ANTON DE KOM UNIVERSITY OF SURINAME
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A HUMAN RIGHTS ANALYSIS OF CHAPTER IX OF THE PUBLIC HEALTH FRAMEWORK BILL OF SURINAME;

A COMPATIBILITY ANALYSIS OF CHAPTER IX ON PATIENT RIGHTS WITH THE RIGHT TO HEALTH

Thesis presented in fulfillment of the requirements for the degree of Bachelor of Law (LL.B.)

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SUMMARY

There is international consensus that guaranteeing patients' rights, such as the right to information and the right to privacy, is instrumental in achieving the highest possible standard of health. This research examines the extent to which the Public Health Framework Bill of Suriname (the Bill)—which seeks to reform the Surinamese healthcare legal framework comprehensively—guarantees the right to information and the right to privacy in the context of the right to health as defined by international law.

This research has an exploratory nature and employs a qualitative methodology with a human rights perspective. It reviews the Bill against the revised Civil Code of Suriname of 2024, relevant jurisprudence, and various other national and international legal instruments.

The research reveals that the Bill generally fails to meet international norms on patients' rights. The rights to information and privacy are not comprehensively secured, while other patient rights are not even recognized by the Bill. The research found that in light of recent developments, the overall protection of patient rights in Suriname is still lacking. This lack is revealed following the review of both international and local enforcement mechanisms thereof.

PREFACE

The process of writing a legal thesis while simultaneously pursuing a medical degree, working a full-time job, and engaging with various organizations both locally and internationally, such as the International Federation of Red Cross and Red Crescent, was daunting, to say the least. Reflecting on this journey of acquiring my bachelor's degree in law, I recognize it as an incredible learning opportunity, largely due to my extracurricular activities. Participating in the Suriname Model United Nations (SUMUN) in various roles, the Model Organizations of American States (MOAS), and the Caribbean Court of Justice International Law Moot Court (CCJ Moot Court), along with co-founding the Surinamese Legal Faculty Association for law students and serving as a student assistant and member of the student committee, has significantly contributed to my development as a jurist.

I want to emphasize that I would not have been able to finish this endeavor successfully without the support that I have received throughout the research and thesis-writing process. I thankfully acknowledge everyone who has contributed to my thesis. I express my eternal gratitude for all the support I received from you. Specifically, I refer to my thesis supervisor, Mr. Milton Castelen, LL.M., whose invaluable guidance was tailored to my needs, demonstrating patience throughout this process. I also could not have undertaken this journey without Mrs. Shaiesta Nabibaks, LL.M., who has encouraged me to write in English and for her continued guidance throughout my entire bachelor's studies while serving as her assistant.

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I wish you a pleasant reading experience and hope that my thesis will inspire you to contribute to a speedier modernization of this area of the law.

LIST OF ABBREVIATIONS

CARICOM	: The Caribbean Community
Civil Code	: The Revised Civil Code of 2024 of the Republic of Suriname
DNA	: The National Assembly
EU	: The European Union
HvJ	: The Court of Justice
ICESCR	: The International Covenant on Economic, Social and Cultural Rights
MTC	: The Medical Disciplinary Board of Suriname
RTC	: The Revised Treaty of Chaguaramas
Suriname	: The Republic of Suriname
SZF	: State Health Insurance Fund
The Bill	: The Public Health Framework Bill
WGBO	: The Medical Treatment Agreement Act of the Netherlands
WHO	: The World Health Organization
USA	: The United States of America
USA CFR 42	: USA Code of Federal Regulations Title 42, Chapter IV, Subchapter G, part 482
WMA	: The World Medical Association

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Introduction

Context of the research

The premise of this research is that the Surinamese legal framework on health needs modernization to adequately safeguard patients' rights as an important component of attaining the highest possible standard of health. Modernization should increase the awareness and protection of patients' rights related to healthcare.

"The right to the enjoyment of the highest attainable standard of physical and mental health is not new."[1] Globally, the WHO constitution of 1946 first expressed it in its preamble, defining health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Additionally, the preamble recognizes that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic or social condition."[2] The right to health obliges States to put in place policy and legal frameworks that will make healthcare available and accessible for all.[3]

Article 36[4] of the Constitution of the Republic of Suriname recognizes the right to health and the duty of the State to promote general healthcare through systematic improvement of living and working conditions and provide information on the protection of health. This right and subsequent duty is also recognized by international treaties,[5] such as the ICESCR[6], and regional treaties, such as the Protocol of San Salvador[7] and the Revised Treaty of Chaguaramas (RTC), to which Suriname is a party to. For example, the RTC recognizes that a healthy population is an essential

[1] OHCHR and the WHO, 2008, p. 1.
[2] OHCHR and the WHO, 2008, p. 1.
[3] Marks & Clapham 2005.
[4] Article 36 of the Constitution of the Republic of Suriname stipulates that:
1. *Everyone has the right to health.*
2. *The state shall promote general healthcare by a systematic improvement of living and working conditions and shall give information on the protection of health.*

[5] Such as the Universal Declaration of Human Rights where the right to health is acknowledged in Article 25 of this treaty.
[6] The Republic of Suriname acceded to this treaty in 1976 and the right to health is delineated in Article 12.
[7] The Republic of Suriname acceded to this treaty in 1990, and the right of health is delineated in Article 10. The Protocol of San Salvador is also known as the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights.

prerequisite for the economic growth and stability of the Caribbean.[8] Furthermore, Article 6(i)(iii) of the RTC[9] explicitly states that one of the Community's objectives is an enhanced functional cooperation in areas, inter alia, health.

Hence, this research argues that the right to health—the highest attainable standard of health—can be considered to be a fundamental and basic human right in all contemporary societies.[10] The realization of the right to health has an interdependency with the realization of other human rights, such as the rights to privacy, informed consent, and access to information.[11] As stated by Lean Lau, patient rights may be defined as encompassing "legal and ethical issues in the provider-patient relation, including a person's right to privacy, the right to quality medical care without prejudice, the right to make informed decisions about care and treatment options, and the right to refuse treatment."[12]

This research found that patient rights are recognized as an integral component of the right to health. To illustrate, reference is made to the World Medical Association's (WMA)[13] Declaration of Lisbon on the Rights of the Patient 1981, which recognizes certain core patients' rights, as defined by Lean Lau. The right to health and its related human rights, imposes obligations on States based on the guiding principles: respect, protect, and fulfill.[14] The obligation to fulfill requires States Parties to give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation.[15] However, health legislation in many countries—especially developing countries—is in dire need of modernization to ensure that the right to health comes to its full fruition.

[8] Caribbean Cooperation in health-IV report 2021.
[9] Article 6 (i)(iii) of the RTC stipulates that: *The community shall have the following objectives, inter alia, enhanced functional co-operation, including intensified activities in areas such as health, education, transportation, telecommunications.*
[10] Sellin 2021.
[11] ICESCR General Comment No. 14, Paragraph 3.
[12] Lau 2020, p. 2.
[13] Although the WMA global policies are not legally binding on states, it contains international agreed upon norms that are aligned with how patients' rights are defined by Lean Lau. Thus, making it a relevant source to highlight the importance of patients' right in achieving the highest attainable standard of health.
[14] UN Guiding Principles on Business and Human Rights, 2011.
[15] ICESCR General Comment No. 14, Paragraph 36.

Description of the problem

The hypothesis of this research is that the Surinamese legal framework on health does not adequately safeguard patient rights and thus the right to attain the highest possible standard of health. In addition, despite minor improvement, patients are also generally unaware of their rights. Prior to the enactment of the revised Civil Code, patient rights were not codified. According to Dr. Veira, the revised Civil Code is derived from the 1995 Dutch Civil Code without the incorporation of updated contemporary standards.[16] Before the enactment of the revised Civil Code, the Public Health Framework Bill was submitted to the National Assembly (DNA)[17] with the aim to reform the healthcare system of Suriname. In Chapter IX, the Bill also lays a legal foundation for enhancing patient rights.

Research Purpose

This study aims to determine the extent to which Chapter IX of the Public Health Framework Bill is compatible with the principles of the right to information and the right to privacy within the context of attaining the highest possible standard of health, as guaranteed by the global and regional human rights frameworks applicable to Suriname.

Research question

Based on the aforementioned context, this study seeks to answer the following primary research question:

To what extent do the provisions in Chapter IX on patients' rights of the Public Health Framework Bill meet international standards on the right to information and privacy in the context of attaining the highest possible standard of health in Suriname?

To answer the primary research question posed above, the following research sub-questions have been formulated:

[16] Veira 2016, p. 42.

[17] Proposal containing general rules concerning the healthcare system and public and individual health services, submitted by DNA members J. Simons, A. Abdoel, D. Sumter, J. Wielzen, and R. illahibaks.

1. *Does the Public Health Framework Bill define patients' rights consistent with the internationally agreed definition of patients' rights?*
2. *Does the Public Health Framework Bill ensure the legal accessibility of health information for patients, including their right to access their own medical records?*
3. *Are the legal provisions within Chapter IX of the Public Health Framework Bill aimed at safeguarding patients' privacy and confidentiality compatible with international legal standards?*
4. *Does the Public Health Framework Bill provide for legal mechanisms to hold healthcare providers and institutions accountable for violations of patients' rights?*
5. *How are disputes related to patients' rights resolved within the legal framework proposed by Chapter IX, and do these mechanisms comply with international legal standards for fairness and efficiency?*

Research relevance

Fulfilling the right to attain the highest standard of health, anchored in the Constitution of the Republic of Suriname, is fundamental to ensuring that all human beings health is prioritized within the Surinamese territory. The relevance of this research will be emphasized below by its social impact and its contribution to scientific knowledge in this area.

Social relevance

With respect to the right to health and patients' rights within the Surinamese healthcare system, the research discusses a significant social issue. Ensuring that every person has the best possible health is directly related to getting the best healthcare possible, which is subsequently directly related to upholding patients' rights. By examining Chapter IX regarding patient rights of the Public Health Framework Bill, this research is expected to influence legal reforms that safeguard patients' rights and empower patients by enhancing their awareness of their rights. Furthermore, the outcome of this study is also expected to contribute to the overall improvement of the health and well-being of the population by prompting a higher quality of healthcare and creating an environment of respect, trust, and accountability in healthcare practices.

Scientific relevance

From a legal perspective, the study holds significance by analyzing the compatibility of Chapter IX of the Public Health Framework Bill in Suriname with the global and regional human rights framework. Through the formulation of specific research questions, the study conducts a thorough legal analysis to determine if the provisions in Chapter IX of the Public Health Framework Bill adhere to internationally agreed standards for privacy and information in relation to patients' rights and the right to health. This study will therefore contribute to identifying potential gaps or strengths in the Bill. It will advance the scientific understanding of the legal mechanisms for safeguarding patients' rights in Suriname—which is an area relatively understudied and underrepresented in Surinamese literature. This legal research will aid competent authorities in amending the Bill, if deemed necessary, or formulating new legislation in this field. Additionally, conducting this study in English instead of Dutch will give easier access to relevant Surinamese research data to non-Dutch-speaking researchers in this research area. The latter may encourage international and regional scholars to conduct further research in this field, advancing the right to health but more specifically patients' rights within the region.

Methodology

This was an exploratory study that followed a human rights approach in the understudied field of health law, specifically focusing on the rights of patients in Suriname. A qualitative research method was chosen, utilizing both primary and secondary sources, to gather in-depth insights into patients' rights and the right to health.

The primary sources examined include, inter alia, the Public Health Framework Bill, the Constitution of the Republic of Suriname, Ordinance Medical Disciplinary Act 1944, and the revised Civil Code of Suriname. Additionally, semi-structured interviews were conducted with the permanent secretary of the Ministry of Health of Suriname, Mr. Rakesh Gajadhar Sukul, M.D., MSPH; the legal advisor of the Ministry of Health of Suriname, Mrs. Andjenie Autar, LL.M.; the chair of the Medical Disciplinary Board of Suriname, Judge Anandkumar Charan; Mr. Milton Castelen, attorney at law; and the chair of the Working Group on the Establishment of Complaints Committees in Hospitals (WOKZ), Mr. Lorenzo Irion.

The secondary sources included, among others, journal articles and books from various legal databases pertaining to health law and, specifically, patients' rights. Subsequently, all the collected data was analyzed, based on which conclusions were drawn.

Overview of Chapters

Chapter one contains a legal analysis related to the four (4) essential, interrelated elements to the right of health. It furthermore identifies and describes a non-exhaustive outline of the numerous internationally recognized patients' rights as well as those stated in the Public Health Framework Bill. This Chapter concludes with an introduction to a comparative analysis of patients' rights in other regional and international jurisdictions.

Chapter two contains a comparative analysis and its findings on the right to health information and privacy. Furthermore, it includes a legal analysis of the Public Health Framework Bill, the revised Civil Code of the Republic of Suriname, the Dutch Civil Code, and various regulations from other nations.

Chapter three contains a comparative analysis of enforcement mechanisms within Suriname and in other jurisdictions, based on relevant international best practices. It also contains an analysis of the Public Health Framework Bill, highlighting provisions that impose sanctions for violations of the right to information and privacy by healthcare providers[18]. The analysis contained in this Chapter also takes into consideration relevant national and international jurisprudence, focusing on cases where healthcare providers infringed upon the rights to information and privacy.

The concluding Chapters of this thesis contain the conclusions and subsequent recommendations of the research conducted.

[18] Throughout this research, the terms "healthcare provider", "healthcare professional", and "medical professionals" are used interchangeably and refer to natural persons who performs medical action actions on others.

Chapter 1 Foundations of patients' rights

1.1. The AAAQ framework of the right to health

The Public Health Framework Bill[19] must be consistent with the right to health,[20] including its four (4) intertwined and essential components, which are availability, accessibility, acceptability, and quality.[21] These are collectively known as the AAAQ framework. This framework translates the general provisions of international human rights instruments into concrete indicators and benchmarks to ensure the realization of the right to health. In accordance with the interpretation of the right to health provided by General Comment 14 of the ICESCR, the AAAQ framework categorizes the State's obligations regarding the right to health into the four areas, as indicated above.[22]

Patient rights in Suriname

Suriname, formerly a Dutch colony until 1975, was required to align its legal framework with Dutch standards, following the principle of concordance.[23, 24] Before the enactment of the revised Civil Code, Suriname recognized three (3) patient rights through jurisprudence: the right to information, the right to informed consent, and the right to access the medical record.[25]

Civil Code of Suriname

In Book 7, Title 7, Section 5 of the Civil Code, largely inspired by the Dutch Civil Code, the regulation of the medical treatment agreement is outlined. This section includes provisions

[19] This bill contains general rules concerning the healthcare system and public and individual health services, submitted by five (5) DNA members J. Simons, A. Abdoel, D. Sumter, J. Wielzen, and R. illahibaks based on Article 78 of the Constitution of the Republic of Suriname. This Article grants each member of the National Assembly the authority to propose a Bill before the National Assembly.
[20] According to General Comment No. 14 of the ICESCR, the right to achieve the highest attainable standard of health extends beyond merely the right to healthcare. Conversely, the legislative history and explicit language of Article 12.2 recognize that the right to health encompasses a broad spectrum of socio-economic factors that foster conditions conducive to a healthy life and includes the fundamental determinants of health, such as nutrition, housing, access to safe drinking water and adequate sanitation, safe and healthy working environments, and a healthy ecosystem.
[21] ICESCR General Comment No. 14, pp. 4-5.
[22] The Danish Institute for Human Rights, AAAQ Toolbox.
[23] Jadnanansing, 2018.
[24] Article 48 of the Statute of the Kingdom of the Netherlands.
[25] As of the 1st of May 2025, more than the three mentioned patient rights are codified in the Civil Code and are in effect.

regarding patient rights such as the right to information and the exception thereof, the right to consent, the right to access and obtain a copy of your medical records, the right to privacy and confidentiality, and the liability of hospitals.[26]

1.2. A non-exhaustive list of relevant patients' rights

The influence from the EU, especially the Netherlands, on Surinamese legislation stems from our historical ties and the principle of concordance. Moreover, human rights charters from non-EU countries were reviewed based on their comprehensive nature and alignment with international standards. Hence, various patient rights charters of EU and non-EU countries were analyzed to identify the fundamental patients' rights, each accompanied by a brief description of the respective rights.

The right to information

Every individual has the right to access all kinds of information regarding their state of health, the available health services and how to use them, and all the information that scientific research and technological innovation make available.[27]

Healthcare providers must provide information tailored to their services, such as their condition, treatments, and potential complications.[28] The information should also consider patients' religion, ethnicity, and linguistic backgrounds. Related to the right of information is the entitlement of patients to be informed of the identity and professional status of the healthcare providers taking care of them and of the rules and routines that could influence their stay and care. In addition, patients have the right to choose who should be informed on their behalf and receive a written summary of their diagnosis, treatment, and care upon discharge. Information may be withheld only in exceptional circumstances where harm is expected or where the patient has requested so.[29]

[26] The Civil Code (S.B. 2024 No. 164) was adopted by DNA on August 13, 2024, with 28 votes. By resolution S.B. 2025 No. 14, the revised Civil Code of the Republic of Suriname has taken effect starting from the 1st of May 2025.
[27] European Charter of Patient's Rights, p. 4.
[28] Treatments include the proposed medical procedures as well as alternatives, including the potential risks and advantages with each procedure.
[29] Summary of the definition of the "right to information" as established in the European Charter, Declaration on the Promotion of Patient Rights in Europe, and the Draft Patient Charter of India.

The right of access to medical records

Every individual has the right to access and correct their medical records, to photocopy them, to ask questions about the content of their medical records, and to obtain the correction of any errors they might contain, regardless of whether the patient has been discharged or not.[30]

The information in medical records depends on the nature of the treatment and the practitioner's profession. At the minimum, the medical records must include basic data, such as examination findings, test results, medical scans, diagnoses, treatments, reports, and referrals.[31] Furthermore, patients have the right to obtain at least their first copy of medical records free of charge.[32, 33] Medical records must be kept secure and handled with necessary precautions to guarantee the patients' right to privacy and confidentiality.

The right to privacy and confidentiality

Every individual has the right to confidentiality of personal information, including information regarding his or her state of health and potential diagnostic or therapeutic procedures, as well as the protection of his or her privacy during the performance of diagnostic exams, specialist visits, and medical/surgical procedures in general.[34]

All personal health data, including medical treatments, must be treated as private and protected accordingly. Human substances from which identifiable data can be derived must be protected as well. Patient confidentiality extends beyond their lifetime and must be respected at all times, except in those cases where explicit permission or consent has been obtained from the patient to share information with third parties or when mandated by law. Consent to disclosing a patient's health data may be presumed in the instances where disclosure is required to provide other healthcare services as part of an agreed treatment scheme. Patients have the right to request

[30] The right to access one's medical records is closely related to the overarching right to information. The European Charter of Patient's Rights enshrines this right inside the right to information; nevertheless, other States, such as Norway and Suriname, explicitly acknowledge this right – albeit intertwined with other patient rights.
[31] The Medical Treatment Agreement Act of the Netherlands, and in the case C-307/22 Bundesgerichtshof-Germany, ECLI:EU:C:2023:811, the court provided a non-exhaustive description of the contents required in the medical record within the operative part of the judgment.
[32] The case C-307/22 Bundesgerichtshof-Germany, ECLI:EU:C:2023:811.
[33] The court asserts that the decision about whether this copy should be digital or in hard form must be made by legislators, considering the existing fiscal and digital infrastructure.
[34] European Charter of Patient's Rights, p. 5.

corrections, completion, deletion, clarification, and/or updating of inaccurate or irrelevant personal and medical information that is not relevant for the purposed diagnosis, treatment, and care. Intrusions into a patient's private life are only permissible with their consent or when deemed necessary for diagnosis, treatment, and care.[35]

The right to informed consent[36]

Every individual has the right to access all information that might enable him or her to actively participate in making decisions regarding his or her health; this information is a prerequisite for any procedure and treatment, including participation in scientific research.[37]

Healthcare providers must inform patients in detail about upcoming treatments or operations with sufficient advance notice, at least 24 hours, to enable the patient to give informed consent. Informed consent is mandatory before any medical intervention is performed, and patients have the right to refuse or halt any medical intervention. Healthcare providers are responsible for clearly explaining the (potential) consequences of refusing or halting a medical intervention. Informed consent is also required for participation in clinical teaching and scientific research.

When patients are unable to express their will, consent may be presumed unless there is evidence to the contrary. Legal representatives may give consent on behalf of minors or adults who are incapable of expressing their will; however, the patient should still be involved in the decision-making process to the fullest extent possible. Hospitals must ensure that doctors are properly trained to seek informed consent, adopt appropriate policies, and that consent forms and protocols are available and provided to patients as required.

[35] European Charter of Patient's Rights in conjunction with the Patient Charter of India.
[36] In numerous legal texts and regulations of various nations, this right is referred to as "the right to consent"; nonetheless, the aspect of being informed is deemed crucial and should explicitly be incorporated in the articulation of this right. The latter aims to prevent patients from providing consent without adequate knowledge regarding the intervention.
[37] European Charter of Patient's Rights, p. 5.

The right to free choice

Every individual has the right to freely choose from among different available treatment procedures and providers on the basis of adequate information.[38]

Patients have the right to freely decide which diagnostic exams and therapies to undergo and which primary care doctor, specialist, or hospital to use. The full exercise of this right must be guaranteed as long as it aligns with the healthcare system's operation. Healthcare systems are obligated to facilitate the full exercise of this right by providing information about, for example, available health centers and physicians, as well as their rates. All barriers restricting the full exercise of this right must be eliminated. Additionally, patients have the right to seek a second opinion from a clinician of their choice. All necessary records and information needed for seeking a second opinion must be provided by healthcare providers and/or institutions without additional cost or delay. Furthermore, the patient's decision to seek a second opinion should not be met with negative reactions from the healthcare provider, nor should it impact the quality of care received while the patient remains under that provider's care.

The right to lodge complaints

Every individual has the right to lodge complaints whenever he or she has suffered or is believed to have suffered any form of harm due to a healthcare intervention and the subsequent right to receive a response or other feedback to the filed complaint.[39]

The healthcare providers and/or institutions must ensure that patients can exercise their right to file healthcare-related complaints by providing them sufficient information on their right to health, how to recognize violations of that right, and how to file complaints. Complaints and feedback made by patients must be thoroughly, fairly, effectively, and promptly examined by the thereto appointed healthcare authorities. Outcomes of complaint examinations must be communicated to the complaint-filing individual within a specified and reasonable timeframe. Standard procedures for filing complaints should be in place and facilitated by an independent authority. In addition to legal avenues, independent mechanisms at institutional and other levels should be in place to

[38] European Charter of Patient Rights, p. 5.
[39] European Charter of Patient's Rights, p. 7.

facilitate the process of adequately filing complaints and mediating or adjudicating those. These mechanisms should ensure that everyone has access to information about complaint filing and handling procedures. They should also guarantee that everyone in need of consulting with an independent person for advice on the best course of action can do so.

The right to pain management

Every individual has the right to access adequate pain management.[40]

Alleviating pain transcends beneficence and is integral to the obligation to prevent harm. An unjustifiable omission to act can be considered negligent, a breach of human rights, and a form of professional misconduct.[41] Although the ICESCR does not explicitly state the right of access to pain management, it is nonetheless considered a component of healthcare and hence falls under the overall right to health. As part of countries' core obligations under the right to health, they are required to ensure that medications listed on the WHO List of Essential Medicines[42], such as morphine and codeine, are available and accessible to all patients who require them. This requirement applies regardless of whether these medications have been included in their own domestic essential medicine list.[43]

1.3. International & regional codification of patients' rights

An example of the codification of patients' rights in the Western Hemisphere is the regulatory framework on patients' rights of the United States of America (USA). Within this framework, the Code of Federal Regulations Title 42[44] delineates pertinent provisions governing patients' rights notably in § 482.13. Subsection § 482.13a (2) articulates the procedural aspects and obligations incumbent upon the hospital concerning the right to lodge complaints. Additionally, subsections § 482.13c and 482.13d respectively regulate the right to privacy & confidentiality and the right to information.

[40] Lohman, Schleifer & Amon 2010, p. 2.
[41] Brennan, Carr & Cousins, 2007.
[42] WHO EML 23rd List, 2023.
[43] Lohman, Schleifer & Amon, *BMC Medicine* 2010/8.
[44] Includes the codified United States Federal Laws and regulations effective as of the date related to public health in the United States and its territories.

In Australia's[45] regulatory framework, an example from the Asia-Pacific region, patients' rights are delineated within the Consent to Medical Treatment and Palliative Care Act 1995 and the Health and Community Service Complaints Act 2004. These Acts respectively regulate the right to consent and the right to lodge complaints. In China,[46] also belonging to the Asia-Pacific region, many patients' rights are regulated in the Patient Right to Autonomy Act of 2016, including the right to information, privacy and confidentiality, consent, free choice, and lodging complaints.

In Russia, within the European-Asia region, patients' rights, in particular the right to information, consent, privacy & confidentiality, free choice, and the right to lodge complaints, are established in the fundamentals of the Russian Federation on Health Protection Act no. 5487-1 of July 22nd, 1993.

Looking towards the Schengen area, in Norway patients' rights are regulated in the Patient's Rights Act. Regulated rights are, inter alia, the right to information, consent, privacy and confidentiality, and to lodge complaints. Within the European Union, patients' rights are established through Directive 2011/24/EU. The directive recognizes the right to information, privacy & confidentiality, consent, free choice, and lodging complaints.

CARICOM

With respect to the region Suriname belongs to, CARICOM, patients' rights have not yet matured. Although CARICOM does not have a single Model Act titled "Patient's Rights" or a similar legislative framework to serve as a basis for legislation in the Member States, the principles of patients' rights are embedded in various regional and international agreements, national policies, and health frameworks. The CARICOM Charter of Civil Society[47] provides a framework for the protection of fundamental human rights, which inherently supports the protection of what is now known as patients' rights. Specifically, Article 20 of this Charter states that "the State shall use their best endeavors to provide a healthcare system that is sufficiently comprehensive to deal with

[45] Specifically, South Australia, which is one of the federated States of the Commonwealth of Australia.
[46] Taiwan, not mainland China, acknowledging the existing international dispute.
[47] CARICOM Charter of Civil Society 1997, p. 20.

all health challenges, including epidemics, and is well administered, adequately equipped, and accessible to all without discrimination."

Furthermore, the CARICOM Declaration on Non-Communicable Diseases (NCDs) 2007 underscores the right to health by advocating for universal access to quality care and prevention for NCDs. While primarily focused on public health strategies, this declaration contains various components that implicitly and explicitly support the protection of patients' rights. Additional initiatives, such as the Chronic Care Policy and Model of Care,[48] aim to address the increasing burden of NCDs in the region and include actions that advance several key patients' rights, such as the right to information, the right to privacy and confidentiality, and the right to informed consent. Similarly, the CARICOM universal standard of care handbook for the treatment and rehabilitation of drug dependence emphasizes several fundamental patients' rights through proposed implementation strategies, including the right to informed consent, the right to privacy and confidentiality, and the right to information.[49]

The CARICOM Secretariat Strategic Plan 2022-2030 emphasizes building upon approved regional policy frameworks to advance health and well-being. It highlights key components from the Nassau Declaration, the Caribbean Regional Strategic Framework for HIV 2019-2025, the petition Ville Declaration, and the Caribbean Roadmap for Adolescent and Youth Health.[50] These policy frameworks collectively contain components that recognize and support core patients' rights.

Overall, analysis of these regulations and/or policies in this paragraph demonstrates that fundamental patients' rights, i.e., the right to information, the right to privacy and confidentiality, the right to consent, the right to free choice, and the right to lodge complaints, have been incorporated either explicitly or implicitly. Many of these documents provide detailed provisions that outline how these rights should be exercised and protected, reflecting a growing recognition of patients' rights in the CARICOM.

[48] Chronic Care Policy & Model Care for the Caribbean Community, pp. 12-13.
[49] The CARICOM Universal Standard of Care Handbook for the Treatment and Rehabilitation of Drug Dependence, p. 13.
[50] CARICOM Secretariat Strategic Plan 2022-2030, p. 22.

1.4. Public Health Framework Bill defining patients' rights

As of June 2025, the Public Health Framework Bill defining patients' rights, which was submitted to the parliament of Suriname in 2020, remains awaiting approval. Before discussing the specific patients' rights outlined in this Bill, it is essential to examine the definition of a "patient" as set out in this framework Bill. According to Article 1, Section j, the Bill defines a patient as "a person entitled to care to whom medical, paramedical, and/or nursing care is provided." Compared to Norway's Patient's Rights Act, this definition is comparatively narrow. The Patient's Rights Act of Norway defines a patient as "a person who contacts the health service requesting healthcare or to whom the health service provides or offers healthcare."[51] The more limited definition in the Bill raises concerns about circumstances where individuals might not be recognized as patients, such as those seeking a second opinion or simply gathering healthcare information. The broader Norwegian definition of a "patient" supports legal certainty and reinforces the rights of anyone seeking or receiving healthcare services, explicitly including individuals during the process of requesting or being offered care. This approach ensures that a person is entitled to the rights associated with being a patient whenever they are engaged with healthcare services, thereby strengthening legal protection and clarity.

Within Chapter IX of the Bill, the following rights are included: the right to information and the right to privacy & confidentiality. Article 28[52] recognizes that patients or their legal representatives have the right not only to receive their health information but also to receive it in such a manner that is comprehensible to them. Furthermore, the Article stipulates that patients are entitled to privacy regarding their medical data and mandates that explicit written permission must be obtained from patients prior to disclosing this data to third parties.

Article 29[53] sets forth specific requirements for the provision regarding the right to information. It stipulates the appropriate format in which information should be provided and emphasizes the

[51] Norway Patient's Rights Act, Section 1-3a.
[52] Article 28 of the Public Health Framework Bill stipulates that: *Patients or their legal representatives have the right to understandable information from the healthcare institution and healthcare provider about their health condition or illness, and they are entitled to privacy protection of their medical data. They must explicitly and in writing give consent in advance before this data is disclosed to third parties.*
[53] Article 29 of the Public Health Framework Bill stipulates that:

obligation that patients below the age of 12 years must be informed about their treatment in a manner that reflects their comprehension level, alongside communication to their legal representatives. Additionally, this Article provides healthcare providers and institutions with a legal basis to withhold certain information from patients when disclosing it, is beyond a reasonable doubt, likely to cause serious harm to the patient or if the patient has explicitly indicated the preference not to receive such information. While Article 29 grants healthcare providers and institutions a mandate to withhold information under certain circumstances, it also establishes restrictions to prevent misuse of this mandate.

Article 30[54] further expands on the right to information by establishing general standards for the retention and disposal of patients' medical records. It specifies the period during which records

1. *The healthcare institution or healthcare provider shall inform the patient clearly, and upon request in writing, about the proposed investigation and the suggested treatment, as well as developments regarding the investigation, treatment, and the patient's health condition. The healthcare institution or provider shall inform a patient who has not yet reached the age of twelve in such a careful and appropriate manner that aligns well with their capacity for understanding. Additionally, the parent(s) or legal representative(s) are to be fully informed.*
2. *When fulfilling the obligation referred to in Paragraph 1, the healthcare institution or provider shall be guided by what the patient reasonably needs to know regarding:*
    a. *The nature and purpose of the investigation or treatment they consider necessary;*
    b. *The expected consequences and risks for the patient's health;*
    c. *Other methods of investigation or treatment that are available;*
    d. *The state of and prospects concerning their health related to the investigation or treatment.*
3. *The healthcare institution or provider may withhold the information intended as per the first Paragraph only if providing it would likely cause serious harm to the patient's well-being. If the patient's best interest requires the latter, the healthcare provider must provide the relevant information to someone other than the patient. The information shall be provided to the patient once the aforementioned harm no longer exists. The healthcare institution or provider shall not use their authority mentioned in the first sentence without first consulting another healthcare institution or provider about it.*
4. *If the patient has indicated that they do not wish to receive information, the healthcare provider shall refrain from providing it, unless the patient's interest in receiving that information outweighs the potential harm that could result for themselves or others.*
5. *Further rules concerning patients' rights under Articles 28 and 29 shall be established by State Decree.*

[54] Article 30 of the Public Health Framework Bill stipulates that:

1. *The healthcare institution or healthcare provider shall establish a written and/or electronic patient file concerning the treatment of the patient. This file shall include notes on information regarding the patient's health and the procedures performed on them, as well as other documents and/or data containing such information, to the extent that it is necessary for the proper care of the patient.*
2. *Upon request, the healthcare institution or provider shall attach to the file a statement issued by the patient regarding the documents contained therein.*
3. *Notwithstanding what is otherwise stipulated by law, the healthcare institution or provider is required to retain the data referred to in the previous paragraphs for fifteen years, calculated from the time they were created, or for as long as is reasonably necessary in the care of a good healthcare provider.*
4. *The healthcare institution or provider shall destroy the data mentioned in the previous paragraphs after an explicit request from the patient, unless it is reasonably likely that the preservation of the data is of significant importance to someone other than the patient, or if statutory provisions prevent destruction.*

should be kept and outlines conditions under which they may or may not be disposed of. Article 30 also recognizes that patients have the right not only to access their medical records but also to receive a copy upon request.

1.5. Conclusions

Chapter one reveals that, although the Bill aims to regulate patients' rights as addressed by the first research sub-question, it falls short of comprehensively regulating these rights. The Bill appears to primarily emphasize broad principles aimed at the right to health while leaving less emphasis on specific patients' rights. For example, the Bill does not define several fundamental patients' rights found in other legal and regulatory frameworks, such as the right to informed consent, the right to free choice, and the right to lodge complaints. Moreover, specifically regarding the rights to information and privacy, which are the primary focus of this research, the bill, considering its nature as a framework law, does not regulate certain elements of these rights. These shortcomings will be further discussed in greater detail in the upcoming chapters. Having examined which patients' rights are regulated in other jurisdictions and those included in the Bill, a comparative analysis will be undertaken in the next Chapter.

5. *The healthcare institution or provider shall, upon request, provide the patient with full access to and copies of all their data, regardless of whether the patient is currently being treated medically.*
6. *The healthcare institution or provider who previously treated the patient shall, upon request, immediately provide the treating or any other healthcare institution or provider (inside or outside of Suriname) with full access to or copies of the data as referred to in Paragraph 5, under the conditions specified therein.*
7. *Further rules concerning the uniform arrangement of the file, the reports and data included therein, privacy protection, responsibilities, and the provision of data from the file shall be established by State Decree.*

Chapter 2 Comparative analysis of the right to health information and privacy

2.1. The relevance of a comparative analysis

Chapter two addresses the second and third research sub-questions executing a comparative analysis of patients' rights in Suriname and other jurisdictions. This analysis offers valuable insights for several reasons. First, it enables Suriname—especially its legislators—to contextualize the provisions of the Bill pertaining to patients' rights within a broader international framework. Such comparison allows Suriname to evaluate how other countries approach patients' rights, regardless of differing philosophical or cultural traditions, and to consider how legal systems and social dynamics influence these rights. It also provides an opportunity to learn from other nations' experiences in addressing implementation challenges and enforcement mechanisms, which can inform Suriname's own legal development.[55]

Second, this analysis can serve as a foundation for policy recommendations aimed at strengthening patients' rights provisions or guiding the development of related policies, drawing on best practices from around the world.

Third, it supports Suriname's efforts to fulfill its treaty obligations by aligning its legislation on patients' rights with established international norms. Therefore, a comparative legal analysis of the Bill's provisions regulating the right to information and the right to privacy and confidentiality is particularly relevant. Focusing specifically on these rights, the comparative analysis of the Public Health Framework Bill will consider the Civil Code—which came into effect on the 1st of May, 2025—, and patients' rights acts of various jurisdictions.

[55] Jost 2004.

2.2. Analysis of the right to health information

2.2.1. Introduction

The Public Health Framework Bill of Suriname addresses the right to information in Articles 28 and 29. Notably, the framing of these rights is very concise, consistent with the nature of a framework Bill. As previously discussed in Chapter 1, the right to access medical records is considered a component of the right to information and is regulated in Article 30 of the Bill. Looking towards the Civil Code, patients' rights are codified in Book 7, Title 7, Section 5, regulating patients' rights such as the right to information,[56] the right to informed consent,[57] and the right to access medical records.[58] This section of the Civil Code closely mirrors the text from the Medical Treatment Agreement Act (WGBO) of the Kingdom of the Netherlands, which was enacted in 1995. Between the implementation of the WGBO of the Netherlands and the submission of the Civil Code of Suriname for approval at the DNA, numerous developments have occurred in the Netherlands. This will also be considered in the comparative analysis.

2.2.2. Analysis

Articles 28 & 29 of the Bill, clearly state that patients or their legal representatives have the right to receive information—if asked, in a written format—in an understandable manner regarding their (health) condition, the proposed medical examination or research, and treatment. Article 29, Paragraph 2, continues to provide specific guidelines for healthcare institutions and/or providers when carrying out this obligation to follow what patients reasonably need to know. These areas are:

a. the nature and purpose of the examination or treatment that he considers necessary and of the operations to be carried out;
b. the expected consequences and risks for the patient's health;
c. other methods of examination or treatment that may be considered;

[56] Article 7:448 of the Civil Code of the Republic of Suriname.
[57] Article 7:450 of the Civil Code of the Republic of Suriname.
[58] Article 7:456 of the Civil Code of the Republic of Suriname.

d. the state and prospects of the patients' health in relation to the area of the research or treatment.

Additionally, the Bill recognizes that healthcare institutions and/or providers may have valid grounds to withhold information but delineates guidelines to prevent abuse of this rule. For example, consultation with another healthcare institution or provider is required prior to withholding information. Furthermore, the Bill recognizes that the right to receive information also encompasses the patients' right to refuse to receive information, unless the patients' interest in receiving information outweighs the potential harm to themselves or others.

Branching out towards the right to access one's medical records, the Bill regulates this in Article 30. It recognizes that healthcare institutions or healthcare providers must keep a record of the patients' health and the procedures performed by them in written or electronic form, including other relevant documents or data necessary for delivering quality care. The Bill also establishes that patients have the right, upon request, to full access to their data and to obtain copies, regardless of whether they have been treated medically. Furthermore, the Bill states that medical records must be preserved for 15 years and may be destroyed upon the patients' explicit request, provided that retaining the data is no longer reasonably relevant to the patient or others.

According to the Civil Code, the right to information is delineated in Articles 7:448 and 7:449. Similarly to the Bill, Article 7:448 recognizes the right to information and provides guidelines on how this obligation should be fulfilled, focusing on what the patient reasonably should know. It also includes provisions allowing healthcare providers or institutions to withhold information and mechanisms intended to prevent abuse of this authority. Additionally, the Civil Code, like the Bill, acknowledges that patients may choose not to receive certain information if they so request.

Regarding the access to one's medical records, the Civil Code establishes this right in Articles 7:454, 7:455, and 7:456. Similarly to the Bill, it recognizes the obligation of healthcare providers or institutions to maintain medical records of patients and sets guidelines for their content. The Civil Code also regulates the preservation of such medical records, the ability to request termination, and the access to and obtain a copy of those records. Unlike the Bill, the Civil Code

does not stipulate a maximum preservation period for the medical records but states that records should be terminated within three months upon request. Furthermore, it explicitly states that the healthcare provider or institutions can charge a reasonable fee for providing copies of medical records. The practice of charging fees and the lack of a defined maximum for record preservation raise concerns about potential barriers to access and the arbitrary exercise of discretion by healthcare providers or institutions regarding the preservation of medical records.

The Civil Code also establishes explicitly that patients have duties alongside their rights. One such duty relating to the right to information is that the patient must provide, to the best of their knowledge, relevant information and cooperate reasonably with healthcare providers or institutions to facilitate quality care.[59]

Dutch Civil Code

Although the Civil Code of Suriname is heavily based on the Dutch Civil Code, several differences pertaining to patients' rights are noteworthy. With regard to the right to information, the Dutch Civil Code explicitly states that information must be provided to patients in a timely manner and tailored to the patients' comprehension level.[60] The Bill and the Civil Code of Suriname fail to explicitly acknowledge that information must be provided timely and in a manner that fits the patients' comprehension level. Additionally, in contrast to the Civil Code of Suriname and the Bill, the Dutch Civil Code further states that healthcare providers or institutions are obligated to familiarize themselves with the patients' situation and needs and are required to ask the patients if they have questions relating to their care.[61] The Dutch Civil Code also specifies a period of 20 years for the preservation of patients' medical records or as long as reasonably necessary, based on the standard of good care, whereas the Surinamese Civil Code does not specify a maximum preservation period.[62] Moreover, the Dutch Civil Code does not specify a maximum period when the records needs to be destroyed, upon request for termination by the patient. It does, however, recognizes the option to request electronically the termination of one's medical records, unlike the

[59] Article 7:452 of the Civil Code of the Republic of Suriname.
[60] Article 7:448, Paragraph 1 of the Dutch Civil Code.
[61] Article 7:448, Paragraph 3 of the Dutch Civil Code.
[62] Article 7:454, Paragraph 3 of the Dutch Civil Code.

Bill.[63] The Dutch Civil Code does not impose a fee for patients to obtain their medical records, in contrast to the Civil Code of Suriname.[64]

Norway Patient's Rights Act

Norway has established a standalone Act that creates a mechanism to strengthen patients' rights, which covers many patients' rights. These rights include the right to healthcare, the right to participation and information, the right to informed consent, the right to access medical records, and the right to complain. With regard to the right to information, Section 3-2 of Norway Patient's Rights Act stipulates an explicit obligation that patients shall be informed if they sustain injury or serious complications during care—regardless of when these are discovered, even after treatment has ended. Furthermore, the act requires that patients are informed about their right to apply for compensation through the Norwegian System of Compensation to Patients. In contrast, the Bill and the Civil Code, is lacking in imposing similar obligations on healthcare providers and institutions.

The Norway Patient's Rights Act also includes clear, non-exhaustive factors that healthcare providers should take into consideration when conveying information to the patient. These include the patients' age, maturity, experience, and cultural and linguistic background. The Act provides that healthcare providers must use their best efforts to ensure that the patient has understood the contents and significance of the information provided. Additionally, it requires that the information provided is documented in the patients' medical records.[65] The aforementioned creates a more comprehensive mechanism to enforce patients' rights, providing safeguards for both patients and healthcare providers.

USA Code of Federal Regulations Title 42, Chapter IV, Sub Chapter G, Part 482

This research also looked at the USA patients' rights laws. The USA Code of Federal Regulations Title 42, Chapter IV, Sub Chapter G, Part 482 (USA CFR 42), contains patients' rights such as the right to information, the right to complain, the right to access one's medical records, and the right

[63] Article 7:455, Paragraph 1 of the Dutch Civil Code.
[64] Article 7:456 of the Dutch Civil Code.
[65] Section 3-5 of the Norway Patient's Rights Act.

to privacy and confidentiality.[66] With regard to the right to information, this Code obligates that the hospital must inform each patient of their patients' rights before initiating or terminating patient care, a requirement not found in the Bill or the Civil Code. Furthermore, the USA CFR 42 provides specific safeguards for accessing medical records, mandating that patients must be provided in a reasonable time frame, access and copies. Additionally, it stipulates that hospitals must not frustrate the legitimate efforts of individuals to obtain their medical records. In contrast, the Bill and the Civil Code do not provide explicit provisions guaranteeing timely access to medical records free from unnecessary bureaucracy or delays.

2.3. Analysis of the right to privacy

2.3.1. Introduction

While individuals in Suriname have the right to information about their own health and the most extensive free flow of information between themselves and their healthcare providers, they also have the right to have that information treated confidential. The foundation of the right to privacy—and patients' rights overall—is rooted in the Constitution of the Republic of Suriname.[67,68] The right to privacy and confidentiality is also traceable to the oath[69] that every healthcare provider is required to take, as outlined in Article 1[70] of the Practice of Medical Professions Act. The right to privacy and confidentiality is established in Article 28 of the Bill and in Articles 7:457, 7:458, and 7:459 of the Civil Code.

[66] This code recognizes an additional component to the patients' rights arsenal, i.e., the right to safety, regulating that the patient has the right to receive care in a safe setting and to be free from all forms of abuse or harassment.
[67] Article 9, Paragraph 1; Article 17, Paragraph 1; and the overarching right to health articulated in Article 36 of the Constitution of the Republic of Suriname.
[68] Veira 2016, p. 36.
[69]Veira asserts in her work "Patiëntenrechten in Suriname. Van de totaal machteloze naar de volledige autonome patiënt?" that the oath established in Article 27 of the Practice of Medical Professions Act is less comprehensive than the original Hippocratic oath taken 430-377 BCE. The oath in Article 27 of the Practice of Medical Professions Act is as follows. "*I swear (promise) that as a doctor, pharmacist, dentist, pharmacy assistant, midwife, youth dental care provider, or oral health therapist, I will practice ……and that I shall not disclose any information entrusted to me as confidential or acquired during my profession, unless compelled to testify as a witness or expert in court or obligated by law to disclose such information."*
[70] The medical professions recognized in Article 1 of the Practice of Medical Professions Act are doctors, pharmacists, pharmacy assistants, dentists, midwives, youth dental care providers, and oral health therapists.

2.3.2. Analysis

Article 28 of the Bill clearly states that all patients or their legal representatives have the right to privacy protection of their medical data. The Article states that such information may only be disclosed to third parties if the patient provides explicit, written consent in advance. Similarly, Article 7:457 of the Civil Code stipulates that no information about a patient or access to or copies of medical records may be shared without prior patients' consent. This Article further states that anyone directly involved in the execution of the medical treatment agreement, is exempted from this rule.

Article 7:458 of the Civil Code further outlines exemptions stipulating that information or access to medical records may be provided to third parties without the patients' consent for the purpose of statistics or scientific research related to public health. Such data sharing is only allowed if safeguards are in place to prevent re-identification, the research serves a public interest, the data is necessary, and the patient has not objected. Moreover, the healthcare provider must make an entry of sharing the patients' medical data in his/her medical record. Article 7:459 of the Civil Code requires that any procedures related to the patients' care is executed outside the observation of others, unless the patient has consented to such procedures being observed.

Dutch Civil Code

The Dutch and Suriname Civil Codes both have fairly identical provisions on the right to privacy.[71] However, the Dutch Civil Code provides an additional provision concerning the sharing of a deceased patients' medical record. It allows such information to be shared with a third party if the patient had given written or electronic consent while alive, or with anyone who has a significant interest and can demonstrates that their interest may be harmed, with access to or copies of the medical records being necessary to safeguard that interest.[72] Furthermore, the Dutch Civil Code regulates that the healthcare provider or institution can deny a person requesting access to or obtain a copy of the medical records of a deceased patient due to a suspicion of medical error. However, in such cases, the healthcare provider or institution is required to provide access or copies of the

[71] Articles 7:457 & 7:458 of the Dutch Civil Code.
[72] Article 7:458a of the Dutch Civil Code.

medical record to an independent physician designated by the requester. This independent physician will assess whether the refusal to provide access to or a copy of the medical record of the deceased patient is justified. If the independent physician determines that the refusal is unjustified, the healthcare provider or institution is required to grant access or provide a copy of the medical record to the requester.[73] Additionally, Article 7:458a of the Dutch Civil Code also prohibits sharing the medical records of a deceased patient who has reached the age of 12, capable of reasonably assessing their interest, and who has expressed in writing or electronically their wish not to share their medical records with third parties.

Norway Patient's Rights Act

Sections 3-6 of Norway Patient's Rights Act regulates the right to privacy similarly to the Civil Code but more explicitly than the Bill. The Act stipulates generally that medical, health-related, and other personal information must be treated in accordance with the current provisions regarding confidentiality, unless the patient consents otherwise. Unlike the Bill and the Civil Code, the Act also states that if a healthcare provider or institution discloses information that is subject to a statutory duty of disclosure, the patient whom the information concerns shall be informed that their data has been shared and about the nature of the information in question.

USA Code of Federal Regulations Title 42, Chapter IV, Sub Chapter G, part 482

Regarding the right to privacy, USA CFR 42 regulates that patients have the right to personal privacy, including the right to confidentiality of their clinical records. In contrast, the Bill recognizes the patients' right to personal privacy but leaves detailed regulation of this right to be addressed separately by State Decree.

[73] Article 7:458b of the Dutch Civil Code.

2.4. Conclusions

Chapter two reveals that the provisions of Chapter IX of the Bill do not add new safeguards beyond those outlined in Book 7, Title 7, Section 5 of the Civil Code, which regulates more comprehensively the right to information and the right to privacy & confidentiality.

Furthermore, this research revealed gaps in the Civil Code of Suriname compared to the Dutch Civil Code with respect to advancing patients' rights. This gap is noticeable particularly regarding providing medical information in a timely and comprehensible manner that fits the patients' level of understanding. Adopting the non-exhaustive factors from the Norwegian Patients' Rights Act may further strengthen safeguarding patients' rights. Additionally, charging patients a fee to obtain a copy of their medical record might act as a barrier, potentially discouraging patients from reviewing their records. The latter protects both the patient as the healthcare provider and institution.

In terms of the discretion that healthcare providers or institutions have regarding the retention of patients' medical records in the Civil Code, this may result in inconsistent application of the rules regarding how long records are kept. This could potentially undermine the right to access and obtain a copy of their medical record. Moreover, ensuring that patients are informed of their rights before initiating or terminating care, documenting such communications in the patients' records— including information shared with third parties— would further safeguard patients' rights.

Lastly, both the Bill and the Civil Code of Suriname remain silent pertaining to the exchange of information regarding deceased patients. Overall, neither the Bill nor the Civil Code fully ensures the legal accessibility towards the right to information and privacy, as addressed by the second and third research sub-questions.

Chapter 3 Jurisprudence and enforcement mechanisms for patients' rights

3.1. Introductions

Chapter 3 addresses the fourth and fifth research sub-questions, focusing on the enforcement and dispute resolution mechanisms. Enforcement can be categorized as sensu stricto and sensu lato.[74] According to the broad interpretation, enforcement "includes any effort aimed at promoting the application and compliance of laws and regulations in accordance with their purpose and intent."[75] Various mechanisms exist for the enforcement of patients' rights. These mechanisms can range from traditional, such as court-based inquiries in civil, criminal, and administrative law, to the law of medical liability or personal injury.[76] In the context of civil liability, the individual seeks redress, while in the case of criminal liability, the community seeks justice. Conversely, in the realm of disciplinary liability, the profession seeks to uphold the standards of conduct.[77] One of the key challenges that exists within the Member States of the European Union[78] relating to patients' rights is the actual enforcement of the patients' rights[79], which is also a common challenge in Suriname with various laws—including health law.

3.2. Enforcement mechanisms in other jurisdictions

Attention shall be directed towards how other countries enforce the right to privacy and confidentiality and the right to information, as understanding these mechanisms could offer useful insights to enhance the enforcement of these rights in Suriname.

[74] Sensu stricto denotes a narrow or strict interpretation of enforcement, while sensu lato denotes a broader interpretation of enforcement.
[75] Michiels 2006, p. 8.
[76] Study on Patient's Rights in the European Union – Mapping Exercise, p. 5.
[77] Verbogt 1992, p. 49.
[78] In addition to the comprehensive nature and general alignment of patients' rights in the European region with internationally excepted standards, the Inter-American Court of Human Rights—an institution recognized by Suriname—frequently utilizes judgements from the European Court of Justice as guidance when their perspectives coincide. Consequently, this research utilizes the mapping exercise conducted within the European Union as a key source.
[79] Study on Patient's Rights in the European Union – Mapping Exercise, p. 27.

Mechanisms to enforce Patients' Rights in Finland

Finland is a pioneer in legally establishing and enforcing patients' rights with the Patient Rights Act 785/1992 and the Patient Injury Act of 1986. In addition to these Acts, the right to privacy and confidentiality[80] is protected by the Constitution, the Act on National Electronic Health and Social Care Archives, the Data Protection Act, and the Act on Healthcare, which imposes obligations. Moreover, healthcare providers can also face criminal liability under the Penal Code if they violate patients' rights.[81] Internal complaints and dispute resolution mechanisms are outlined by Chapter 3, Paragraph 11 of the Patient Rights Act, which requires healthcare institutions to appoint a patient ombudsman. The Regional State Administrative Agencies (AVI)[82] are tasked with the responsibility of supervising healthcare services within Finland, allowing patients to submit complaints that shall subsequently be subjected to investigation. Furthermore, patient advocacy groups play an important role by offering support and resources to help patients to assert and protect their rights.

Mechanisms to enforce Patients' Rights in the Netherlands

The Kingdom of the Netherlands was the first European nation to codify patients' rights as an integral component of the medical treatment contract between patients and healthcare providers within its Civil Code. The right to information is governed by the Medical Treatment Contract Act. Pursuant to Article 7:449 of the Dutch Civil Code, patients are not only granted the right to information but also to decline to receive certain information if they choose. Information may be conveyed verbally; however, it must be provided in written form upon request and must encompass what a "reasonable" patient would wish to be aware of. The right to privacy is established in Article 10 of the Dutch Constitution, along with provisions within civil, criminal, and administrative law. Key protections are delineated in Article 7:457 of the Dutch Civil Code, Article 88 of the Individual Healthcare Professions Act, and Article 272 of the Dutch Penal Code. The Personal Data Protection Act also plays an important role in this legal landscape. The Healthcare Quality, Complaints, and Disputes Act (WKKGZ) establishes certain enforcement mechanisms, including the appointment of a complaints officer, complaints mediation, and obligating that all healthcare

[80] The right to information is also integrally included in the various legislations. The Patient Rights Act, for example, dictates the types of information to which patients are entitled.
[81] Study on Patient's Rights in the European Union – Mapping Exercise, p. 57-59.
[82] Toiviainen, Vuorenkoski en Hemminki 2010.

institutions have a complaint committee. Another component that contributes to the enforcement of patients' rights is the disciplinary courts for healthcare providers.

Furthermore, the Dutch Data Protection Authority[83] possesses supervisory powers and the authority to impose sanctions. Healthcare providers are mandated to disclose information regarding the services rendered and their performance as stipulated in Article 38, Paragraph 4 of the Dutch Healthcare Market Regulation Act. They are also obligated to submit quality of care information to the Quality Institute for Healthcare, which is tasked with disseminating clear and reliable information to patients, providers, and insurers. Several websites are available to assist patients in making informed choices regarding healthcare providers or institutions.[84]

3.3. Enforcement mechanisms in Suriname

The Public Health Framework Bill contains various provisions aimed at the general enforcement of the law, which may also contribute to the enforcement of patients' rights specifically. Article 8[85] of the Bill establishes a healthcare authority as an independent regulatory body. This independent regulator is tasked with ensuring compliance by the State Health Insurance Fund (SZF), healthcare institutions, healthcare providers, and other actors and stakeholders with the rules and regulations pertaining to the financing of individual healthcare services. Expanding this authority's responsibilities to monitor the quality of care could contribute to strengthening the safeguard mechanisms for patients' rights. Article 18[86] of the Bill mandates the creation of a

[83] The Dutch Implementation Act (Uitvoeringwet Algemene Verordening Gegevensbescherming) translates the General Data Protection Regulation (GDPR) of the EU into national law and provides specific details on its application in the Dutch context. The GDPR is the overarching EU regulation that governs data protection across all Member States.

[84] Study on Patient's Rights in the European Union – Mapping Exercise, pp. 83-85.

[85] Article 8, Paragraph 1 of the Public Health Framework Bill stipulates that: *There is a Healthcare Authority, hereinafter referred to as the Authority. The Authority is a legal entity and is established in Paramaribo.*

[86] Article 18 of the Public Health Framework Bill stipulates that:

1. *Registers for professions in healthcare shall be established, in which individuals who meet the conditions and regulations to be specified by State Decree can request to be registered, namely as: doctor, dentist, basic dentalcare provider, pharmacist, psychotherapist, physiotherapist, midwife, nurse, doctor/expert in alternative medicine and/or treatment, and other healthcare professions.*
    a. *For each registration, the relevant register shall include the name, given names, gender, date of birth, nationality, address, profession, specialization, and education of the individual, along with the registration number and date. By order of the Minister, information may be designated that is necessary for identifying healthcare professionals during registration.*
    b. *The name, initials, gender, registration number, and the relevant profession and specialization of a registered person are public. By order of the Minister, other information may be designated as public*

register of healthcare professions, including details such as the address of each healthcare provider. This contributes to the enforcement and legal certainty. Notably, the legal certainty is currently limited, as illustrated by the Medical Disciplinary Board's Judgment in the MTC case of 13th of November 2020, wherein the complainant was deemed inadmissible for not being able to provide the residence or office address of the physician.

Furthermore, Article 21[87] provides specific requirements for healthcare institutions and providers, including the requirement to establish and clearly communicate the complaints procedure for patients and their relatives. Article 26[88] of the Bill explicitly assigns the Ministry of Health the

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to facilitate locating a healthcare professional in the register, in accordance with legal privacy protections.

c. *The registers shall be established and maintained by the Minister. The Minister shall ensure that the register data is also stored in a sufficiently protected digital database.*
d. *The Medical Disciplinary Board and the Court of Justice shall have full access to the full information in the registers for the exercise of their duties. The registers do not contain complaint procedures. Complaints about healthcare providers can be submitted to the complaint body of a healthcare organization or to the Medical Disciplinary Board.*

2. *Further rules and conditions regarding Paragraph 1 shall be established by State Decree.*

[87] Article 21 of the Public Health Framework Bill stipulates that:

1. *The Minister shall, by Ministerial Decree, establish the categories of healthcare institutions, the requirements they must meet, and the manner in which they are mandatorily registered with the Ministry of Public Health. This concerns:*
   a. *The various types of hospitals, nursing homes, care homes, mental health facilities, nursing institutions, and other healthcare organizations;*
   b. *Institutions for primary care, midwifery care, maternity care, dental care, paramedical care, and other healthcare providers functioning either independently or in collaboration.*
2. *Healthcare institutions and providers are obliged:*
   a. *To offer at least all services that form part of primary healthcare as referred to in this law and as further regulated by the Healthcare Financing Act for residents;*
   b. *To ensure equal access to care and to safeguard the quality and efficiency of the services;*
   c. *To provide the Authority, the Council, and the National healthcare Fund (SZF) with all information, reports, and data, as well as to cooperate as needed for the implementation or supervision of this law or the Healthcare Financing Act, provided that providing or cooperating does not conflict with medical confidentiality;*
   d. *To adhere to the indicators, quality standards, and care protocols established by or pursuant to this law and/or applicable to the professional group; and*
   e. *To comply with the cost reimbursement system established through agreements with the SZF.*
3. *Healthcare institutions are obliged to establish a complaints procedure for patients and their families and to make this clearly known to them. A model complaints procedure shall be established by the Minister through a Ministerial Decree. This decision shall be published in the official Gazette of the Republic of Suriname and on the website of the respective ministry.*

[88] Article 26 of the Public Health Framework Bill stipulates that:

1. *If the Minister considers that the provision of Articles 21 through 25 are not being complied with, or are being only partially complied with, or are being violated in an incorrect manner, he may issue a written warning to the healthcare institution.*
2. *In the warning, the Minister shall specify, with reasons, the measures that the healthcare institution is required to take to ensure compliance with the aforementioned Articles.*

responsibility to monitor compliance with the Bills' provisions to improve the quality of care. Should the minister determine that these obligations are not complied with or improperly fulfilled, he may issue a written directive to the healthcare institutions specifying corrective measures accompanied with deadlines. Sanctions are also laid out in Article 27[89] of the Bill. However, the effectiveness of these provisions is yet to be seen, as the Bill is awaiting approval in the DNA.

3.3.1. Compensation claims through civil procedure

Civil liability in health law primarily aims to provide reparations or (financial) compensation when a patient has suffered detriment or incurred damage due to the healthcare provider's breach of duty.[90] The healthcare provider shall conduct his practice in accordance with the standards of care expected of a competent provider, adhering to the responsibilities outlined in Article 7:453 of the Civil Code[91]. This means that if a healthcare provider fails to deliver the care that a reasonably competent practitioner or an average practitioner in similar circumstances, might be expected to provide, they could be subjected to civil litigation for breach of contract or tort. However, for a claim of damages or breach of contract to succeed, certain conditions must be satisfied. Such conditions include fault, foreseeability, and a causal relationship between the act and the damage.[92] Contractual obligations within the healthcare sector are not exclusively effort obligations. Result

3. *The warning shall specify the deadline within the healthcare institution must comply with the measures referred to in Paragraph 2.*
4. *If taking measures related to an immediate danger to safety or health cannot be postponed, the competent inspector authorized under Article 31 may issue a written order, sworn under oath, requiring immediate action. The healthcare institution is obliged to comply immediately within the specified deadline.*

[89] Article 27 of the Public Health Framework Bill stipulates that:

1. *The Minister has the authority to impose an administrative fine of up to SRD 1.000.000 for conduct or omissions that are in violation of or violate the provisions established under or pursuant to Articles 21 Paragraph 2, 23 Paragraph 1, 25a, and 26 Paragraph 5.*
2. *A conduct in violation of Articles 21 Paragraph 2, 23 Paragraph 1, and 26 Paragraph 5 constitutes a criminal offense if:*
    a. *Within the previous 24 months, a final administrative fine has been imposed twice for the same or similar conduct or omission; or*
    b. *Negligent, intentional, or reckless conduct or omission results in a direct danger to human health or safety.*
3. *Whoever commits a criminal offense as referred to in Paragraph 2 shall be punishable by imprisonments for up to six months and a third category fine, or both.*
4. *An offense referred to in Paragraph 2 is classified as a misdemeanor.*

[90] Legemaate 1997, p. 38.

[91] Article 7:453 of the Civil Code of Suriname stipulates that: *The healthcare provider must, in the course of their duties, observe the care expected of a competent healthcare provider and act in accordance with the responsibilities incumbent upon them, arising from the professional standards applicable to healthcare providers.*

[92] Gangaram Panday 2005, p. 6.

obligations or a combination of both obligations may be applicable.[93] Effort obligation requires that the healthcare provider demonstrate the exertion of effort to attain the specified result. Whereas results obligations require the healthcare provider to show that force majeure prevented the intended outcome.[94]

3.3.2. Enforcement mechanism through the penal system

Article 332[95] of the Penal Code of Suriname provides a general rule on professional confidentiality, which can also be applied to doctor-patient confidentiality relating to the right of privacy and confidentiality. Violation of Article 332 can result in sanctions ranging from a fine of the third category to one year of imprisonment. Article 332 is an enforcement instrument of one facet of medical malpractice, specifically the right to privacy and confidentiality.

Additionally, the penal code contains provisions in Articles 309[96], 357[97], and 358[98] that ban abortion, carrying more severe penalties for healthcare providers aiding abortion. Some experts have argued medical malpractice lawsuits may increase, particularly those claiming that healthcare providers harmed patients by failing to provide timely, necessary abortion care, i.e., providing information for safe abortion.[99] Not providing information on safe abortion procedures undermines the right to information. According to Article 358 of the Penal Code of Suriname, physicians, midwives, or pharmacists who are complicit in an abortion are subject to a penalty of imprisonment

[93] Leenen 2020, p. 639.
[94] Mannoe 2005, p. 48.
[95] Article 332 of the Penal Code of Suriname stipulates that: *Anyone who intentionally discloses any secret which he is obliged to keep, whether because of his current or former office or profession, shall be punishable by imprisonment for a maximum of six months or a fine up to six hundred guilders. If this offense has been committed against a specific person, it can only be prosecuted upon that person's complaint.*
[96] Article 309 of the Penal Code of Suriname stipulates that: *Anyone who deliberately provides treatment to a woman or undergoes treatment, indicating or creating the expectation that pregnancy may be disturbed, shall be punishable by imprisonment for a maximum of three years or a fine up to three thousand guilders.*
[97] Article 357 of the Penal Code of Suriname stipulates that: *Anyone who deliberately causes the termination or the death of the fetus of a woman with her consent shall be punishable by imprisonment for a maximum of four years and six months. If the act results in the death of the woman, the responsible person shall be punished with imprisonment for a maximum of six years.*
[98] Article 358 of the Penal Code of Suriname stipulates that: *If a medical practitioner, midwife, or pharmacist is accessory to the offense (interpretate 'abortion'), or guilty of or an accomplice to any of the offense in articles 356 and 357, the penalties specified in those articles may be increased by one-third, and he may be disqualified from practicing the profession in which the offense was committed.*
[99] Harris M., Malpractice lawsuits over denied abortion care may be on the horizon, 2023.

for a term of up to five and a half years or a fine of the fourth category. If the abortion results in the patient' death, the penalty increases to imprisonment for a term of up to eight years or a fine of the fourth category.

According to the explanatory memorandum to Articles 309, 357 and 358 of the Penal Code of Suriname that unequivocally criminalizes abortion, the legislator recognizes that despite the religious objections, several arguments suggest that a move toward openly regulating this complex issue is necessary. However, due to the sensitivity of the matter, a broad societal debate must first take place. Consequently, these Articles have remained unchanged since their enactment in 1915.[100]

This research found no criminal case based on Articles 309, 357 and 358 of the Penal Code of Suriname. Therefore, suggesting that these articles are plausibly unenforced law, potentially serving as symbolic and/or a dead letter law. Healthcare providers have also indicated that within the medical field there is a general consensus that allows in practice for the termination of a pregnancy prior to the twelfth week. However, the inaction between the legal and medical fields on this topic is thus far undocumented, which makes it difficult for this research to make further statements thereof.

Additionally, the Penal Code contains several provisions dealing with breaching the right to privacy, as well as the right to information in a healthcare setting. These provisions criminalize actions that breach the aforementioned rights and are related to actions that undermine the public trust in the medical profession. Examples of these provisions are:

- Article 287[101], forgery of documents. This may be the case when incorrect or incomplete information is recorded in the medical records.

[100] Explanatory memorandum of the Penal Code of Suriname, S. Title XIX, p. 220.
[101] Article 278 of the Penal Code of Suriname stipulates that:

1. *Any person who fabricates or falsifies a document intended to serve as proof of any fact, with the intent to use it or to cause others to use it as genuine and unaltered, shall be punished for forgery of documents with imprisonment for a maximum of six years and a fine of the fifth category.*
2. *The same penalty shall be imposed on anyone who deliberately uses the false or forged document as if it were genuine and unaltered, or deliberately delivers or possesses such a document, knowing or reasonably suspecting that it is intended for such use.*
3. *If an act described in the first or second paragraph is committed with the intent to prepare or facilitate a terrorist offense, the imprisonment imposed for the act shall be increased by one-third.*

- Article 280[102], a physician who willfully issues a false declaration regarding a birth, a cause of death, or the existence or past existence of diseases, weaknesses, or impairments.
- Article 281[103], a physician who willfully issues a declaration with the intent to have someone involuntarily committed to or detained in a psychiatric hospital.
- Article 304, Paragraph 2, Section 3[104], a physician who engages in sexual misconduct with an individual who is admitted to a care facility where they are employed.
- Article 314[105], a physician who leaves a patient in a helpless condition with whom he has established a treatment agreement.
- Article 347[106], a physician who willfully deprives another of life.
- Article 349[107], a physician who willfully and deliberately takes the life of another.
- Article 353[108], a physician who performs euthanasia.

[102] Article 280 of the Penal Code of Suriname stipulates that:

1. *Any person who makes a false statement within an authentic deed regarding a fact that the deed must prove to be true, with the intent to use or cause others to see the deed as if the statement were in accordance with the truth, shall be punished with imprisonment for a maximum of six years and a fine of the fifth category.*
2. *The same penalty shall be imposed on anyone who deliberately uses the deed as if its contents are in accordance with the truth or deliberately delivers or possesses the deed, knowing or reasonably suspecting that it is intended for such use.*

[103] Article 281 of the Penal Code of Suriname stipulates that: *If the declaration is made with the aim of having someone admitted to or detained in a psychiatric institution, a prison sentence of up to seven years and six months, along with a fine of the fifth category, shall be imposed.*

[104] Article 304, Paragraph 2, Section 3, of the Penal Code of Suriname stipulates that: *Any person working in healthcare or social care who commits acts of indecency with someone who has entrusted them with their treatment or care as a patient or client, shall be punished with imprisonment for a maximum of fifteen years and a fine of the fifth category.*

[105] Article 314 of the Penal Code of Suriname stipulates that: *Anyone who intentionally causes or allows a person, to whom they are legally or contractually obligated to provide support, care, or assistance, to be in a helpless state shall be punished with imprisonment for a maximum of two years and a fine of the fourth category, or with one of these penalties.*

[106] Article 347 of the Penal Code of Suriname stipulates that: *Anyone who deliberately takes the life of another person shall be punished for homicide with imprisonment for a maximum of twenty years and a fine of the fifth category.*

[107] Article 349 of the Penal Code of Suriname stipulates that: *Anyone who deliberately and premeditatedly takes the life of another person shall be punished for murder with life imprisonment or a temporary sentence of up to fifty years.*

[108] Article 353 of the Penal Code of Suriname stipulates that: *Anyone who deliberately and unlawfully ends the life of another person at their explicit and serious request shall be punished with imprisonment for a maximum of twelve years and a fine of the fifth category.*

- Article 360[109], a physician who mistreats a patient. Intentional harm to health is equated with assault.[110]

The Penal Code of Suriname also contains provisions dealing with negligence of a physician in providing surgical or obstetric advice and/or assistance, causing serious harm to a person. These provisions are outlined in:

- Article 367[111], a physician whose negligence results in the death of an individual.
- Article 368[112], a physician whose negligence results in serious bodily injury to another.

Noteworthy is that pursuant to Article 316[113] of the Criminal Procedure Code of Suriname, the offended party who has directly suffered damage and wishes to assert a claim for compensation, may join the proceedings on the criminal case at first instance. This means that the victim does not need to pursue a separate civil procedure to obtain compensation. As a result, this arrangement provides an economic benefit to the victim by consolidating claims into a single process. However, if the application to join the criminal proceedings is deemed inadmissible, the victim retains the option to seek compensation through civil action.[114] Evidence obtained during the criminal trial of a physician can be used in a civil procedure to seek compensation for damages. Once causality is

[109] Article 360 of the Penal Code of Suriname stipulates that:
1. *Assault shall be punishable by imprisonment for a maximum of two years and a fine of the fourth category, or one of these penalties.*
2. *If the act results in serious bodily injury, the offender shall be punished with imprisonment for a maximum of four years and a fine of the fourth category.*
3. *If the act results in the death of another person, the offender shall be punished with imprisonment for a maximum of eight years and a fine of the fifth category.*
4. *Deliberate endangerment of health is considered equivalent to assault.*
5. *An attempt to commit this offense is not punishable.*

[110] HR 24 June 2014.

[111] Article 367 of the Penal Code of Suriname stipulates that: *Anyone whose negligence is attributable to death of another person shall be punished with imprisonment for a maximum of three years and a fine of the fourth category, or one of these penalties.*

[112] Article 368 of the Penal Code of Suriname stipulates that: *Anyone whose negligence results in another person sustaining serious bodily injury, or such injury causing temporary illness or inability to perform official or professional duties, shall be punished with imprisonment or detention for a maximum of one year and a fine of the third category, or one of these penalties.*

[113] Article 316 of the Criminal Procedure Code of Suriname stipulates that:
1. *The offended party may join the proceedings regarding their claim for damages in the criminal case at first instance.*
2. *The joinder takes place at the hearing through a statement of the content of the claim, no later than before the public prosecutor submits their claim pursuant to Article 297.*

[114] Wirosemito 2022, p. 8.

established between the negligent conduct and the damages suffered, a civil action for reparations of damages may be successful.[115]

3.3.3. Medical Disciplinary Board

The right to file a complaint pertains to grievances directed against both a healthcare institution and individual healthcare practitioners. In contrast, disciplinary law exclusively concerns healthcare practitioners' conduct. The purpose of disciplinary law is to ensure confidence in and uphold the quality of a particular profession. Disciplinary law may result in measures imposed in individual cases; however, it can also be regarded as a quality assurance instrument within the healthcare sector.[116]

In Suriname, complainants can submit a complaint to the Medical Disciplinary Board (MTC) under Article 10[117] of the Medical Disciplinary Act. Recognized complainants include:

1. directly concerned party;
2. the management of the organization wherein the individuals who are the subject of the complaints are employed or registered;
3. the Director of Public Health[118];
4. the Public Prosecution Office.

[115] Veira 2017, p. 11-12.
[116] Legemaate 1997, p. 22-23.
[117] Article 10 of the Medical Disciplinary Law of Suriname stipulates the following:
1. *Unless otherwise provided in the second paragraph of Article 8, a case shall initially be brought before the Board through a written complaint from a person who, in the view of the Board, has direct interest. This person could be a member of the management of an entity where the doctor, dentist, pharmacist or midwife is registered or employed to provide medical, surgical, obstetric, or dental assistance, or the Director of Public Health. Both the complaint and all related documents are exempt from seal and court fees.*
2. *Once a complaint has been received, the Chairperson shall initiate a preliminary investigation. If it appears that the complaint has been filed by someone authorized under the first paragraph, the Board shall declare the complainant inadmissible without further investigation. If the complaint is evidently unfounded or of trivial nature, the Board may dismiss it without further inquiry. In all other cases, the board will only make a decision after summoning, and in the case of appearance, hearing the doctor, dentist, pharmacist, or midwife about whom the complaint has been made. This provision applies accordingly in cases covered by the second paragraph of Article 8.*
3. *The withdrawal of the complaint after it has been received, or the discontinuation of the practice by the doctor, dentist, pharmacist, or midwife involved in the case, shall not affect the further proceedings, when, in the opinion of the Board, the public interest requires that the proceedings to continue.*

[118] Also referred to formerly as the Medical Inspector or in Dutch as the "Geneeskundige Inspecteur" as stated in the explanatory note of S.B. 1981 no. 189, p. 1.

Complaints submitted to the MTC are limited to the following defined medical professions, which are physicians, dentists, pharmacists[119], and midwives.[120] The composition of the MTC is delineated in Article 2 of the Regulation of Medical Disciplinary Law and Dispute Resolution 1955.[121] An appeal may be lodged with the Court of Justice.[122] Complaints are only admissible if they are based on a healthcare contract between the patient and the medical professional. Additionally, the complaint must demonstrate a direct interest in the matter. This requirement will be further discussed through jurisprudence analysis.

3.3.4. Internal complaints and dispute resolution mechanisms of institutions

Cooman[123] asserts that the complaints mechanism in Suriname for institutions functions with moderate effectiveness in practice. Various impediments have been identified following an empirical study, which pertain to:

I. a lack of awareness of the procedure among patients;
II. deficiencies in the provision of information;
III. instances of exceeding the maximum allowable time frame;
IV. cultural considerations;
V. the independence of the members involved;
VI. uniformity within the process;
VII. the composition of the membership;
VIII. an absence of continuing education and training;

[119] The Medical Disciplinary Act of 1944, no. 71, was amended by G.B. 1951, no. 79, to expand its scope to encompass the profession of pharmacist in addition to the medical professions of physicians, dentists and midwives.
[120] These limited medical professions are established in Articles 1, 2, 2a, and 3 of the Medical Disciplinary Act.
[121] Article 2 of the Regulation of Medical Disciplinary Law and Dispute Resolution stipulates that:
1. *The Board consist of a chairperson, two members who are medical doctors, and one member who is a dentist, additionally, a deputy chairperson, two deputy members who are medical doctors, and a deputy member who is a dentist are active, in accordance with Articles 18 Paragraph 3 and 38 Paragraph 2.*
2. *A secretary shall be added to the Board.*
3. *In case of impediment or absence of the secretary, their functions shall be performed by a deputy secretary appointed by the designated person.*

[122] Article 62 of the Regulation of Medical Disciplinary Law and Dispute Resolution 1955 stipulates that: *A written appeal against the final decisions made by the Medical Disciplinary Board may be filed with the Court of Justice within one month, counting from the day of ruling or, if the person filing the appeal was not present at the time of the ruling, from the day on which the final decision was communicated to him.*
[123] Cooman 2024, p. 62.

IX. and a lack of financial compensation to complainants during the settlement procedure.

Patients can submit a complaint to the complaints committee of the healthcare institution, provided the concerned healthcare institution has a functional complaints committee in place. In 2009, the Ministry of Health started to set up complaints committees in hospitals and established the national regulation for complaints committees in hospitals.[124] Unfortunately, this regulation currently lacks any legal basis.[125] An assessment conducted by Cooman[126] determined that the regulation for complaints committees in hospitals in Suriname does not align with the standards for a transparent complaints procedure according to the Dutch National Council for Public Health. As a result, she concluded that the efforts are inadequate. It is widely recognized that policy is more effective when it is enshrined in law[127] rather than being implemented on an ad hoc basis. Moreover, Cooman's assessment of four hospitals revealed that some of them do not utilize the national regulation for complaints committees for hospitals. This non-compliance undermines the necessary uniformity in processing complaints from patients, which in turn affects an effective enforcement of the right to complain.[128]

3.4. Jurisprudence analysis

In the following section, two judgments regarding the right to privacy and the right to information of the Medical Disciplinary Board of Suriname will be analyzed using the IRAC model[129].

[124] Regulations for Complaints Committees in Hospitals, 2016.
[125] Cooman 2024, p. 30.
[126] Cooman 2024, p. 32.
[127] Martin 2008, p. 36.
[128] Cooman 2024, p. 37.
[129] Trautman et al. 2017, p. 10.

3.4.1. Medical Disciplinary Board case, 14 December 2018[130]

The legal questions arising out of this case are as follows: *Is the doctor or specialist liable to the complainant for negligence resulting in serious harm to a person who sought and/or to whom he provided his medical advice or assistance to? Is the doctor or specialist liable to the complainant for showing gross incompetence in the practice of medicine*? *Is the doctor or specialist liable to the complainant*[131] *for committing acts that undermine the trust in the medical profession?*

The MTC ruled that there was no negligence or gross misconduct in this case, as the specialist acted in a timely manner and made the necessary efforts to provide medical assistance to the critically ill patient upon admission. However, regarding the specialist's failure to comply with the duty to inform and the breach of professional confidentiality—actions viewed as undermining the trust in the medical profession—the complaint was well-founded. As a result, under Article 5 of the Medical Disciplinary Act 1944, the specialist was imposed the measure of a warning.

Article 1 of the Medical Disciplinary Act 1944 provides the following: *A physician who is guilty of actions that undermine trust in the medical profession or of negligence that causes serious harm to a person for whom medical, surgical, or obstetric advice or assistance was sought and who provided such advice or assistance, or who demonstrates gross incompetence in the practice of medicine, may, without prejudice to their liability under the Surinamese Civil Code or the Surinamese Penal Code, be punished with one of the measures mentioned in Article 5*.

Article 5[132] of the Medical Disciplinary Act 1944 provides that the measures include warning; reprimand; imposition of a fine up to two thousand guilders; suspension from practicing medicine for up to one year; and prohibition from practicing medicine.

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[130] Surinaamse Juristen Blad (SJB) 2019, pp. 117 – 126.
[131] In this the case, the complainant is the daughter of the deceased patient.
[132] Article 5 of the Medical Disciplinary Act of Suriname stipulates that:

1. *The measures referred to in Articles 1 through 4 are:*
    a. *Warning;*
    b. *Reprimand;*
    c. *Imposition of a fine up to two thousand guilders;*
    d. *Suspension from the practice of medicine for a maximum of one year;*
    e. *Revocation of the authority to practice medicine.*
2. *The proceeds of the fine shall benefit the State.*

With respect to the question of standing and admissibility, the MTC asserted that a complaint must be based on a recognized patient-physician relationship. Additionally, the complaint must demonstrate a direct interest in the issue at hand. In this case, the MTC found that the complainant acted on behalf of her mother, who was a patient under the physician's care and has since died. Hence, the MTC granted her standing and declared the complaint admissible since the conditions were met.

This research identifies a point of concern in the abovementioned MTC decision that relates to the question of how comprehensively and effectively patients' rights are protected. The MTC decision addressed a component of the complaint involving how the nursing staff treated the complainant's father (the deceased patient' husband). The complainant's father fell ill while waiting with her for a consultation with the physician to obtain information about his wife's condition. The nursing staff refused to allow the father to lie on a bed. The MTC declined to address this component of the complaint, stating that the nursing profession falls outside of the jurisdiction of the Medical Disciplinary Act. Articles 1, 2, 2a, and 3 of the Medical Disciplinary Act stipulate that the MTC only has authority over complaints concerning doctors, dentists, pharmacists, or midwives. Moreover, pursuant to Article 1[133] of the Practice of a Medical Profession Act, the nursing profession is legally not recognized as a medical profession. Hence, the MTC did not refer the complaint against the nurses' conduct to another disciplinary body. Additionally, this research could not identify any disciplinary law applicable to healthcare professionals beyond those who are included in the Medical Disciplinary Act.

The inability of the MTC to decide on the complaint against the nursing staff is quite alarming and raises questions concerning the enforcement of patients' rights in Suriname. This is particularly important considering the critical role nursing staff plays in patient care. Even more disturbing is the observation made by the MTC that the notes in the medical records were neither clear nor well-articulated, suggesting inadequate record-keeping practices. These findings underscore the need

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3. *When a fine is imposed, the decision may specify one or more payment installments within which the fine must be paid. Enforcement of a imposed fine shall be carried out by the Colonial Collector and Treasurer in the manner prescribed or to be prescribed for the collection of taxes.*

[133] Article 1 of the Practice of Medical Profession Act of Suriname stipulates that: *The term 'medical professions' refers to the occupations of doctor, pharmacist, dentist, pharmacy assistant, midwife, dental youth care provider, and oral therapist.*

to address the gaps in both the Public Health Framework Bill and the Civil Code of Suriname with respect to keeping satisfactory medical records of a patient. Standardized guidelines will stimulate uniformity in the record-keeping practices. This will potentially facilitate more effective preliminary investigations by the MTC, ensuring the quality and fairness of its decisions. Thus, strengthening the enforcement of patients' rights and upholding a high standard of conduct for medical professions.

In its decision, the MTC also asserted that in the patient-physician/specialist relationship, the specialist has significant influence not only over the patient who is experiencing a deterioration in health but also over the patient' family members. The power imbalance exists due to the following reasons:

1. As a physician/specialist, the practitioner possesses comprehensive and pertinent medical information;
2. The physician/specialist determines the treatment protocols applicable to each patient;
3. The physician/specialist is solely authorized to communicate medical information to the patient or their immediate family members.

In this case, the analysis indicates that the physician failed to adequately provide detailed information to the patient or family about the treatment plan or provide a comprehensive explanation of the cause of death, beyond simply stating that the death was caused by "dehydration." Additionally, the specialist felt compelled to publicly defend himself and the hospital publicly through the media. The latter was done because, in his view, the accusations made were unfounded. However, the Board states that physicians will maintain and consistently exhibit professional conduct toward both the patient and their close family members. The Board further emphasizes that physicians must uphold patient confidentiality and refrain from disseminating private health information to third parties or the media without patient consent.[134]

[134] The Board further clarified in the MTC case of 25th of August 2020 that professional confidentiality is primarily intended to protect the patient, not the provider. Moreover, disclosing health information of patients to third parties or using it for other purposes without their consent undermines the public trust in the medical profession.

The MTC concluded that, given that the complainant was solely informed of the patient's death as a result of "dehydration" combined with the specialist' actions of sharing sensitive health information with the media about the complaint and the deceased patient, led to their decision. These actions were deemed to constitute a breach of the right to information and the principle of professional confidentiality, thereby undermining the public trust in the medical profession.

3.4.2. Medical Disciplinary Board Case, 13 November 2020[135]

The legal questions arising out of this case are as follows: *Are the doctors "A" and "C" liable to the complainant for negligence resulting in serious harm (death) to the child whom they provided medical advice and assistance to? Is doctor "B" liable to the complainant for committing acts that undermine the trust in the medical profession?*

In this case the MTC ruled as follows: The MTC found that Doctor A exerted adequate efforts and acted in accordance with the applicable medical protocols in treating a prematurely born child with dysmaturity. Regarding Doctor C, the MTC ruled that the complaint was inadmissible because the complainant could not provide the correct residence or office address of Doctor C. The MTC concluded that Doctor B was not liable for actions that could undermine the public trust in the medical profession, although the verbal conduct of Doctor B seemed to support the complainant' claim.

The MTC determined that Doctor B did not treat the child as the attending physician but did participate in a conversation with the complainants after the child's death. According to the MTC, Doctor B did not make sufficient effort to communicate carefully with the child's family. His choice of words was found to be inadequate, considering the patient's parents their emotional state. Therefore, it appeared that Doctor B's verbal conduct had substantiated the complaint. However, the MTC clarified that no penalty could be imposed because "verbal treatment" alone is not considered a criterion for disciplinary measures. This raises serious concerns about safeguarding the right to information, which obligates healthcare providers to provide information tailored to their patients' background and emotional state at the moment. The latter ensures that the patient

[135] Annex one.

and/or his or her family fully understand the information being provided. This research argues that Doctor B's verbal conduct resulted in providing inadequate information, constituting a breach of the right to information. Such actions should have been considered as undermining the public trust in the medical profession.

Regarding the complaint against Doctor A, the MTC found no evidence to suggest that Doctor A's conduct was negligent.[136] Doctor A exerted adequate efforts to provide the appropriate medical care to the patient, all within the limitations of the available medical knowledge and resources at the relevant time. However, the MTC did conclude that Doctor A communicated insufficiently with the family. This resulted in the family being inadequately informed about the critical condition of the child. This inadequate communication constitutes a breach of the right to information. Contrary to the decision of the MTC, the verbal conduct or the lack thereof, of Doctor A should have been characterized as committing actions that undermine the public trust in the medical profession and dealt with accordingly.

Regarding Doctor C, the MTC found that the complainant's inability to provide the correct residence of Doctor C outweighs the prosecution of Doctor C, thereby raising serious concerns regarding the protection of the rights of patients.

[136] Notably, in a similar case on the 22nd of October 2021, the complainant submitted a complaint against the hospital for being liable for negligence resulting in serious harm during the IVF treatment. In this case the complainant was of the opinion that the IVF treatment carried out by the physician did not follow standard procedures – that these protocols were not in place at the hospital — and that it was done hastily, which left the complainant with a feeling of distrust and having been deceived. The MTC ruled quite clearly that the current Medical Disciplinary Act does not include hospitals for disciplinary liability. Reference was made to Articles 1, 2, 2a, and 3 of the Medical Disciplinary Act. This research notes that a new circumstance has emerged with Article 7:463 of the Civil Code of Suriname that came into effect on the 1st of May 2025. It is yet to be seen how the MTC will consider liability of hospitals in their rulings following the 1st of May 2025.
Article 7:463 of the Civil Code of Suriname stipulates that: *The liability of a caregiver or, in the case referred to in Article 462, of the hospital, cannot be limited or excluded.*

3.5. Conclusions

Chapter three reveals that the Bill—alongside the Civil Code—contains certain mechanisms to safeguard and address disputes to patients' rights, as addressed by the fourth and final research sub-questions. Nonetheless, it is evident that laws without effective enforcement are merely words on a piece of paper. The existing mechanisms to enforce patients' rights include the pursuit of cases in civil, criminal, or administrative courts. Additionally, the professional disciplinary board plays a critical role in upholding the standards of conduct among physicians, pharmacists, dentists, and midwives. This research adopts a broad interpretation of enforcement (sensu lato). Enforcement, as expected, varies across jurisdictions, with some being more comprehensive than others. However, due to various factors, reality shows that the enforcement, in general, poses significant challenges in many jurisdictions, including Suriname.

Finland and the Kingdom of the Netherlands are regarded as the pioneers of patients' rights within the EU, possessing mature enforcement mechanisms. In contrast, Suriname has a less mature enforcement mechanism concerning patients' rights. Prior to the codification of patients' rights in the Civil Code of Suriname 2024, the Medical Disciplinary Board decisions had already acknowledged the rights to information and to privacy and confidentiality. While certain mechanisms exist to enforce the rights to information and privacy, there remains much to be done to enhance the effectiveness of these mechanisms and to comply with international standards.

Conclusions

To conclude, looking back to the central question posed in this research, "*To what extent do the provisions in Chapter IX on patients' rights of the Public Health Framework Bill meet international standards on the right to information and privacy in the context of attaining the highest possible standard of health in Suriname?"* This question arose out of the need for modernization of the Surinamese healthcare legal framework and the lack of awareness that exists among patients about their rights. This study seeks to assess the compatibility of Chapter IX of the Public Health Framework Bill of Suriname with the rights to information and privacy in the pursuit of attaining the highest possible standard of health, in alignment with the regional and global human rights framework.

Patients' rights are directly linked to the right to health, which is recognized by many countries and conventions, including Suriname in its constitution. However, patients' rights are relatively underdeveloped in Suriname and the CARICOM. In contrast, EU countries like Finland and the Kingdom of the Netherlands have more developed legal frameworks to safeguard patients' rights. This study identified a non-exhaustive list of key patients' rights based on discourse that has taken place and what other nations have recognized in their jurisdictions. A significant finding is that the Bill fails to recognize patients' rights, such as the right to informed consent, the right to free choice, and the right to lodge complaints. In addition, numerous elements of the right to information and the right to privacy have not been included. This legislative gap holds significance given that the lack of clarity of regulations undermines the effective implementation, potentially leading to inconsistencies in the protection of patients' rights. Another key finding from the comparative analysis is that patients' rights have been codified in the revised Civil Code of Suriname. However, only the following rights have been codified: the right to information, including the right to access and copy one's medical record; the right to informed consent; and the right to privacy. Furthermore, Book 7, Title 7, Section 5 of the Civil Code of Suriname replicates the text from the Medical Treatment Agreement Act (WGBO) within the Dutch Civil Code, enacted in 1995. Noteworthy is that numerous developments have occurred in the interim that have not been reflected in the revised Civil Code of Suriname. An example of more comprehensive regulation of the right to information is the Norway Patient's Rights Act. This act includes provisions regarding, inter alia, non-exhaustive factors that should be considered when conveying information to the

patient and the obligation that a patient shall be informed if injury or serious complications are inflicted upon them, even when discovering this after the treatment has concluded. Moreover, neither the Bill nor the Civil Code provides safeguards regarding receiving access to and a copy of one's medical records in a timely manner, as the USA CFR 42 does.

This study adopts a broad interpretation of enforcement and highlights various enforcement mechanisms ranging from civil, criminal, and administrative court-based procedures to professional disciplinary mechanisms to uphold the professional standards of conduct. The Bill contains provisions to establish an independent regulatory body, a healthcare authority, responsible for monitoring the financing of individual healthcare services as well as the creation of a register for healthcare professions. The Bill also sets out requirements for healthcare institutions and providers, along with sanctions for non-compliance. If the responsibilities of the independent regulatory body are expanded to include monitoring of the quality of care, it could play a significant role in the enforcement of patients' rights. This study also showcased the existing enforcement mechanisms in Suriname, including the civil, penal, and medical professional disciplinary avenues. The internal complaints mechanism initiated by the Ministry of Health through policies was briefly highlighted. However, it has not been fully implemented yet due to the lack of a legal basis. Implementing Article 21, Paragraph 3 of the Bill obligating healthcare institutions to establish a complaints procedure will create the legal foundation required.

In summary, the Public Health Framework Bill appears to not comprehensively define or recognize many patients' rights according to internationally accepted norms. Further clarification and expansion could be beneficial. While the Bill makes progress to recognize the right to information, including one's right to access and receive a copy of their medical records, it fails to regulate other components to safeguard this right. Similarly, although the Bill recognizes the right to privacy, additional regulations are needed to close existing gaps and meet international standards. The Civil Code addresses some of those gaps, yet it still lags noticeably compared to the Dutch Civil Code. Although the Bill includes mechanisms to hold healthcare providers and institutions accountable for violations of patients' rights, it still lags behind accepted international norms, particularly the dispute resolution mechanisms. The latter has yet to be regulated comprehensively due to the nature of the Bill.

Recommendations

Expand the Bill or enact a standalone Patient Rights Act

Chapter IX of the Public Health Framework Bill could be supplemented to further recognize other patients' rights, such as the right to informed consent, the right to free choice, the right to pain management, and the right to lodge complaints. However, preferably a separate Patients' Rights Act should be enacted, building on the existing provisions in the revised Civil Code of Suriname. This Act should regulate currently recognized and other patients' rights more comprehensively.

Mandatory national complaint procedure

A detailed national complaint procedure for patients and/or their families should be developed through a Ministerial Decree, stemming either from the Bill or the standalone Patients' Rights Act. This procedure should be mandatory for all healthcare institutions to adopt and implement, ensuring uniformity in handling complaints.

Guidelines for medical records

Guidelines should be developed regarding keeping medical records through a Ministerial Decree, stemming either from the Bill or the standalone Patients' Rights Act. Not only will this ensure uniformity in keeping medical records, but it will also improve the ability of the MTC to conduct its preliminary investigation, guaranteeing the quality of its decisions.

Provisions regarding information sharing of deceased patients

The provisions outlined in Articles 7:458a and 7:458b of the Dutch Civil Code, regulating the sharing of information of a deceased patient with other parties, should be considered to be included in Surinamese regulations.

Expand the mandate of the Healthcare Authority

The responsibilities of the Healthcare Authority outlined in Article 8 of the Bill should be expanded to include monitoring the quality of care. This responsibility should include investigating registered health professionals and supervising healthcare institutions including elderly care homes, either proactively or in response to a complaint, similarly to the Danish Patient Safety

Authority.[137] The authority should focus on broad patient safety issues, such as monitoring healthcare facilities (compliance audits), incident reporting, guidelines for patients' rights[138], and education. Additionally, Article 8, Paragraph 2 of the Bill stipulating the composition of the Healthcare Authority should be expanded to include representatives from patient advocacy groups, healthcare providers, government representatives, academia, and legal and medical ethics experts.

Alternatively develop a Patient Rights Charter

An alternative route to the Patients' Rights Act or the Bill in the short term, albeit leading to less legal certainty, is that healthcare institutions take the lead to develop a patients' rights charter in line with international standards. Even though this will not be legally binding, it will contribute significantly to the awareness of patients' rights and social discourse on the matter. Such efforts could assist in creating a conducive political environment to further safeguard patients' rights in Suriname.

Recognize the nursing profession

The nursing profession should be recognized as a medical profession in the Practice of a Medical Profession Act. Subsequently, nursing should be included in the list of medical professions that fall under the authority of the Medical Disciplinary Board as outlined in the Medical Disciplinary Act. This will ensure that nurses are also subject to disciplinary measures.

Publication of the Medical Disciplinary Board decisions

Lastly, it is recommended that the Medical Disciplinary Board should publish their judicial decisions in a timely and anonymized manner to ensure that case laws are more accessible to the public. This will contribute to breaking down barriers for academia to research this understudied area of the law in Suriname.

[137] https://en.stps.dk/health-professionals-and-authorities/supervision

[138] Such as patient safety protocols, incident reporting systems, staff training (ongoing/continuing education), and equipment maintenance.

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Annexes

1. MTC case, 13 November 2020.

Beslissing van het Medisch Tuchtcollege inzake van:

1. **[KLAGER 1],**
2. **[KLAGER 2],**
3. **[KLAGER 3],**
4. **[KLAGER 4],**

allen wonende te Paramaribo,

procederende in persoon,

klagers,

tegen

1. **[BEKLAAGDE 1]**
2. **[BEKLAAGDE 2]**
3. **[BEKLAAGDE 3]**

voor sub 1 en 2 treedt als gemachtigde op, mr. A.R. Baarh, advocaat,

de personen over wie geklaagd is,

Het Medisch Tuchtcollege, hierna te noemen het College, zitting houdende in het gebouw van de Griffie der Kantongerechten aan de Grote Combeweg no. 2 te Paramaribo;

Gezien de op 04 april 2019 door de klagers ingediende klacht tegen [BEKLAAGDE 1], [BEKLAAGDE 2], [BEKLAAGDE 3], het proces-verbaal van het gehouden voorlopig onderzoek d.d. 29 mei 2019 naar aanleiding van bovenvermelde klacht, de verweerschriften van [BEKLAAGDE 1] , en [BEKLAAGDE 2] naar aanleiding van bovenvermelde klacht, de diverse processen-verbaal van behandeling van de klacht, de inhoud van het medisch dossier inzake [KLAGER 1] alsmede de schriftelijke conclusies tot uitlating zijdens de klagers alsmede de gemachtigde van [BEKLAAGDE 1], en [BEKLAAGDE 2] voornoemd;

1. <u>Ten aanzien van de feiten:</u>

1.1. De klacht van de klagers houdt, zakelijk weergegeven, in dat zij de [BEKLAAGDE 1], en [BEKLAAGDE 3] het navolgende verwijten: grove nalatigheid hunnerzijds bij de behandeling van het [KINDJE] heeft geleid tot de dood van het kindje.

1.2. [BEKLAAGDE 1] en [BEKLAAGDE 2] bestrijden voormelde zienswijze en hebben aangegeven – althans zo vat het College dit op - naar beste weten en kunnen binnen het kader van de beschikbare mogelijkheden te hebben gehandeld en dat hen geen blaam treft in verband met het overlijden van [KINDJE] op 21 februari 2019.

1.3. Ten aanzien van [BEKLAAGDE 2] spitst de klacht zich toe op het navolgende (althans zo vat het Tuchtcollege dat op), namelijk dat de klagers niet correct zijn bejegend door voornoemde arts. [BEKLAAGDE 2] voornoemd heeft de klagers gezegd dat het kind vanaf het begin een nuloptie was en door deze opmerking voelen klagers zich in de maling genomen en niet correct bejegend (althans zo vat het College dat op).

1.4. [BEKLAAGDE 2] bestrijdt voormelde zienswijze en heeft aangegeven – kort gezegd - dat hij slechts als invaller vanwege ontstentenis van een collega aanwezig was bij het gesprek met de klagers en hij ontkent de gewraakte bewoordingen gebezigd te hebben.

2. <u>Ten aanzien van het recht:</u>

2.1. Uit hetgeen de klagers en de personen over wie geklaagd is naar voren hebben gebracht in het klaagschrift en de mondelinge toelichting daarop respectievelijk het verweerschrift, kan van het volgende worden uitgegaan:

2.1.1. Op maandagmiddag 18 februari 2019 is [KINDJE] geboren in het Academisch Ziekenhuis Paramaribo.

2.1.2. Het ging om een ernstig prematuur, dysmatuur geboren kindje.

2.1.3. Het kindje werd direct na de geboorte op de NICU-afdeling van het Academisch Ziekenhuis Paramaribo opgenomen en is op donderdag 21 februari 2019 overleden.

2.2. Naar het oordeel van het College blijkt uit het verhandelde ter terechtzitting alsmede de verklaringen van degenen over wie geklaagd wordt het navolgende. De beklaagde [BEKLAAGDE 3] kon niet opgeroepen worden om gehoord te worden en heeft zich evenmin kunnen verweren omtrent de klacht. Aangezien het op de weg van klagers ligt om het juiste verblijf- dan wel kantooradres van de beklaagde op te geven en betrokkene op het in de klacht door klagers opgegeven adres ten aanzien van [BEKLAAGDE 3] niet kon worden bereikt, zullen de klagers niet-ontvankelijk worden verklaard in de mede tegen [BEKLAAGDE 3] voornoemd ingediende klacht.

2.3. Ten aanzien van [BEKLAAGDE 1] en [BEKLAAGDE 2] zal er een opdeling worden gemaakt in dier voege dat eerst het onderdeel van de klacht dat betrekking heeft op de kinderarts [BEKLAAGDE 1] aan de orde zal worden gesteld. Dienaangaande gaat het College uit van het navolgende uitgangspunt. De behandelende arts als professionele beroepsbeoefenaar heeft de taak om zich in te spannen om een patiënt adequate medische bijstand te verlenen. Uiteraard is het de taak van de behandelende arts op dat moment om de in geding zijnde belangen af te wegen tegen de beschikbare mogelijkheden en keuzes te maken in het belang van de gezondheid van de patiënt.

In casu heeft de kinderarts [BEKLAAGDE 1] in de visie van het College met inachtneming van de ter zake geldende protocollen de prematuur en dysmatuur geboren [KINDJE] behandeld en zich afdoende ingespannen om de pasgeborene –binnen het kader van de beschikbare mogelijkheden en de stand van de medische wetenschap op dat moment- adequate medische behandeling te bieden. Helaas is het resultaat uitgebleven en is het kindje komen te overlijden. In de visie van het College is van grove nalatigheid aan de zijde van [BEKLAAGDE 1] casu quo dat zij heeft gehandeld op zodanige wijze dat het vertrouwen in de stand der artsen is ondermijnd, niet gebleken. Het daartoe strekkende onderdeel van de klacht is derhalve in de visie van het Tuchtcollege ongegrond gebleken, hetgeen als consequentie heeft dat de klacht ten aanzien van [BEKLAAGDE 1] voornoemd ongegrond zal worden verklaard. Kennelijk is er – in de visie van het College - niet afdoende gecommuniceerd door [BEKLAAGDE 1] met de familie teneinde de familie deelgenoot te maken van de kritieke situatie waarin het kindje verkeerde waardoor de verwachtingen van de familie heel hoog gespannen waren. Ook is de reden van het afzien van het toedienen van bloed aan het kindje kennelijk niet in voldoende mate uitgelegd aan de familie ten gevolge waarvan er een vertekend beeld aan de zijde van de familie is ontstaan.

2.4. Ten aanzien van [BEKLAAGDE 2] voornoemd overweegt het College als volgt. [BEKLAAGDE 2] heeft het kindje niet als behandelende arts gezien. [BEKLAAGDE 2] heeft wel deelgenomen aan een gesprek met de klagers na het overlijden van het kindje. Uit het verhandelde ter zitting is het voor het College aannemelijk geworden dat [BEKLAAGDE 2] naar de familie van het kindje toe niet adequaat heeft gecommuniceerd. Hij heeft zich als verantwoordelijke van de afdeling onvoldoende ingespannen om zorgvuldig te communiceren naar de familie van het kindje toe en heeft kennelijk bij het gesprek met de familie verzuimd om zijn woorden zorgvuldig te kiezen en daarbij eveneens rekening te houden met de gemoedstoestand van de familie op dat moment. Het voorgaande heeft als consequentie dat het onderdeel van de klacht dat betrekking heeft op het handelen van [BEKLAAGDE 2] (de verbale bejegening) gegrond is gebleken. Aangezien de verbale bejegening door de arts ingevolge de huidige Wet Medisch Tuchtrecht niet als maatstaf geldt voor het opleggen van een maatregel, zal het Tuchtcollege volstaan met de constatering dat de klacht ten aanzien van [BEKLAAGDE 2] gegrond is gebleken, zonder oplegging van een maatregel.

3. <u>Beslissende:</u>

3.1. Verklaart klagers niet-ontvankelijk in de mede tegen de arts [BEKLAAGDE 3] ingediende klacht.

3.2. Verklaart het onderdeel van de klacht dat betrekking heeft op de [BEKLAAGDE 1], ongegrond.

3.3. Constateert dat het onderdeel van de klacht dat betrekking heeft op [BEKLAAGDE 2] gegrond is, zonder oplegging van een maatregel.

Aldus gegeven op heden, vrijdag 13 november 2020 door : mr. A. Charan, voorzitter, dr. W. Jap Tjoen San en drs. A. Bueno de Mesquita-Voigt, leden, en op vrijdag 27 november 2020 uitgesproken in tegenwoordigheid van mr.M. E. van Genderen-Relyveld, secretaris.

w.g. M.E. van Genderen-Relyveld

w.g. A. Charan
w.g. W. Jap Tjoen San
w.g. A. Bueno de Mesquita-Voigt

Voor afschrift
De secretaris van het Medisch Tuchtcollege,

Mr. M.E. van Genderen-Relyveld