Law on “Patients’ Rights”

An invitation to dialogue

This brochure is intended for patients and their families, as well as for healthcare practitioners and other actors in the healthcare sector.

It provides information on the current content of the Law on Patients' Rights.

The law was amended in 2024, but has retained its original purpose:
to promote a lasting partnership between the patient and the healthcare practitioner involved in their care.

More information on patients' rights can be found on our website: www.patientrights.be.

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Foreword

Since 2002, there has been a Law on Patients' Rights in Belgium. This law brings **together in a single text the fundamental rights of the patient vis-à-vis the healthcare practitioner providing them with care.** In addition, the law clarifies the modalities governing the patient's access to their patient record; provides for the role of confidant to assist the patient and determines the possible person who can represent a patient if the patient is not capable of exercising their rights themselves. Ombudsman Services for Patients' Rights have also been established, where patients can lodge a complaint about a healthcare practitioner.

In early 2024, the Law of 22 August 2002 on Patients' Rights was amended in response to certain developments in society and in healthcare in particular. The goal was also to harmonise certain provisions of the Law of 2002 with the Healthcare Practice Quality Act of 2019.

The 2024 law, which amended the Law of 22 August 2002, reinforces the *patient-centred* approach: the healthcare practitioner must consider the patient's life goals, preferences and values. While retaining their therapeutic freedom, healthcare practitioners are encouraged to take *the patient's history and wishes* into account to the extent possible.

The 2024 amendments also concern *persons acting in conjunction with the patient:* they broaden the possibility of assistance that can be performed by the patient's confidant; they clarify the role of the representative of a patient who is unable to exercise their own rights; and they take greater account of the patient's closest relatives in certain situations (for example, by providing the possibility of recourse to the ombudsman service after the death of a patient).

In addition, the 2024 provisions aim to ensure that *patients are as active and involved as possible* in managing their own health. The importance of how patients are informed about their state of health and the provision of care is emphasised and specified in greater detail; in particular, healthcare practitioners should adapt to the patient, take their time and invite the patient to ask questions.

The lawmakers also remind us in 2024 that while the patient has rights, they is equally obliged to *work with* the healthcare practitioner to the best of their ability to *help create* a high-quality care relationship.

The model of cooperation and dialogue and mutual respect between patients and healthcare professionals will improve the quality of the care provided.

I. Who does the law target? In which situations? In what context?

The law applies to healthcare practitioners in the context of providing healthcare to patients.

1. The patient

The law defines a patient as any person who receives healthcare, whether or not at their own request (e.g. at the request of an employer when verifying inability to work).

Patients are actively involved in the management of their own health and express their preferences with regard to the care provided.

2. The healthcare practitioner

The following professionals must respect patients' rights within the scope of their legal competencies: physicians, dentists, pharmacists, midwives, physiotherapists, nurses, nursing auxiliaries, clinical psychologists/orthopedagogues, emergency assistance providers/ambulance personnel and paramedical practitioners (bandagists, orthotists and prosthetists, dietitians, occupational therapists, pharmaceutical technical assistants, medical imaging technologists, medical laboratory technologists, speech therapists, chiropodists, audiologists and hearing aid specialists, dental hygienists, orthoptists, optometrists, non-urgent ambulance drivers, practice assistants). Any person who, as a non-healthcare practitioner, practices psychotherapy in accordance with the conditions set forth in the 2015 Law on the practising of health care professions is also bound to comply with the patient's rights.

3. The healthcare sector

The Law on Patients' Rights relates to all services provided by a healthcare professional for the purpose of promoting, establishing (e.g. insurance medicine), maintaining, restoring (e.g. revalidation) or improving a patient's health condition; for the purpose of changing a patient's appearance primarily for aesthetic reasons, or for the purpose of accompanying the patient at the end of their life (e.g. palliative care).

4. Cooperation and mutual respect

The healthcare practitioner and the patient work together in a context of mutual respect in order to ensure the quality of the healthcare relationship.

5. Multidisciplinary consultation and consultation with the patient's intimates

The healthcare professional conducts multidisciplinary consultation in the interests of the patient (where appropriate and to the extent that the patient does not object). At the patient's request, the healthcare professional will consult with the person that the patient designates or has designated.

II. What are the patient's rights?

1. To receive a quality service

Each patient must receive the best possible service according to their needs and in accordance with medical knowledge and the available technology. Services are provided with respect for the human dignity and autonomy of the patient, and without any distinction or discrimination (e.g. their socio-economic situation, sexual orientation, or philosophical beliefs).

While preserving their therapeutic freedom, the healthcare practitioner must take into account the patient's life goals, values and preferences (whether these have been formulated in writing or not) when providing care. Where applicable, the healthcare practitioner shall organise, in good time, a care plan based on those (a continuous process of thought and communication with the patient and – at the patient's request – with the patient's intimates).

Forms of care aimed at preventing, treating and alleviating physical and psychological pain form an integral part of high-quality treatment provided to the patient.

2. To freely select a healthcare practitioner

The patient chooses the healthcare practitioner and can approach another healthcare practitioner at any point in time.

However, this free choice may, in some cases, be limited by law (e.g. when a person suffering from a psychiatric condition is compulsorily commited (under the Law of 26 June 1990), when care is being provided in prison or when transportation is provided in the context of emergency medical care) or by the circumstances peculiar to the way in which the healthcare itself is organised (e.g. when only one specialist is present in a hospital).

The healthcare practitioner selected by the patient must provide information regarding their competence and experience, should the patient so request. The healthcare practitioner must inform the patient about whether or not they are insured.

Any healthcare practitioner who, in whole or in part, no longer meets the conditions to practise their profession shall inform the patient of this accordingly.

On the other hand, any healthcare practitioner may refuse to provide a patient with services for personal or professional reasons, except in the case of an emergency. In the event that the healthcare practitioner discontinues treatment or practice, they must take prior steps to ensure continuity of care [1] (e.g. inform the patient of the healthcare practitioner to whom they can turn for follow-up treatment or transfer the patient's records to another healthcare practitioner at the patient's request or with the patient's consent).

3. To be informed about their state of health

The healthcare practitioner will provide the patient with all the information necessary to understand their health condition (this concerns the diagnosis, even if unfavourable) and its probable evolution. The healthcare professional also indicates what behaviours are consequently desirable (for example, in connection with risks during pregnancy).

How will the patient be informed about their state of health?

The healthcare professional will find out and take account of the patient's personal situation and preferences regarding their current and future care.

They will communicate this information about the patient's state of health orally and in a manner that is tailored to the patient; amongst other things, with due consideration for the patient's age, education and their ability to understand.

He will provide sufficient time for this and will invite the patient to ask questions.

At the patient's request or whenever they deems it opportune for the patient, the healthcare practitioner will additionally provide a written confirmation of the information provided (on paper or electronically).

If the patient does not wish to receive the information

The healthcare practitioner will respect the patient's wish not to learn information about their health status (for example, a refusal to know whether or not one is a carrier of an

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[1] Article 17 of the Healthcare Practice Quality Act of 22 April 2019 (Quality Act).

incurable disease such as Huntington's disease) and will make a note of this in the patient record.

However, the healthcare practitioner cannot comply with this "patient's request not to know" if not informing the patient would cause serious harm to the health of the patient or of third parties (e.g. infectious disease). In such a case, the healthcare practitioner must consult another healthcare practitioner in advance and consult with the designated confidant, if any.

If the information may cause serious harm to the patient's health

If the healthcare practitioner believes that providing all the information about the patient's state of health could result in serious harm to the patient's health, they must consider whether the sensitive information can be communicated gradually (rather than all at once).

Exceptionally, the healthcare practitioner may decide not to communicate the information to the patient, provided they have consulted another healthcare practitioner about the case.[2]

When following this unusual and temporary course of action, the healthcare practitioner must enter the reason(s) for their decision into the patient record and inform the confidant, if there is one.

At regular points in time, the healthcare practitioner must review whether the apparently serious harm that the patient would suffer on receiving the sensitive information is still present. If this is no longer the case, the healthcare practitioner must communicate the relevant information to the patient.

4. To freely consent to an intervention , with prior information

Before any intervention is initiated, the healthcare practitioner must obtain the patient's free and informed consent to do so.

The intention is that the patient and the healthcare practitioner come to a decision about the proposed care together.

This means that the healthcare professional must have clearly informed the patient in advance of the characteristics of the intended intervention.

The information must be provided in advance and at an appropriate time.

The healthcare practitioner must inform the patient in a tailored manner, take sufficient time to do so and invite the patient to ask questions. The patient's personal situation and preferences must also be taken into account.

The information must cover the following aspects of the intervention: the purpose (e.g. a diagnosis), the nature (e.g. is the in-

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[2] This situation is referred to in legal doctrine as the situation of the *therapeutic exception.*

tervention painful?), the degree of urgency, the duration, the frequency, the expected developments and the aftercare following the interventions, the contra-indications, side effects and risks relevant to the patient, the possible alternatives and any other clarifications relevant to the patient, such as specific legislation relating to a particular intervention (such as aesthetic medicine or surgery, for example).

The healthcare practitioner must also inform the patient of the financial implications of an intervention (e.g. fees, whether or not the health care practitioner has signed an agreement with the health insurance companies and charges agreed rates).

The healthcare practitioner must also provide the patient with written confirmation of the information regarding the care provided if the healthcare professional deems it appropriate or at the patient's request.

How does the patient give consent?

Once the patient has been informed, consent is given orally or the healthcare practitioner deduces this from the patient's behaviour (for example, the patient holds out their arm for an injection). The patient may give consent under certain conditions (e.g. the discontinuation of chemotherapy in the absence of results).

When requested by the patient or the healthcare practitioner, the consent can be put in writing (on paper or electronically) and is added to the patient record (e.g. in the case of an important test or treatment).

If the patient refuses or withdraws consent

The healthcare practitioner must respect the refusal of or the withdrawal of consent to an intervention, until such time as the patient revokes it. However, the healthcare practitioner must continue to provide a quality service (e.g. continued physical care, nutrition and hydration and pain management).

The healthcare professional must inform the patient of the possible consequences of refusing or withdrawing consent to an intervention. They will discuss possible alternatives with the patient, whether these can be performed by another healthcare practitioner, or not.

At the patient's or the healthcare practitioner's request, the refusal or the withdrawal of consent will also be recorded in writing (on paper or electronically) and be added to the patient record.

If the patient is incapable of expressing their will and has drawn up a declaration of will in advance

If the patient is in a state of health that renders them incapable of expressing their own will (for example, in a coma, or suffering from a degenerative mental disorder), the healthcare practitioner *must take into account* a written prior living will (wishes or preferences regarding care) that was drafted when the patient was still able to exercise their rights.

In this prior declaration, the patient may have made it known that they *refuses* to consent to a particular intervention. In this case, *the healthcare practitioner must respect that refusal.*

This prior declaration of will is preferably drawn up in the presence of a third person (such as a healthcare practitioner), in order to avoid divergent interpretations. The declaration is not limited in time unless it is revoked by the patient at a time when they are able to exercise their rights.

A prior declaration of will can be placed in the patient record at the patient's request or brought to the attention of the healthcare practitioner by the patient's confidant or representative.

In an emergency

In an emergency, when it is impossible to ascertain the patient's true will or if the representative is not present (for example, in the case of an unconscious person in an emergency department), the healthcare practitioner will immediately perform all necessary interventions in the interests of the patient's health.

The healthcare practitioner will make a note of this in the patient record. As soon as possible, they will discuss the continuation of care with the patient's representative or with the patient themselves, as soon as they regain consciousness.

5. To be assured that all patient records are carefully maintained and updated and to be able to access them and obtain a copy

The healthcare practitioner must be in possession of carefully maintained records for each patient and must keep them in a safe place. This record contains information about the identity of the patient and the healthcare professional, as well as information relating to the provided care (e.g. test results, diagnoses, a chronological record of care provided,...).[3]

The patient may ask the healthcare practitioner to add certain documents to the record (e.g. a scientific article about his illness, a relevant medical certificate, a document designating a confidant or representative, an advance declaration of will, documents relating to his values, life goals and preferences for current and future care).

If the patient changes healthcare practitioner, they may request that their patient record be transferred to their new healthcare practitioner in order to safeguard the continuity of care.

How can a patient access their record?

A patient can access their record upon request. They also have the right to obtain clarification of the contents of their file. That explanation will be provided by the healthcare practitioner to avoid misinterpretation.

The healthcare practitioner must respond to the patient's request to view their records within no more than 15 days following receipt of the request.

They will allow access to the entire record with the exception of data relating to third parties.

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[3] Article 33 of the Healthcare Practice Quality Act of 22 April 2019 (the Quality Act) specifies all the information which, where appropriate and within the limits of their competence, the healthcare practitioner must include in the patient's record.

If the healthcare practitioner has decided not to inform the patient about an aspect of his health condition for fear that it might cause serious harm to the patient's health (*see II above*), the patient will only have indirect access to their patient record. Only a healthcare practitioner designated by the patient can then view the record.

How can patients obtain a copy of their record?

Subject to the same conditions as for inspection, patients can ask to obtain a copy of their patient record. They will also be able to obtain clarification regarding the contents of the file.

Patients may choose to receive the copy of their record on paper or electronically.

The first copy of the patient record will be provided free of charge. Additional copies may be subject to a reasonable, justifiable administrative fee that must not exceed the actual costs.

The healthcare practitioner will respond to the patient's request to receive a copy within no more than 15 days following receipt of the request.

The healthcare professional will not provide a copy if they have indications that the patient is under pressure to disclose the information contained in the patient record to third parties (such as an employer or an insurance company).

The healthcare practitioner will not provide the patient with information from the record that relates to third parties and, exceptionally and on a temporary basis, with any information which, if disclosed, could seriously harm the patient's health (*see II.3*).

In the latter case, the patient may request indirect access to the data in the record via a healthcare practitioner of their choice.

How can the next of kin of a deceased patient access the record?

- **If the deceased patient was of age:**

If the patient did not oppose it during their lifetime, the spouse, partner, parents, children, siblings, grandparents and grandchildren who can invoke valid reasons (e.g. a suspicion of medical error, tracing any family antecedents) may designate a healthcare practitioner (for example, the family's general practitioner) to review the deceased person's patient records on their behalf.

In order to protect the patient's privacy, access will be indirect and will be limited to the data directly relating to the reasons for access invoked by the next of kin.

- **If the deceased patient was not of age:**

The persons who had parental authority when the patient was a minor (parent(s), guardian(s)) or, if applicable, foster carer(s) may directly view or obtain a copy of the deceased patient's file. They do not have to give reasons for this.

In addition, family members of the deceased minor up to and including the second degree (grandparents, adult siblings) may also directly view the deceased patient's record and obtain a copy, on condition that they provide reasons for their request.

The persons concerned have the opportunity to obtain an explanation from the healthcare practitioner about the patient record.

Regardless of who requests access to the record, the healthcare practitioner may refuse direct access or the direct provision of a copy of the record in order to protect the privacy of the deceased minor. Access will then be granted via a healthcare practitioner chosen by the applicant.

An applicant will have no right to access or receive a copy of the record if the minor patient objected during their lifetime and the patient was considered capable of exercising their rights independently.

A copy will not be provided to an applicant if the healthcare practitioner believes they are being pressured to provide the copy to third parties.

6. To be assured that their intimacy is respected and their privacy protected

Subject to the patient's consent, only the persons whose presence is professionally justified may be present during examinations and while healthcare services and treatments are being provided.

The patient has the right to request the presence of a confidant while care is being provided. This request will be respected unless the healthcare provider has legitimate reasons to oppose it, such as hygiene reasons, for example.

Subject to specific legal exceptions[4], information relating to the patient's health may not be disclosed to third parties by virtue of the rules governing professional confidentiality and the obligation to respect the patient's privacy.

7. To lodge a complaint with an ombudsman service

If a patient feels that one of their rights as a patient has not been respected, they can lodge a complaint with a competent ombudsman service (*see V below*).

The next of kin of a deceased patient may also lodge a complaint with the ombudsman's service, unless the patient would have opposed that. More information on this can be found below (*see V.4 below*).

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[4] E.g. legislation governing the notification of certain contagious diseases or concerning data-sharing between healthcare providers with the same purpose of providing healthcare, with the consent of the patient and in accordance with the conditions provided by law (the Quality Act).

III. The possibility of being assisted by a confidant

The patient may be *assisted* by *one or more* confidants when exercising their rights as a patient. This can be a family member, a friend or acquaintance, another patient, or any other person designated by the patient to assist them.

This option applies to all rights as a patient, but the patient themselves determines the scope of the confidant's authority. The patient thus indicates the right(s) to which this assistance applies.

When explicitly requested by the patient, the confidant may also act *in the patient's absence* in connection with the following specific rights: the right to information about the patient's state of health, the right to information regarding an anticipated healthcare intervention (in the context of informed consent) and the right to access the patient record and/or obtain a copy of it.

How does a patient designate a confidant?

The patient *can designate their confidant without fulfilling any (written) formalities, i.e. verbally*. One way they can do this is by being accompanied by the confidant during a consultation. In any event, the healthcare professional records the identity and authority of the confidant in the patient record.

However, the patient *can also designate their confidant in a more formal way, in writing or by filling in a form*. This allows to clarify the patient's situation and their wishes.

If the patient authorises a confidant to intervene *in his absence* in the exercise of the specific rights mentioned above, a *written mandate is particularly recommended*, taking into account the professional secrecy of the healthcare practitioner.

A sample form indicating the identity and authority of the confidant can be found on the www.patientrights.be website.

At the patient's request, the written designation of the confidant and their authority will be included in the patient record.

IV. What happens if the patient is not capable to exercise their rights? Who is their representative?

1. If the patient is of age

In principle, an adult person exercises their rights as a patient independently themselves.

Only if it is found that, according to the healthcare practitioner's assessment, the patient is not (or no longer) capable of making independent and autonomous judgements, will the representative exercise the patient's rights on the patient's behalf. The representative will act on behalf of the patient for as long as the patient is unable to make decisions (for example, if the patient is in a coma, or is suffering from a degenerative disease, etc.).

The representative exercises the patient's rights in the patient's best interests and in accordance with the patient's expressed values, their preferences regarding current and future care and their life goals.

The representative will involve the patient as much as possible and in proportion to their ability to understand (e.g. in their lucid moments).

Who is the representative of an adult patient who is not capable to exercise his rights himself?

In this case, we distinguish between the situation in which the patient designates a representative themselves and the situation in which the patient does not designate a representative and consequently the legal cascade rule applies:

When designated by means of a written mandate by the patient:

-The patient can, at the time when they are still able to do so and in view of a possible incapacity to exercise their rights themselves issue a specific, written, dated and signed mandate to designate a representative who will exercise their rights in the event that they are incapable to exercise their rights themselves. This in the event that and as long as the patient, in judgement of the healthcare practitioner, will no longer be able to do so himself.

This mandate, which is free of charge, should include the consent of the representative and should be signed by both the patient and the designated representative. It can be revoked by the patient or the designated representative at all times.

In the event that multiple possible representatives are appointed, the patient must clearly stipulate the order in which those persons are to act as representative. It is of utmost importance that a healthcare practitioner is able to see at all times who can make decisions for a patient who is incapable to exercise themselves.

The patient may also designate one or more person(s) close to him to assist the representative.

A sample form for the mandate to appoint a representative under the Law on "Patients' Rights", can be found on the website www.patientrights.be.

-The patient may eventually choose to designate their representative by means of the mandate for extrajudicial protection provided for under the Civil Code (care proxy), taking into account the applicable formal requirements and the costs involved. In this case, it is important to respect the terminology and conditions of the mandate that are provided for in the Law on Patients' Rights.[5]

-The patient must ensure that their next of kin and healthcare professionals are aware of the mandate (a copy of this mandate can be added to the patient's record with their general practitioner for example).

When no representative has been designated by the patient by means of a written mandate:

If the patient has not designated a representative or the patient's designated representative does not act, the patient's rights will be exercised by the administrator of this person. That administrator of the person is designated by the justice of peace for the specific exercise of these rights (to the extent and for as long as the protected person is not capable, in the opinion of the healthcare practitioner, to exercise their rights themselves).

If the patient has not designated any representative or the patient's designated representative does not act and if no administrator has been authorised to represent the patient, the patient's rights will be exercised in substitute order by the cohabiting spouse or partner, an of age child, a parent or an of age sister or brother.

In the event of a conflict between multiple potential representatives of the same level (e.g. multiple children) or in the absence of a representative, the healthcare practitioner will represent the patient's interests, if applicable in consultation with the multidisciplinary team.

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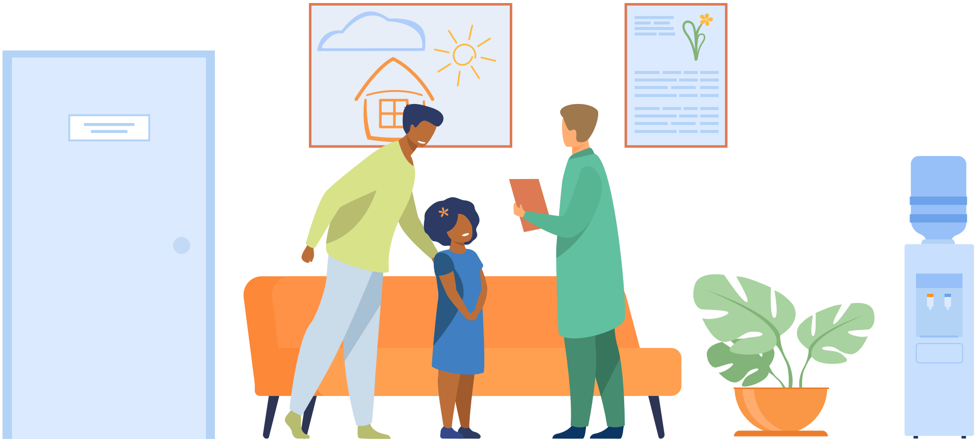
[5] For more information, see: www.notaris.be – Anticiperen met een zorgvolmacht (Preparing for the future with a care proxy). It is up to the patient to communicate this mandate to the healthcare practitioners with whom they come into contact.



2. If the patient is a minor

The exercise of the patient's rights is entitled to the persons exercising parental authority over the minor: the parents, guardians or, where applicable, foster carers.

The patient will be involved in the exercise of their rights as much as possible, taking into account their age and maturity.

However, the minor can fully or partly exercise their rights independently, if the healthcare practitioner assesses that the patient is capable of reasonably judging their own interests.

3. What are the limits of the representative's authority?

To protect the patient's privacy, the healthcare practitioner can deny the representative access to all or part of the patient record. Only the healthcare practitioner designated by the representative can then access or obtain a copy of the patient record. The healthcare professional must state, in the patient record, the rationale for denying the representative access to the record.

In the interests of the patient and in order to avert a threat to the patient's life or to prevent serious impairment to their health, the healthcare practitioner may also deviate from the representative's decision, where applicable, within the scope of a multidisciplinary consultation (e.g. if the representative refuses life-saving treatment).

However, the healthcare practitioner cannot deviate from the representative's decision if the representative provides proof that their decision is consistent with the express will of the patient (e.g. a testimony confirming their will or a video recording).

The healthcare practitioner states the motivation underlying their decision not to follow a decision by the representative in the patient record.

The representative can never oppose a prior declaration of will that the patient drafted at the time they was capable of exercising their rights and that includes a prior refusal of a clearly defined intervention.

If, in the case of an emergency, the patient's will is unclear or the representative is not present, the healthcare practitioner will act in the best interests of the patient's health.

The distinction between the role of confidant and the role of representative

The confidant	**The representative**
The confidant **helps and supports a patient who is still able to exercise their own rights.**	The patient's representative **acts on behalf of a patient who is incapable to exercise their rights themselves.**
The confidant intervenes only at the patient's request. The patient determines the rights for which they seek assistance.	The representative will intervene automatically in the event that the patient is not competent to exercise their own rights. The representative exercises all of the patient's rights on behalf of the patient.

V. The right to lodge a complaint: how do the ombudsman services provided for in the Law on "Patients' Rights" operate?

1. What is the role of the "Patients' Rights" Ombudsman Services?

If a patient considers that one or more of their rights have not been respected (e.g. a lack of information about their state of health, difficulty accessing the patient record, inadequate quality of care), they can lodge a complaint with the competent ombudsman service.

Before initiating a mediation process, the ombudsperson will invite the patient to first attempt to work with the healthcare practitioner to reach a solution themselves.

If this does not lead to a desired outcome, the ombudsperson will mediate between the patient and the healthcare practitioner in order *to promote dialogue between the two* (without taking up a position themselves). Based on the question/complaint formulated by the patient, an attempt will be made to *help the parties find a solution*.

If mediation is not possible (e.g. the ombudsperson is not competent or mediation is incompatible with the patient's expectation) or if the parties do not reach a resolution through mediation, *the ombudsperson will inform the patient of other* options in order to address their complaint.

2. How does mediation work?

Complaints can be formulated to the competent ombudsperson in writing (by letter or e-mail) or orally (telephone, in person).

A complaint can be lodged by the patient (or their representative). Where applicable, the patient may be assisted by a confidant.

The ombudsperson works independently, whether or not they are an employee of a healthcare facility. They also cannot be sanctioned for acts undertaken in the proper performance of their duties.

When the complaint is first lodged, the ombudsperson listens to the patient and tries to obtain an overview of the situation. When the complainant's expectations are clear, the ombudsperson will contact the healthcare practitioner concerned, in writing or verbally. The healthcare practitioner will be asked for their opinion regarding the facts cited by the patient.

The ombudsperson will observe strict neutrality and impartiality throughout the procedure, without taking sides for the patient or for the healthcare practitioner. Moreover, they must not have been involved in the facts or with the persons to which the complaint relates.

In order to restore dialogue, the ombudsperson may at some point propose that the parties contact one another again or meet in their presence, if they so agree. If they refuse, the ombudsperson will assume the role of intermediary for the duration of the procedure; keeping each party informed (in writing or verbally) of the other party's reactions and expectations.

The ombudsperson encourages the parties to express their feelings and their proposed solution in a mediation setting. They will try to moderate the conflict and resolve the disagreement by means of negotiation, exchange of information and communication. In order to reach a solution with the parties, the ombudsperson will exercise their mediation function scrupulously and within a reasonable time. However, the management of the conflict will largely depend on the good will of the parties involved, who can stop the mediation process at any time and initiate another procedure.

If the parties reach an agreement and/or if communication is restored, the mediation procedure can be concluded.

If no solution is reached, the ombudsperson will direct the patient towards another possible means of conflict resolution (e.g. the health insurance funds, the Fund for medical accidents, the Federal Control Commission of Quality Healthcare Practice, the Order of Physicians, a lawyer, front-line legal assistance, the inspection services of the communities and regions, etc.).

All steps taken by the ombudsperson are free of charge to the parties involved.

Since the ombudsperson is obliged to respect professional secrecy, they may not disclose to third parties any information entrusted to them by the patient or healthcare practitioner.

Moreover, mediation is subject to the principle of confidentiality, which protects the documents and communications that were exchanged in the context of and for the purpose of mediation.

Subject to exceptions provided by law, they may not be used outside the context of mediation. They cannot therefore be used for example in judicial, administrative or disciplinary proceedings.

The duty of confidentiality may be waived if the parties give consent in writing.

3. Who can the patient contact to lodge a complaint?

If the complaint involves a healthcare practitioner working in a hospital, the patient (or the immediate family of a deceased patient) should contact the ombudsman service of that hospital.

If the healthcare practitioner in question works in a psychiatric hospital, a sheltered housing initiative or a psychiatric nursing home, the patient may be able to appeal to the ombudsperson at the mental health care concertation platform with which the institutions are affiliated.

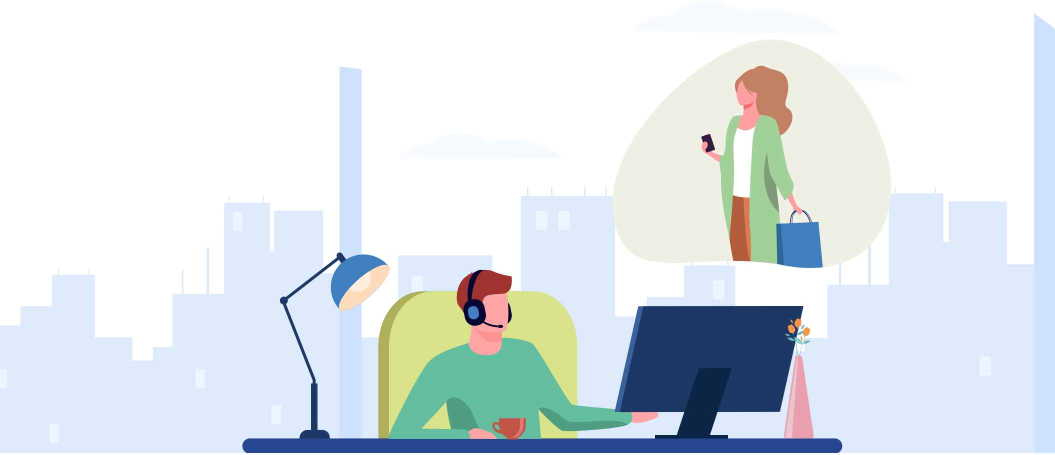
The contact details of the ombudspersons are available on the FPS Public Health website (www.patientrights.be). Patients may also enquire directly with the hospital concerned.

On the other hand, if the complaint concerns an ambulatory healthcare practitioner working outside a hospital (e.g. a general practitioner or specialist in their private practice, an independent nurse practitioner, a dentist, a physician in an assisted living facility or a prison physician), the patient should address to the Federal Ombudsman Service for “Patients’ Rights”.

4. Who can lodge a complaint when the patient is deceased?

After the death of an adult patient, the spouse, the legally cohabiting partner, the de facto cohabiting partner, the patient’s blood relatives up to the second degree and the person acting as a representative at the time of the patient’s death have the right to lodge a complaint with the competent ombudsman service.

After the death of a minor patient, the parents or guardians or, if any, the foster carers may exercise the right to complain.



Contacts

Ombudsmen services of hospitals and mental health care concertation platforms

The list of ombudsmen is available at the following website: www.patientrights.be

Federal Ombudsman Service
FPS Public Health, Food Chain Safety and Environment
DG Healthcare
Federal Ombudsman Service "Patients' Rights"
Avenue Galilée 5/2
B - 1210 Brussels
www.patientrights.be

Dutch-speaking
Tel. +32 2 524 85 20
e-mail: bemiddeling-patientenrechten@health.fgov.be

French-speaking
Tel. +32 2 524 85 21
e-mail: mediation-droitsdupatient@health.fgov.be

Patient Rights Ed.in charge: Dirk Ramaekers, Chairman of the Steering Committee, Avenue Galilée 5/2, 1210 Bruxelles

You can request a free copy of this brochure from the FPS Public Health, Food Chain Safety and Environment.

Please contact:
cell Patients' Rights
DG Healthcare
Avenue Galilée 5/2
1210 Saint-Josse-ten-Noode

brochurespatient@health.fgov.be

www.patientrights.be

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Health
Food Chain Safety
Environment