DUTCH
SAFETY BOARD

Summary

The bankruptcies of MC Slotervaart and MC IJsselmeer-ziekenhuizen

Patient Safety Risks

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The Hague, December 2019

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The Dutch Safety Board

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Dutch Safety Board

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N.B. The full report is published in the Dutch language. If there is a difference in interpretation between the Dutch report and English summary, the Dutch text wil prevail.

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SUMMARY

On 23 October 2018, MC Slotervaart and MC IJsselmeerziekenhuizen were granted suspension of payments. MC Slotervaart almost immediately found itself compelled to cancel all surgeries and transfer its in-patients to other hospitals. The next day, MC IJsselmeerziekenhuizen decided to close the obstetric emergencies unit. For both hospitals, the requests for suspension of payments and the subsequent declarations of bankruptcy on 25 October 2018, marked the start of a turbulent period. Medical staff and patients were suddenly confronted with an uncertain future due to the possibility of an imminent closure or takeover of 'their' hospital. No contingency plans were in place to assure the controlled and orderly resolution of the bankruptcies. As a result, the bankruptcies ended in a 'hard landing', thereby raising questions regarding the assurance of patient safety.

These events prompted the Dutch Safety Board (OVV) to conduct an investigation into how the issue of patient safety was taken into account during the prelude to and the course and aftermath of the bankruptcies of MC Slotervaart and MC IJsselmeerziekenhuizen. The purpose of this investigation was to contribute to (the improvement of) patient safety within a healthcare system in which hospitals can go bankrupt.

Increased risks for patient safety

The investigation of the Dutch Safety Board has revealed that various patient safety risks became manifest during the winding down and/or relaunch of healthcare activities at MC Slotervaart and MC IJsselmeerziekenhuizen. No 'calamities' are known to have occurred[1]. However, during the course and aftermath of the bankruptcies a number of risks occurred simultaneously, causing patient safety risk to increase in comparison to the situation of a hospital operating as normal. At MC Slotervaart, this concerned the following risks:

- the collapse of the organizational structure led to a chaotic situation;
- patients were treated in the hospital without backup support to deal with complications;
- the hospitals to which patients were transferred had insufficient operational capacity, resulting in delayed patient treatments;
- the hospitals to which patients were transferred did not always have access to patients' medical records;
- interruption of doctor-patient relationships due to the hospital closure led to risks of treatment delays, patients relapsing and/or avoiding further care.

1 According to the definition given in Article 1 of the Dutch Healthcare Quality, Complaints and Disputes Act (Wkkgz). A calamity is defined here as: *'an unintended or unexpected event relating to the quality of care and leading to the death or a serious consequence for a client'.*

At MC IJsselmeerziekenhuizen, the following risks occurred:

- patients in and around MC IJsselmeerziekenhuizen were treated without backup support to deal with complications (e.g. due to the closure of the obstetric emergencies unit without advance consultation in the region);
- limited operational capacity in the hospitals to which patients were transferred made it difficult to accommodate patients in need of urgent care;
- the availability of patients' medical records was not guaranteed because the party relaunching MC IJsselmeerziekenhuizen struggled to take over the large number of patients and their records;
- interruption of doctor-patient relationships, as a result of doctors changing position, led to risks of treatment delays, patients relapsing and/or avoiding further care.

Some patient safety risks can be specifically traced back to events surrounding the bankruptcies, such as the collapse of the organizational structure and the uncontrolled termination of healthcare functions. Other risks can be traced back to more generic issues that may also occur in other hospitals. The bankruptcies made these generic issues even more pressing as they had to be resolved under high time pressure. Examples are the backlogs in updating patients' medical records and the challenges in finding accommodation for urgent patients at a regional level. It is the combination of and interplay between these specific and generic circumstances – and the ensuing risks – that jeopardized the continuity of good and safe care. According to the Dutch Safety Board, such risks can be controlled and possibly avoided if bankruptcy is appropriately prepared for.

Prelude to the bankruptcies

Since the summer of 2018, MC Slotervaart, MC IJsselmeerziekenhuizen and the health insurer had foreseen a scenario involving the closure of the financially-embattled hospitals. This scenario was, however, never translated into a concrete plan. Instead, the hospitals were primarily focused on securing their own business continuity and effectuating a transition to make their operations financially healthy. Furthermore, the hospitals were reluctant to share information about their financial problems, fearing that this could endanger the envisaged transition and hasten their bankruptcy. Also the health insurer wanted to prevent outsiders getting wind of the possibility of a bankruptcy scenario. This desire for secrecy meant that prior to the bankruptcies, no contingency arrangements for the transfer of care were made with hospitals in the surrounding area.

The Health and Youth Care Inspectorate (IGJ) advised the hospitals to be cautious in the way they approached external stakeholders. It did urge the hospitals to think through a bankruptcy scenario and draw up a continuity plan for this event. The resulting plans, however, were unsuitable to secure an orderly winding down and transfer of care activities after the bankruptcies were declared.

A great deal of consultation took place between the health insurer and the hospitals. The hospitals' problems, after all, were not new and known to everyone involved. Initially, in the summer of 2018, the health insurer granted a request from the hospitals for financial support to work out transition plans towards a financial health. But a second request for financial support in October 2018 was rejected. The health insurer no longer had faith in the hospitals' plans for the future and decided with immediate effect to settle incoming

invoices against outstanding debts. This made bankruptcy unavoidable for both hospitals. The hospitals were aware of this and requested the health insurer to finance the orderly 'winding down' of all care activities at MC Slotervaart and the winding down of certain care activities at MC IJsselmeerziekenhuizen. The insurer also turned down this request. The health insurer considered an orderly winding down of healthcare activities prior to a declaration of bankruptcy too uncertain, as the costs involved were unknown. As a consequence, the hospitals had insufficient resources to finance an orderly winding down of care.

The IGJ was surprised by the speed at which the bankruptcies came about. The healthcare inspectorate had been confident that the hospitals and health insurer would jointly work out a concrete action plan for the winding down of healthcare activities. After the fact it appeared that this had never happened.

In the Netherlands, the legal principle of *duty to provide care* (in Dutch 'zorgplicht') obligates health insurers to guarantee customer access to the appropriate care that they are entitled to. Current rules and regulations with regard to the duty to provide care are not explicit about the health insurer's role in the preparations for a hospital bankruptcy. In the cases of MC Slotervaart and MC IJsselmeerziekenhuizen, the health insurance company gave a narrow interpretation of its duty to provide care in such preparations; in response to the financial problems at the hospitals, it focused on whether sufficient alternative care was available in the region and not on how the process of winding down healthcare activities should be carried out in concrete terms and what the implications would be for individual patients of the bankrupt hospitals. The Dutch Healthcare Authority (NZa), in its role as regulator of the healthcare insurer, endorsed this interpretation of the health insurer's role towards the subject of its duty to provide care. This meant that the principle of the duty to provide care did not act as a guarantee for the organization of an orderly winding down of care.

The course and aftermath of the bankruptcies

The suspension of payments and bankruptcy of MC Slotervaart and MC IJsselmeerziekenhuizen entailed that the in-patient and outpatient healthcare had to be wound down and/or relaunched. At MC Slotervaart, this winding down process started abruptly because the staff that was not on the permanent payroll, stopped working on the day that suspension of payments was granted. Many of these employees worked in the hospital's emergency and intensive care units. Without them, patient safety was no longer guaranteed and in-patients had to be immediately discharged or transferred to other hospitals. The medical staff worked hard to effectuate discharges and transfers while lacking proper organizational support. Discharges and transfers was achieved under great time pressure and within three days. MC IJsselmeerziekenhuizen was able to continue providing in-patient care in the first weeks after bankruptcy. Here, the transfer of in-patients was therefore not immediately necessary. The staffing of the emergency and intensive care units (with the exception of urgent and in-patient maternity care) remained intact thanks to a financing agreement between the trustees and the health insurers to keep the hospital operational until the relaunch.

At MC Slotervaart the transfer of the outpatients took significantly longer than the transfer of in-patients. This operation concerned many more patients and it was necessary to draw up a detailed list of all the outpatients involved, before the transfer of these patients and their files could take place. Moreover, the possibility of a relaunch meant that doctors were reluctant to release outpatients from their care. This delayed the transfer even further. Throughout this prolonged period, outpatients were kept in uncertainty regarding the continuity of their diagnostic and/or curative processes.

Within the catchment area of MC IJsselmeerziekenhuizen, finding alternative accommodation for urgent patients at hospitals in the surrounding area was a regional issue. In addition, some outpatient care functions (such as bariatric care) were to be continued at a different hospital after the relaunch. It was mainly during this relaunch period that groups of patients were confused and uncertain about where they could go to for the continuation of their treatment.

The Dutch Safety Board concludes that the lack of preparation complicated the post-bankruptcy winding down of healthcare activities. In addition, the transfer of patients and their data was impeded by inherent problems that arise after a hospital bankruptcy. First of all, many patients' medical records still had to be brought up to date before being transferred to alternative care providers. Secondly, it was not clear to the parties involved (bankrupt hospitals and receiving hospitals, but also IGJ and NZa) how patient data could be transferred without violating the General Data Protection Regulation (GDPR). The Personal Data Authority (PDA), as regulator, declined to give an advance opinion and said it would assess retrospectively whether parties had complied with the GDPR. This stood in the way of a rapid transfer of patients and their data.

A final complicating factor was the presence of conflicting interests in relation to the transfer of patients. Immediately after it became known that MC Slotervaart and MC IJsselmeerziekenhuizen had filed for suspension of payments, both medical staff and other parties in the bankrupt hospitals proceeded to act in the interest of the patients. At MC Slotervaart, for instance, everyone joined forces to wind down the provision of urgent care as well as possible. When attention shifted to the transfer of patients who were less in need of care (non-urgent in-patients, outpatients), some room arose for looking after other interests. These included:

- The interests of doctors (working in partnerships or otherwise) in terms of the preservation of their job, career, income and/or market position. These interests led to strategic actions: doctors declined to release patients from their care in order to remain a commercially interesting market player.
- The interests of creditors of the bankrupt hospitals, represented by the trustees. The trustees needed to weigh up the interests of creditors (who wanted to recover as much of the outstanding debt as possible) versus the interests of patients who needed the (temporary) continuation of care activities in the bankrupt hospitals.
- The interests of hospitals, operating in the same region as the bankrupt hospitals, regarding the protection of their financial health. These hospitals needed to make a decision about the patients and patient groups that could be taken over and the additional staff that needed to be employed. This, without having any assurances that such patients (who are free to choose their own healthcare provider) would actually come to their hospital and thus without any assurance regarding the resulting revenues.

- The privacy interests of patients as laid down in the GDPR. Due to the scale on which patients' medical records had to be transferred, the need to comply with the privacy requirements impeded a rapid transfer.
- The interests of health insurers in keeping care affordable through the reorganization of the healthcare landscape. In their role as purchasers, the health insurers were able to influence patients' transfers to other healthcare providers. Their preferences did not always correspond with the preferences of the bankrupt hospitals, which led to delays.

The presence of these interests conflicted with the interests of individual patients regarding the continuity of their diagnostic and curative processes. The outcome in this case was that the interests of the patient did not always receive the required priority.

CONSIDERATIONS

Hospitals can go bankrupt. That is one of the fundamental principles of the Dutch healthcare system. At the same time, the patient must be able to trust the system to provide him or her with safe healthcare whenever necessary. The investigation of the Dutch Safety Board into the bankruptcies of MC Slotervaart and MC IJsselmeerziekenhuizen revealed that the bankruptcies took place in a disorderly manner, leading to increased risks for patient safety. The Dutch Safety Board observes that insufficient arrangements are in place regarding *the manner in which* hospital bankruptcies should be carried out. This is an omission in the current Dutch healthcare system.

Disorderly bankruptcy

In the event of bankruptcy, patients depend for their safety on the arrangements made between healthcare providers and insurers about time, money, equipment and medical treatments. In this case, patients became the victims of the inability of the hospitals and the healthcare insurer to achieve an orderly bankruptcy.

The bankruptcies of both hospitals led to an accumulation of risks for patient safety. Cross-departmental healthcare provision was no longer coordinated, planned operations were cancelled and medicines were not available on time. For weeks, patients remained in the dark as to where they could go for the continuation of their diagnosis and/or treatment. The continuity and quality of care was no longer assured and patient safety was compromised.

Crucial duty to provide care

The healthcare system places a duty to provide care on health insurers to protect the rights of patients. This statutory duty is designed to ensure that insured patients receive the care they need and to which they are legally entitled. To fulfil this duty to provide care, health insurers purchase care from various sources, including hospitals. Ultimately, the health insurer (based on its statutory duty to provide care) and the hospital with medical staff (based on the obligations of healthcare providers pursuant to e.g. the Medical Treatment Agreement Act and the Healthcare Quality, Complaints and Disputes Act) carry a joint responsibility towards patients for the organization of continuity of care.

In the cases of MC Slotervaart and MC IJsselmeerziekenhuizen, the health insurer fulfilled its duty to provide care – prior to the bankruptcies – by making an assessment as to how the bankruptcies would affect the regional accessibility of healthcare. Based on the estimated available capacity, the health insurer concluded that it could continue meeting its duty to provide care if the hospitals went bankrupt. The NZa, as duty to provide care regulator, endorsed this interpretation of duty to provide care based on regional accessibility and population numbers. The potential impact of the discontinuation of the hospitals on the continuity of care for individually insured patients was left out of consideration.

The health insurer ultimately rejected the hospitals' request to work out a joint plan for an orderly winding down of care. In making the decision to settle, with immediate effect, the invoices submitted by the hospitals against outstanding debts, the health insurer shortened the available time for preparing an orderly bankruptcy. It basically turned off the cash tap, without violating its obligations under the statutory duty to provide care. Here, the health insurer did not act in the interests of individual patients, but in the general interests of its premium payers. The health insurer was thus able to shift the responsibility for the bankruptcy preparations entirely to the hospitals. The duty to provide care statutes required no additional efforts from the health insurer, even though such additional efforts were necessary in the interests of patient safety. This points to a design flaw in the healthcare system.

It has become clear that the current duty to provide care requirements provide no assurances for the orderly winding down of care in a bankrupt hospital, or for the continuity of individual diagnosis and treatment processes. According to the Dutch Safety Board, the statutory duty to provide care should provide such assurance. This entails that health insurers should, as part of their collective responsibility, facilitate bankrupt hospitals with the orderly winding down or relaunch of their care activities.

Not a normal bankruptcy

The bankruptcy of a hospital differs from a normal bankruptcy, as a hospital cannot immediately discontinue its healthcare activities: the care for patients must be wound down in the bankrupt hospital and transferred to a different healthcare provider. This takes time and money. However, bankruptcy inexorably places the hospital in a statutory and strategic context that is not consistent with the important social function that it fulfils.

Bankruptcy law does not lay down explicit regulations for hospital bankruptcies with due regard to the socially important role of hospitals. Bankruptcy law chiefly focuses on the interests of creditors. The trustee must seek to secure as much cash as possible for the creditors after the bankruptcy. Over the years, case law has added other socially significant factors that need to be taken into consideration, such as the protection of employment and the facilitation of criminal investigations. But the interests of the collective creditors still come first. In the case of a hospital bankruptcy, the trustee is given the responsibility to ensure an orderly winding down and/or continuation of care until a relaunch is realized. This responsibility can conflict with his statutory task to liquidate the enterprise and secure as much cash as possible for the creditors. There is currently no guarantee that the trustee will give priority to patient safety (as a socially significant factor) over the interests of the creditors. Bankruptcy law in its current form is therefore not suitable for guaranteeing a safe winding down of a hospital's activities.

Each of the multiple parties involved in the prelude to and course and aftermath of the bankruptcy also has its own interests to consider, such as the limitation of financial losses, the retention or acquisition of patients as clients, and the fulfilment of their own role in the system, such as keeping healthcare affordable. The investigation shows that the dynamics (market forces) within the healthcare system can place these interests in direct competition with the individual patient's immediate interest in receiving good, timely and safe care.

Even when, in the prelude to the bankruptcies, the IGJ urged the parties to come together and jointly prepare the bankruptcies in the interests of patient safety, other strategic and financial interests continued to prevail. This is undesirable in the light of patient safety; the interests of affected patients must be the central priority in the resolution of hospital bankruptcies.

VWS: towards a solution

The Ministry of Health, Welfare and Sport (VWS) also concludes in its Letter to the Parliament about '*the further development of policy concerning health providers in financial problems*' (dated 11 October 2019), that a disorderly bankruptcy can lead to unacceptably large risks for patient care. It is of crucial importance to acknowledge the danger of disorderly hospital bankruptcies – all the more so, now that various hospitals in the Netherlands are known to be contending with financial problems. An investigation into the financial health of hospitals for the year 2018 (October 2019, BDO Accountants) concludes that eleven of the 64 analyzed hospitals score unsatisfactory.

To remedy this situation, the minister wants to obtain more insight into the financial problems of hospitals so that, in the future, he can intervene at an earlier stage to mediate there where parties fail to reach an agreement. To this end, the ministry is currently expanding an 'early warning system' for health providers in financial problems. The minister's plans are thus primarily aimed at the health provider. The investigation of the Dutch Safety Board indicates that the actions of health insurers also influence the available time for preparing and enabling an orderly hospital bankruptcy. Moreover, the emphasis that the minister places on improved information sharing and cooperation between the parties involved fails to give due weight to the strategic dynamics that arise around a hospital bankruptcy. After all, a hospital that is open about its financial problems puts itself at a strategic disadvantage and cannot necessarily rely on a cooperative stance from its competitors (other hospitals) and counterparties (health insurers) in the healthcare market.

The investigation shows that early warnings, information sharing and cooperation cannot be taken for granted in the context of healthcare market dynamics. In July 2018, all parties involved in MC Slotervaart and MC IJsselmeerziekenhuizen were aware of the financial problems. Nevertheless, these parties failed to come up with a joint plan to prevent a disorderly bankruptcy.

No guarantee of a safe hospital bankruptcy

The guarantee of an orderly bankruptcy is an essential precondition for a healthcare system in which hospitals can go bankrupt. However, the Dutch Safety Board notes that the Dutch healthcare system makes it possible for hospitals to go bankrupt without assurances for an orderly winding down and transfer of care to other care providers. Within the current system, the duty to provide care requirements for health insurers provide no guarantee for the continuation of good and safe care. The responsibility for the preparations for an orderly winding down of care is not explicitly or coherently arranged within the system. Moreover, current bankruptcy law is not geared to the reality of hospital bankruptcies. Taking everything into consideration, the Dutch Safety Board concludes that patient safety is currently not assured in the event of a hospital bankruptcy.

RECOMMENDATIONS

A hospital bankruptcy should not be the cause of additional or increased risks for patient safety. It is therefore important that the winding down and transfer of care takes place in an orderly manner that guarantees the continuity of care for the individual patient. The patient must be able to trust the system to provide the care he or she is entitled to. A recalibration of the duty to provide care requirements should ensure that health insurers and bankrupt hospitals work together to realize an orderly resolution of the bankruptcy. The NZa, in its role as regulator, must supervise and enforce compliance with the duty to provide care requirements.

Due to the strategic dynamics that arise around a hospital bankruptcy, timely preparation is of crucial importance. A hospital largely depends on health insurers for the financing of its healthcare activities. After a bankruptcy, health insurers must continue providing hospitals with financial support until the care for patients has been transferred to other healthcare providers – or until a relaunch has been realized.

The Dutch Safety Board therefore makes the following recommendation:

To the Minister for Medical Care and Sport:

1. Ensure that the resolution of hospital bankruptcies always takes place in an orderly manner. To this end, the Board considers the following measures important:
   a. Recalibrate the duty to provide care requirements for health insurers in such a manner that the continuity of individual diagnosis and treatment processes is guaranteed in the event of a hospital bankruptcy.
   b. Oblige health insurers, on the grounds of their duty to provide care, to collectively guarantee sufficient financial resources for the orderly winding down and/or transfer of care in the event of a hospital bankruptcy. This can be done, for instance, through the formation of a collective fund or a collective guarantee scheme.

The healthcare that a hospital provides is of great social significance. In addition to timely preparation, it is also important to ensure – when weighing up conflicting interests during the settlement of a hospital bankruptcy – that the public interest (i.e. patient safety) prevails over the private interests of creditors. As things stand, adequate preparations and the protection of public interests versus private interests are not guaranteed within bankruptcy legislation. In conjunction with the above recommendation, the Dutch Safety Board therefore makes the following recommendation which can be implemented within the framework of the current 'Bankruptcy Law Recalibration' Programme.

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To the Minister for Legal Protection:

2. Adjust the bankruptcy laws in relation to hospital bankruptcies in such a manner that:
   a. A hospital can only go bankrupt after a period of 'silent administration' during which adequate preparations are made for an orderly resolution of the hospital bankruptcy.
   b. When weighing up conflicting interests, the trustee shall give priority to the public interest (i.e. patient safety during the winding down operation and/or continuation of healthcare activities) over the interests of creditors.

CONCLUSIONS

The Dutch Safety Board focused in this investigation on the question as to how the issue of patient safety was dealt with in the prelude to and the course and aftermath of the bankruptcies of MC Slotervaart and MC IJsselmeerziekenhuizen. This chapter contains the main conclusions from the investigation.

Increased risks for patient safety

The bankruptcies of both MC Slotervaart and MC IJsselmeerziekenhuizen led to increased risks for patient safety.

Though both bankruptcies were different in nature, both resulted in an increased risk for patient safety. No 'calamities' are known to have occurred. MC Slotervaart was, however, confronted with a chaotic situation due to the speed with which care had to be wound down in an unprepared manner. The winding down process at MC IJsselmeerziekenhuizen was more gradual, but here too, an increased risk for patient safety arose due to a lack of preparation and consultation at regional level. After the hospitals requested suspension of payments, there was a lot of confusion among healthcare providers at MC Slotervaart and healthcare providers around MC IJsselmeerziekenhuizen as to what functions and resources were still available in the hospitals. At both hospitals, for instance, some patients were treated without backup support to deal with potential complications. In addition, many patients were uncertain about the continuation of their treatment and several diagnosis/treatment processes trajectories suffered delays. A number of risks occurred simultaneously during the resolution of the bankruptcies, leading to an increased risk for patient safety compared to the situation at a hospital operating as normal.

The winding down of care in the hospitals demanded great efforts and improvisation from the medical staff working in and around the bankrupt hospitals and the hospitals taking over patients. The safe resolution of the bankruptcies depended on the resilience of medical staff, without adequate organizational measures being taken to assure the continued delivery of good and safe care.

No preparation for an orderly winding down operation

The healthcare system makes it possible for hospitals to go bankrupt, but does not guarantee the orderly winding down of care in a bankrupt hospital. Responsibility for the preparation of an orderly winding down of care is not explicitly and coherently arranged within the system. As a result, the safety of patients affected by a bankruptcy is not guaranteed.

The Board and internal supervisors of the bankrupt hospitals and health insurers involved were not able to prepare an orderly winding down of care in the prelude to the bankruptcies. The external supervision of IGJ and NZa was also not able to do ensure this. The Ministry of Health, Welfare and Sport (VWS) initially remained at a distance in order to let the system run its course. The current healthcare system offers no hard and fast assurances to enforce adequate preparations for an orderly winding down of care in the interests of patient safety.

MC Slotervaart and MC IJsselmeerziekenhuizen were focused on securing their survival in the healthcare market. Until bankruptcy became inevitable, their primary concern was to guarantee their business continuity. Subsequently, they sought to secure continuity of care by attempting to prepare an orderly winding down of care together with the health insurer. The health insurer, however, did not see a role for itself in this process. As a result, the hospitals had to organize the preparations for the winding down of care on their own. However, because they focused on a transition until the very last moment, they lacked the time and resources to achieve this.

The existing regulation with regard to duty to provide care is not explicit about the role of the health insurer regarding the preparation of hospital bankruptcies. In the cases of MC Slotervaart and MC IJsselmeerziekenhuizen, the health insurer gave a narrow interpretation to the statutory concept of their duty to provide care; when confronted with the financial problems at the hospitals, the insurer chose to focus on whether sufficient alternative care was available in the region and not on how the winding down operation should be carried out in concrete terms and what the implications were for individual patients of the bankrupt hospitals. The Dutch Healthcare Authority (NZa), as the regulator of the duty to provide care, endorsed this interpretation of duty to provide care. As a result, the health insurer's duty to provide care did not act as a guarantee for the organization of an orderly winding down of care.

Obstacles in the winding down of care

During the course and aftermath of the bankruptcies of MC Slotervaart and MC IJsselmeerziekenhuizen, multiple obstacles impeded a fast and safe transfer of care. The provision of good care for patients competed with other interests during the winding down of care activities and transfer of patients to alternative healthcare providers. In addition, bankruptcy law is not geared to the practical realities of a hospital bankruptcy. As a result, the interests of the patient were compromised.

The lack of preparation complicated the post-bankruptcy winding down of care. In addition, the transfer of patients was hampered by inherent problems that arise when a hospital goes bankrupt. For instance, patients' medical records still needed to be updated and privacy law issues impeded the rapid transfer of patients and their records to other healthcare providers.

The orderly transfer of patients after a hospital bankruptcy is crucial to control the risks for patient safety. During the in-patient winding down phase, all parties made every effort to ensure the safe and speedy transfer of the ´urgent´ patients. Once the in-patients had been transferred and attention turned to finding a solution for the ´less urgent´ outpatients, patient transfer also turned out to be a strategic issue for the various parties: the health insurer wanted to reorganize the healthcare landscape and renegotiate contract conditions, professional groups in the bankrupt hospitals had preferences for specific new locations, and receiving hospitals were eager to secure new financially attractive patient groups. Moreover, at this stage, medical specialists and trustees could try to influence the possibility of a relaunch by postponing the transfer of patients. All these different interests gave rise to strategic negotiation dynamics that delayed the transfer of patients during the outpatient winding-down phase at MC Slotervaart.

The interests of the parties involved in the bankruptcy, such as doctors, surrounding hospitals, creditors and health insurers, conflicted with the individual patient's interest in the continuity of his or her diagnosis and treatment process. To resolve the bottlenecks, the parties involved needed to do more than what they - according to their own interpretation of their role - were required to do.

The trustees of MC Slotervaart and MC IJsselmeerziekenhuizen made an effort to assure the public interest (i.e. good and safe patient care) at the bankrupt hospitals. This public-minded stance, however, is not something that can be taken for granted: the trustee's statutory task is to protect the interests of the creditors. In practice, this task can conflict with the need to assure patient safety. Bankruptcy law contains no safeguards to guarantee that trustees in a hospital bankruptcy will endeavour to secure a safe winding down of care for patients.

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