie Keij (NIBE SVV), A.J. de Keyzer (Das), G.F.M. Kloppenburg (Ottenschot), Richard Kranendonk (NIS), A. Kruims (Das), Sylvia Kuiper (Waarborgfonds Motorverkeer), Michel Lambers (Das), Han van Leeuwen (De Goudse), Hans Meijer (Adee), Bas du Mez (DEKRA), Nol Monster (Kifid), Marco Muis (Relet), Gert Jan Mijnen (Klik en Regel), Menno Neeser (Stichting Bevordering Kwaliteit Personenschadeberekening), M. Nes (Achmea rechtsbijstand), Karin Nijman (Berntsen Mulder Advocaten/SKL), J.C. Peerbolte (Korevaar van Dijk), Carolien Pietjouw (Stichting De Ombudsman), Ernst Pompen (Verbond van Insurers), Roel van Reenen (Interlloyd Survey), Han Raasveld (Raasveld Expertise), Annemiek van Reenen-ten Kate (NIS), John Reid (Rechtbank Alkmaar), R.E. Reinders (Reinders Letselschade), Bob Rodenburg (GRM Expertises), Edwin Rijsdijk (Nationale-Nederlanden), Rianka Rijnhout (Universiteit Utrecht), Arnout Santen (Centramed), Willemien Scheper (Univé Rechtshulp), Antoine Schonenberg (Allianz), F. Schlicher (Nationale Nederlanden), Onno Sleurink (ASR), Addie Stehouwer (Nationale Ombudsman), Madeleine van Toorenburg (CDA fractie Tweede Kamer), Richard Tijink (Europrotector), F.W. Vergonet (Das), Pauline Verhoeven (NIBE SVV), Henny Vermeulen (Gerechtshof Den Bosch), Monique Volker (PIV), Wytze de Vries (Stichting Univé Rechtshulp), J.W. Walrave (Das), M.J.A. Westenbrink (Arag), P.J. van de Wurf-de Wilde (Nationale Nederlanden), Esther Zandman (Gerechtshof Arnhem), Taco Zuidema (Van der Toorn Personenschade), Remco Zuidervliet (Allianz).

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Index

Related publications of the Personal Injury Council (De Letselschade Raad)

[available in Dutch only]

De Letselschade Raad, *Gedragscode Openheid medische incidenten; betere afwikkeling Medische Aansprakelijkheid (GOMA).* The Hague, March 2012.

De Letselschade Raad, , *Gedragscode Behandeling Letselschade; goede praktijken bij het regelen van schade: Medische paragraaaf.* The Hague, 2012.

De Letselschade Raad,*Grip op uw letselschade.* Brochure for personal injury victims.

De Letselschade Raad, *De Letselschade Definitie Verhoogde Economische Kwetsbaarheid.* The Hague, 2012.

De Letselschade Raad, *De Letselschade Richtlijn Huishoudelijke Hulp.* The Hague, 2012.

De Letselschade Raad, *De Letselschade Richtlijn Kilometevergoeding.* The Hague, 2012.

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De Letselschade Raad, *De Letselschade Richtlijn Zelfredzaamheid.* The Hague, 2012.

De Letselschade Raad, *De Letselschade Richtlijn Ziekenhuis- en Revalidatiedaggeldvergoeding.* The Hague, 2012.

The Personal Injury Council (De Letselschade Raad) aims to increase the harmony and clarity in handling personal injury claims. It strives for a better and more personal treatment of the victim, as well as an improvement in the technical aspects of claims settlement.

Who drafted the GBL 2012?

The first version of the Code of Conduct for Handling Personal Injury Claims (GBL) was published in 2006 (see Sources) and forms the basis for the GBL 2012. Coordinated by the Personal Injury Council, between 2010 and 2012, the first Code of Conduct was updated and improved by the members of the broadly composed Working Group on Revision of the Code of Conduct. In doing so, they were inspired by the experiences and insights gained within their own and related professional groups. Annex 2 lists the participating organizations and their representatives. Annex 3 lists the names of all participants in the consultation rounds held by the Working Group.

Main adaptations

The GBL 2012 has been revised in its entirety. The main changes are:

- The division into 'principles' from the first version has been abandoned in favour of a more refined division into rules of conduct that have been derived from the moral values, standards and responsibilities inherent to the professional handling of a personal injury case.
- The code is organized according to the chronological order of the handling of personal injury claims.
- Good practices and references to case law have been added.