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Report for China Medical Board

## Medical Liability and the Doctor-Patient Relationship in China

Over the sixty-year history of the People's Republic of China, the structure of healthcare delivery has undergone dramatic structural transformations—shifting from a system of government-driven healthcare to a system of market-driven care. The most recent and highly publicized healthcare reforms, the first phase of which was enacted between 2009 and 2011, have sought to find a hybrid model, in an effort to maintain the benefits of a profit-driven delivery system while remedying its shortcomings. The reforms are aimed at guaranteeing a basic level of care for all Chinese citizens, while allowing market demand to allocate more advanced or supplementary services. Such reforms were duly needed; but evidence suggests that improving the Chinese healthcare system will involve more than just increasing access to care and reconfiguring cost incentives. A more difficult to quantify, but no less important issue is a reported lack of “trust” in the Chinese doctor-patient relationship.

Charged disputes and even violent attacks on medical professionals in China by dissatisfied patients or family members have increased in prevalence over the past two decades. In March 2007, a Ministry of Health report revealed that over 9,831 “serious disturbances to medical order,” resulting in 5,519 injuries to medical workers had occurred in the previous year.<sup>1</sup> At a national forum of Chinese hospital presidents in

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November of 2012, it was estimated that about 30 percent of medical personnel have had conflicts with their patients.<sup>2</sup> Stories of clashes between doctors and patients have captivated the Chinese media and blogosphere, as well as rumors of the emergence a new group of professional group of “medical disturbers (*yinaozhe*),” anti-hospital activists available for hire by angered patients and their families.

Medical conflicts have increased, not just within China’s hospitals, but also within its courtrooms. According to a 2011 Chinese Hospital Management Association survey, the number of malpractice lawsuits in China has been increasing at an average rate of 23 percent a year since 2002.<sup>3</sup> While China’s judicial system is improving its institutional procedures for handling such cases, many grey areas, perverse incentives, and points of confusion still exist.

The causes of such conflicts within the doctor-patient relationship are complex—both structural and interpersonal. Overworked, underpaid doctors and access inequalities tend to lead to rushed, impersonal, and unsatisfying doctor-patient encounters.<sup>4</sup> Standards for medical education reportedly can vary widely, and doctors often receive little interpersonal communication training.<sup>5</sup> Most Chinese hospitals are still government owned; yet they receive a very small percentage of their operating budgets from the

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Despite the abovementioned assistance, all errors and faults are my own.

<sup>1</sup> Zeng Liming, “In China Last Year, Nearly 1000 Incidents of Disruption to Medical Order Occurred, Over 5,000 People Injured,” *China News Network*, 19 Apr 2007. Web.

<http://jk.anhuinews.com/system/2007/04/19/001718881.shtml>. [In Chinese]

<sup>2</sup> Cao, Kai. “Hospitals’ Return to Public Service Key to Tackle Doctor-Patient Disputes.” *Xinhua* 19 Nov 2011. Web. 30 Sep. 2013. <[http://news.xinhuanet.com/english/china/2012-11/19/c\\_131985197.htm](http://news.xinhuanet.com/english/china/2012-11/19/c_131985197.htm)>.

<sup>3</sup> Jiang, Jessie. “In Some Chinese Hospitals, Violence Is Out of Control and It’s Doctors Who Are at Risk.” *Time Magazine*. 11 Oct 2011. Web. <<http://www.time.com/time/world/article/0,8599,2096630,00.html>>.

<sup>4</sup> This statement is especially true in regard to higher-tier, urban hospitals. Because of the poor quality of primary care at lower levels of hospitals, many patients—even rural, poor patients—often choose to seek treatment at famous, urban hospitals, leading to serious overcrowding issues. See: Yip, W. C. M., Hsiao, W. C., Chen, W., Hu, S., Ma, J., & Maynard, A. “Early Appraisal of China’s huge and complex health-care reforms.” *The Lancet* 379.9818 (2012): 833-842.

<sup>5</sup> Xu, Dong, Sun, B., Wan, X., & Ke, Y., “Reformation of medical education in China.” *The Lancet* 375.9725 (2010): 1502-1504.

government, and are forced to find other means of raising funds.<sup>6</sup> On the other side, patients often face high medical fees, long waits, and “pay-or-die” payment policies. Facing such barriers to care, many patients place unrealistically high expectations upon doctors; and, doctors have frequently been accused of not properly explaining medical procedures for patients and their families. The result, as many observers have noted, is a “lack of trust” on both sides of the doctor-patient relationship.

To better understand the options available in moving forward to address issues that arise from conflicts between patients and doctors, it is important to appreciate the context in which the institutions and problems have developed. Towards this goal, I will historicize China’s contemporary doctor-patient relationship through an examination of the development of China’s national medical infrastructure and regulatory environment because the status and qualifications for doctors changed dramatically across the twentieth century. After briefly highlighting the structural transformation of the Chinese healthcare system, and the corresponding transformation in the legal treatment of medical liability, I will describe the ways in which these developments have created the complex issues facing Chinese doctors and patients today. I will suggest that a confluence of economic, institutional, and interpersonal factors—which have arisen from China’s unique history of healthcare and legal reforms—have resulted in the contemporary complaints. Finally, though an examination of contextual sources of these issues, I will provide some suggestions for roads forward and reasons for optimism.

Broadly speaking, contemporary doctor-patient problems in China largely have grown out of the transformation of health services from a social welfare benefit to a

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<sup>6</sup> Hu, S., Tang, S., Liu, Y., Zhao, Y., Escobar, M. L., & de Ferranti, D. “Reform of how health care is paid for in China: challenges and opportunities.” *The Lancet* 372.9652 (2008): 1846-1853.

commodity, and the introduction of a greater of profit-motivation as public funding for hospitals and healthcare services decreased after Deng Xiaoping's "Reform and Opening" policies.<sup>7</sup> The introduction of market forces has raised expectations for the effectiveness of care and the quality of service. Further, although Chinese and foreign media often portray malpractice lawsuits as an increasingly problematic phenomenon, it is more likely that such cases have simply gained greater visibility as China has formalized and institutionalized civil liability litigation. Riots and attacks on healthcare practitioners, however, continue to be an insidious problem. Such incidents represent a form of "institutional failure" and signal that legal and health reforms have yet to meet the needs of Chinese citizens. The way forward will depend upon increasing the predictability of the legal system, strengthening medical accreditation and professional ethics standards, stressing the social dimension of medical encounters in medical education, and promoting further research into doctor-patient interactions and medical ethics.

But, before proceeding, a caveat is warranted. Studying the contemporary "doctor-patient" relationship in China, through the lens of medical conflict can result in a form of distortion. Cases of medical conflict—especially those which receive media attention—are the exception, rather than the rule. Medical conflicts will arise in all types of health care systems, and the existence of medical malpractice claims and lawsuits should not be considered a problem in and of itself. Although many Chinese legal and public health scholars often state as the goal of their research to promote conflict-free

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<sup>7</sup> The effects of Deng's reforms upon the Chinese healthcare system are a broad and fascinating topic. Obviously, a thorough discussion of the reforms health policy implications are far beyond the scope of this paper. I will discuss them briefly below, but this paper will focus on how legal reforms interacted with China's transforming healthcare landscape.

“harmonious doctor-patient relations,” such a goal is an ideal, rather than an attainable goal. That said, the public attention which medical conflicts in China garner, I believe, demonstrates broader systemic issues with which the average Chinese patient and doctor can sympathize. Rather, China’s medical malpractice regulatory environment warrants greater attention because of the commonly held perception that China’s medical conflicts have arisen from a deterioration of trust in China’s doctors and contributed to an increasingly adversarial quality in Chinese doctor-patient relationships.<sup>8</sup> Even within quotidian patient-provider encounters, both sides are dissatisfied with their status.<sup>9</sup>

### **Structural Transformations of Chinese Healthcare Delivery**

The Chinese healthcare system’s dramatic transformations during the twentieth century have been correlated with similarly dramatic transformations to the training and status of doctors in China. Western-style medical doctors and Chinese-style medical practitioners both professionalized and rose in social status under a specific set of historical conditions during the Republican era (1911-1949). The rise in status of Western-style medical practitioners occurred largely during the 1920s and 1930s, as increasing numbers of foreign educated doctors and those trained at foreign-run medical schools in China (such as the Peking Union Medical College) sought to transform medical practice into an elite profession. The intellectual traditions of the May Fourth Movement, which placed great hope upon “science” as a panacea for China’s ills combined with generous funds for science and medical departments from the Rockefeller

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<sup>8</sup> For example, see: Xiong Peiyun, “Who Will End Doctor-Patient Conflicts?” *Southern Weekend*. 05 Dec 2007. Web. <<http://www.infzm.com/content/8201>> . [In Chinese].

<sup>9</sup> Zheng Qi and Li Mingming, “Viewing Countermeasures to the Phenomenon of ‘Medical Chaos’ from a Political Perspective,” *Law and Society* 4 (2013): 165-166.

Foundation, gave important support to the budding scientific medical profession.<sup>10</sup>

Further, nascent medical professional organizations petitioned the government, seeking to enforce licensing standards, and advocating for Western-style doctors.<sup>11</sup>

After 1949, this course changed as Chinese hospitals were nationalized and doctors became government employees. Some western-style medical professionals who had supported the Republic of China's government fled, and the Chinese Medical Association moved from Shanghai to Beijing, and became much more closely affiliated with the government. Private medical colleges were nationalized, and, under direction from Mao Zedong, Chinese and Western medical practitioners were required to integrate their practices and "learn from each other."<sup>12</sup>

These reforms resulted in a decrease in the status and salaries of Western-style medical practitioners. Some practitioners who had been closely affiliated with foreign organizations—such as the Peking Union Medical College—often were treated with suspicion and had to demonstrate their patriotism.<sup>13</sup> However, this corresponding lowering in status shifted the emphasis for many in the medical profession away from elite medicine towards basic public health. Yet, despite government control over the Chinese medical system and initial efforts to establish a baseline of medical care in rural areas, access inequalities persisted throughout the first decade or so of Communist rule. In his now-famous June 26<sup>th</sup> directive on public health, delivered in 1965, Chairman Mao sharply criticized the Ministry of Health for only serving "fifteen per cent of the

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<sup>10</sup> Bullock, Mary Brown, *The Oil Prince's Legacy: Rockefeller Philanthropy in China*. Woodrow Wilson Center Press, 2011: 47-81.

<sup>11</sup> Lei, Sean Hsiang-lin. "When Chinese Medicine Encountered the State." PhD diss., University of Chicago, 1999.; Long Wei, "Protecting Medical Rights: Republican Doctors' Occupational Hardship and Professional Protections," *Social Science Research*, March 2010. [In Chinese].

<sup>12</sup> Taylor, Kim. *Chinese Medicine in Early Communist China, 1945-1963: A medicine of revolution*. Routledge, 2012.

<sup>13</sup> *Ibid.*

population, while a vast array of peasants are unable to obtain medical treatment.” In the same directive, Mao called for the reorganization of medical education, placing a greater access on treatment for rural areas, rather than “urban” medicine and an emphasis on “difficult diseases.”<sup>14</sup>

Fulfilling Mao’s call for reform, medical institutions began to establish programs for training rural medical practitioners, and the deployment of “barefoot doctors” became an official part of government public health policy in 1968.<sup>15</sup> By the mid-1970s, an extensive system of government-provided healthcare had been extended to reach over half of China’s urban population, and the much publicized “barefoot doctor” scheme provided dramatic improvements to the baseline of care available for rural Chinese citizens. Barefoot doctors, who usually received between 3 to 6 months of training, earned points like other forms of workers.<sup>16</sup> Trained medical practitioners were employees of the state, and, in rural areas, through a Cooperative Medical System, a basic level of care was provided at village and township health centers.

China’s government-driven healthcare system achieved great progress in expanding access to healthcare for the average Chinese citizen. This expansion of access resulted in impressive improvements, especially for infant mortality and life expectancy. For example, one popular study found that from 1952 to 1982, life expectancy increased from 35 to 68, and infant mortality fell from 200 to 34 per 1000 births.<sup>17</sup> These accomplishments were achieved mainly through investments in public health

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<sup>14</sup> Mao Zedong, “Directive Concerning Moving The Focus Of Public Health To Rural Villages.” **Translated Text Available at:** [http://www.marxists.org/reference/archive/mao/selected-works/volume-9/mswv9\\_41.htm](http://www.marxists.org/reference/archive/mao/selected-works/volume-9/mswv9_41.htm)

<sup>15</sup> Zhang, Daqing, and Paul U. Unschuld. “China’s barefoot doctor: past, present, and future.” *The Lancet* 372.9653 (2008): 1865-1867.

<sup>16</sup> Ibid.

<sup>17</sup> Liu Y, Rao K, Fei J. “Economic Transition and Health Transition: Comparing China and Russia.” *Health Policy* 44 (1998):103-22.

infrastructure and the resultant expansion of care.

However, the emphasis on increasing access came at the cost of reduced medical training. As Daqing Zhang and Paul Unschuld have noted, the government faced a consistent tension in their treatment of “barefoot doctors”: government policy needed to navigate the divide between a desire for mass production and the need to improve the education of doctors and improve standards of care.<sup>18</sup> When Deng Xiaoping, serving as vice-premier at the time, announced in 1975 that barefoot doctors should improve their medical knowledge and “put on shoes” in the future, he was criticized.<sup>19</sup>

The impact of the Deng’s “Reform and Opening” policies, beginning in 1978, upon the Chinese healthcare system was swift and devastating. As the government sought to reintroduce market forces into the economy, and decentralize many administrative state functions, the central government decreased its funding for national healthcare services, transferring the responsibility for funding China’s hospitals and clinics to provincial and local governments. This policy change brought an end to central government efforts to mitigate access inequalities between richer and poorer provinces and municipalities. This reduction of central government funding effectively dismantled the “barefoot doctor” government-driven healthcare model in the span of a few years.<sup>20</sup>

Moreover, as hospitals struggled to compensate for the reduction in public funding, the central government established strict price regulations for basic medical services, but permitted higher premiums for “new” technologies, tests, or procedures. Doctor salaries were also reformed to include bonuses, rewarding those who brought in

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<sup>18</sup> Zhang and Unschuld. “China’s Barefoot Doctor.”

<sup>19</sup> Zhang Zikuan, “The Forward Direction of Grassroots Healthworkers—Commemorating the 30<sup>th</sup> Anniversary of Comrade Deng Speech on Barefoot Doctors” *Journal of Chinese Rural Health Management*, 25.7 (2005): 5. [In Chinese].

<sup>20</sup> Blumenthal and Hsiao, “Privatization and Its Discontents,” 1166-1167.



higher profits for their hospitals. Collectively, these transformations worked to transform China's healthcare system towards a "fee-for-service" model, which incentivized highly profitable "new" drugs and procedures, while disincentivizing basic care. In general, the shift towards a "fee-for-service" model of medical care has, in the eyes of many critics, lead to inefficiencies, inappropriate incentives, cost increases, and the breakdown of medical ethics.<sup>21</sup> These factors and developments have served to increase the potential for conflict between patients and doctors.

Despite several efforts at healthcare reform, healthcare access became increasingly unaffordable for the average Chinese citizen.<sup>22</sup> Out-of-pocket payments in 2002 were at 58%, up from 20% in 1978, when the reforms began.<sup>23</sup> Healthcare—both its quality and affordability—remains one of Chinese citizens' top concerns.<sup>24</sup> Although the government has attempted several rounds of reform—including an effort to create a system of decentralized health insurance policies, run out of patient's work units (*danwei*)—such reforms faced numerous problems.<sup>25</sup>

The most recent round of healthcare reforms in China have sought to provide a better baseline of care to the average citizen. Passed in April 2010, the newest round of healthcare reform aims to provide basic healthcare insurance to all Chinese citizens (with the goal of universal coverage by 2020), improve the quality and availability of primary care, reduce disparities between rural and urban facilities, and promote the provision of

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<sup>21</sup> Yip, Winnie Chi-Man, Yip, W. C. M., Hsiao, W., Meng, Q., Chen, W., & Sun, X., "Realignment of Incentives for Healthcare Providers in China." *The Lancet* 375.9720 (2010): 1120-1130.

<sup>22</sup> Alcorn, Ted, and Beibei Bao. "China Progresses with Health Reform But Challenges Remain." *The Lancet* 377.9777 (2011): 1557-1558.

<sup>23</sup> Liu, Yuanli, Keqin Rao, and William C. Hsiao. "Medical expenditure and rural impoverishment in China." *Journal of Health, Population and Nutrition* 21.3 (2011): 216-222.

<sup>24</sup> Watts, Jonathan. "China's health reforms tilt away from the market." *The Lancet* 371.9609 (2008): 292.

<sup>25</sup> Ho, Christina S. "Health reform and de facto federalism in China." *China: An International Journal* 8.01 (2010): 33-62.

“essential medications (*jiben yao*).”<sup>26</sup> Progress on several fronts—particularly increasing coverage—has been quite successful. Nonetheless, even for those with health insurance, copayments remain high. High out-of-pocket expenses, paired with long waits, and overcrowding leave many patients frustrated and with high expectations for medical service providers.

### **Transformations in Legal Treatment of Medical Liability**

As the structure of the healthcare system in China changed, so too did the legal regime applying to medical practitioners. Some doctors complain that as a lingering effect of the “barefoot doctor” period of Chinese healthcare, doctors in China are not treated with the same respect and professional authority as they might receive in other countries. While the salaries of Chinese doctors and patient attitudes might reflect this prejudice, the treatment of medical practitioners by Chinese legal system reflects the degree to which their historically close-affiliation with the government has provided them certain protections. Liability for medical errors took many decades to be formally established in the People’s Republic of China, and the use of administrative “appraisal panels” and mediation reflect a continued preference for reducing litigation and limiting compensation for medical liability.

In the earliest years of the P.R.C., as healthcare was considered a form of social welfare, and medical institutions were under government control, no laws or legislation existed to establish and regulate medical liability or medical malpractice. Moreover,

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<sup>26</sup> Christina Ho, “China’s Health Care Reform: Background and Policies” in *Implementing Health Care Reform Policies in China: Challenges and Opportunities 1* (Charles W. Freeman III and Xiaoqing L. Boynton eds., CSIS 2011), available at [http://csis.org/files/publication/111202\\_Freeman\\_ImplementingChinaHealthReform\\_Web.pdf](http://csis.org/files/publication/111202_Freeman_ImplementingChinaHealthReform_Web.pdf).

since all Republic of China laws had been repealed with the foundation of the P.R.C., and early efforts to establish a unified Civil Code failed until 1986, cases of medical malpractice were investigated and handled by the local administrative governments.<sup>27</sup> In general, judicial officials favored mediation to litigation for civil liability disputes. Since healthcare was a pillar of Communist China's welfare system and medical practitioners were already in short supply, medical liability was not a high priority for the legal system.<sup>28</sup> In 1964, the Supreme People's Court in a Reply (*pifu*), issued in January of 1964, went so far as to assert that plaintiffs should not be rewarded monetary compensation: "In dealing with medical accidents, the court should not award economic compensation, but may seek other types of remedy for patients who suffer death or liability or loss of income as a result of medical accidents."<sup>29</sup>

After the beginning of Deng's opening reforms, the number of medical disputes receiving legal attention increased. As healthcare costs increased, patients began to expect more. Given the continued absence of civil liability for medical harm, medical malpractice claims were brought as criminal cases under the 1978 Criminal Code. Since the 1978 Code did not actually criminalize "medical malpractice," claims were brought under claims of more general application (i.e., negligent killing, neglect of duty).<sup>30</sup>

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<sup>27</sup> Wang, Zhu, and Ken Oliphant. "Yangge Dance: The Rhythm of Liability for Medical Malpractice in the People's Republic of China." *Chi.-Kent L. Rev.* 87 (2012): 26-30.

<sup>28</sup> Xie Guisheng, "Viewing Trial Philosophy Through Examining A Judgment of in Medical Accident," *Legal Science* 9.26, 1958: 26-28. [In Chinese].

<sup>29</sup> Zhu & Ken, 26-27.

<sup>30</sup> Worth noting is that under Chinese law, victims who sustain harm as the result of a criminal act are allowed to seek compensation through criminal courts. The matter of criminal liability for medical malpractice as a specific crime was not settled until 1997, when Article 335 of the newly amended Penal Code, established the crime of "serious medical malpractice resulting in death or serious harm." The article states: "Medical personnel whose serious failure to carry out their responsibility causes the death of a patient or serious harm to a patient's health shall be sentenced to not more than three years of fixed-term imprisonment or criminal detention." Quoted from Zhu and Oliphant, "Yangge Dance," 28.

Institutional arrangements for civil liability for medical malpractice would not emerge until almost a decade later. The municipal government of Shanghai and the provincial government of Shanxi established an experimental form of “administrative” system for handling civil liability in medical malpractice claims in their local administrative regulations in 1985, providing for an administrative institutional path for addressing medical complaints. With the success of these efforts, the Medical Accident Rules of 1987 (hereafter, 1987 Rules) were drafted by the Ministry of Health and promulgated by the State Council. After these laws were promulgated, civil malpractice suits became more common than criminal.<sup>31</sup> Thereafter, criminal charges have been generally only used in cases of serious misconduct, and used for the sake of providing stronger punishments than would otherwise be available under administrative or civil law.<sup>32</sup> This stands in contrast with the Japanese and Taiwanese legal systems, which tend to have medical malpractice disputes predominantly treated as criminal cases.<sup>33</sup>

The 1987 Rules created a formal procedure for the administrative handling of medical malpractice claims, whereby an aggrieved party would first submit claims to the local health administration. The case would be heard by an “appraisal panel” of medical experts, who would then report their conclusions on the case. The “appraisal panel” was tasked with a two-pronged test. In order for an aggrieved party to proceed with adjudication, the panel needed to find that first, a medical accident had occurred and that

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<sup>31</sup> Ibid., 28-31.

<sup>32</sup> Zhu, Sun, Lei Li, and Yuanchao Li. “China’s Criminal Penalty for Medical Malpractice: Too Lenient or Not?” *Legal Medicine* 13.3 (2011): 116-119.

<sup>33</sup> That said, Japan, like China, tends to have weaker accreditation organizations. For an interesting discussion of the Japanese medical malpractice jurisprudence, see Leflar, Robert B. “Unnatural Deaths, Criminal Sanctions, and Medical Quality Improvement in Japan.” *Yale Journal of Health Policy, Law & Ethics* 9 (2009).

second, there was a direct causal relationship between the accident and the incurred harm. If, after mediation, one or both parties were still in disagreement, the case would be heard in court. However, the judge's ruling in court was limited to applying only the standards of the Medical Accident Rules. Under the 1987 Rules, a patient—or patient's family—can seek redress for “harm caused by a medical accident,” with the harm referring to death, disfigurement, disability, or serious dysfunction as a direct result of a medical personnel's treatment. The law further subdivides “medical accident” into “technical accidents” (negligent treatment) and “malpractice accidents” (breach of duty, violation of rules or regulations) with the latter having more serious punishments.<sup>34</sup>

While establishing a formal system for medical liability created a clearer institutional path for addressing patient's rights, Chinese legal scholars have criticized the 1987 Rules for creating too many barriers for plaintiffs.<sup>35</sup> In this regard, three important points about the 1987 Rules are worth stressing. First, the plaintiff bore the burden of proof, including providing evidence from medical records. While hospitals were responsible for keeping relevant medical records, it would have been easy for hospitals to alter or conceal damaging evidence. Second, the fairness, lack of transparency, and legal applicability of “appraisal panels” was also questioned by several scholars.<sup>36</sup> Since the committee of experts was usually selected from within the locality's health administration itself, and its verdict could not be overturned in court by judicial review,

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<sup>34</sup> Statute on Handling Medical Accidents, Published June 29, 1987. For a translated copy, see: “1987 Rules on Handling Medical Accidents in China,” <<http://www.china.org.cn/english/2002/Jun/35661.htm>>.

<sup>35</sup> Harris, Dean M., and Chien-Chang Wu. “Medical Malpractice in the People's Republic of China: The 2002 Regulation on the Handling of Medical Accidents.” *The Journal of Law, Medicine & Ethics* 33.3 (2005): 456-477.

<sup>36</sup> For example, see Gao, Z. and Zhao, J., “Preliminary Comment on the Question of Legal Application in the Management of Medical Disputes,” *Modern Legal Science* 5 (1999) [In Chinese], and Sun, D. and Wu, J. “Opinions on the Deficits and Reform of Medical Accident Appraisal System,” *Deiking University Law Journal* 5 (1998): 95-97.

the “appraisal panels” frequently favored the hospitals.<sup>37</sup> Finally, the 1987 Rules established a scale for damages, whereby plaintiffs could be rewarded only certain fixed sums depending on the degree of severity of the damages (on a scale from 1-3) with the exact corresponding awards to be set by provincial, regional, or municipal administrative rules. However, the harm was held to a relatively narrow degree of severity, and many felt the compensation for damages remained relatively low.<sup>38</sup>

In response to criticism of the 1987 Rules, the State Council promulgated the Medical Accident Regulations of 2002 (hereafter, 2002 Rules). The 2002 Rules largely maintained the fundamental aspects of the earlier system, however they broadened the scope of liability for medical practitioners and altered certain key aspects of the system.<sup>39</sup> First, the scope of medical liability was redefined to include any physical harm sustained while a patient (*huanzhe*) was receiving medical care. The 1987 Rules had used the word *bingzhe* (sick person) and had limited the types of damage considered to be sufficient.<sup>40</sup> Second, while the burden of proof remained on patients, hospitals had a greater obligation, at least on paper, to maintain good medical records. In addition, the 2002 Rules altered the composition and role of the “appraisal panels.” Under the 2002 Rules, the daily function of the administrative system continued to be under the aegis of the Ministry of Health and local Bureaus of Health, but the Bureaus were to work with local professional organizations to form the “appraisal panels.”<sup>41</sup> Though this change might have been intended to reduce conflicts of interest created by having health administration

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<sup>37</sup> Zhu and Oliphant, “Yangge Dance,” 30.

<sup>38</sup> Harris and Wu, “Medical Malpractice,” 459-465.

<sup>39</sup> For a translated copy of the 2002 Regulations, see “Regulations on Handling Medical Accidents,” <[http://english.gov.cn/laws/2005-07/25/content\\_16885.htm](http://english.gov.cn/laws/2005-07/25/content_16885.htm)>.

<sup>40</sup> Fang Xinjun, *The Law of Torts*, New Century Law Textbooks Series, Peking University Press, 2013: 250-252. [In Chinese].

<sup>41</sup> Zhu and Oliphant, “Yangge Dance,” 30-35; Harris and Wu, 460-474.

officials review complaints against local doctors and hospitals, these local professional organizations were just as interlinked. Finally, the 2002 Rules removed some of the discretion from damage rewards by determining rewards based upon a list of eleven itemized types of damages (instead of the degree of harm). The compensation caps were comparatively low, and, unlike other areas of Chinese tort law, plaintiffs could not claim compensation for death itself. Damages were also judged on the “extent of responsibility,” so that a convicted party, found to be 50% responsible, would pay only half of the damages.<sup>42</sup>

Scholars critical of the Medical Accident Regulations 2002 launched a variety of criticisms. First, many objected to the way in which legal courts continued to be bound by the decisions of “appraisal panels.”<sup>43</sup> Several official surveys demonstrated that in many provinces, “appraisal panels” only upheld the plaintiff’s claim in less than 10% of cases.<sup>44</sup> While national data are not available, there is much evidence that courts rarely, if ever, allowed cases in which the “appraisal panel” did not find “medical accident” liability to pursue redress for their complaints. One official survey conducted at the Shanghai No. 2 Intermediate People’s Court found that appeals of “medical accidents” claims, in which the “appraisal panel” had found the case did not constitute a “medical accident,” were almost uniformly rejected.<sup>45</sup> Plaintiffs in cases of negligence in which a “medical accident” had not been established were thus left with few options to proceed to seek redress. Second, many were critical of the continued limitations on compensation

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<sup>42</sup> Zhu and Oliphant, “Yangge Dance,” 34; Xi, Chao and Lixin Yang, “Medical Liability Laws in China: The Tale of Two Regimes.” *Tort Law Review* 19.2 (2011): 65-75.

<sup>43</sup> Liang H, “Issues Regarding Application of Laws to Cases Involving Medical Injury Compensation” [in Chinese], *People’s Court Daily*, (13 July 2005); Chao Xi and Lixin Yang, “The Tale of Two Regimes,” 67.

<sup>44</sup> Xi and Yang, 70-71.

<sup>45</sup> Zhang Z. and Wu Z., “An Analysis of Appellant Cases on Medical Personal Injury Compensation and of Major Changes After the Implementation of the Regulations on the Handling of Medical Accidents” *Shanghai Medicine* 2.29 (2006). [In Chinese]; Xi and Yang, “Medical Liability Laws,” 67.

generally, and specifically the prohibition on plaintiffs for claiming compensation for a patient's death.

The low “conviction rates” of “appraisal panels” and the degree to which courts were bound by the expert panel’s decisions made the administrative system resulting from the 2002 Rules unpopular with patients and lawyers, who felt the system was still overly biased in favor of doctors and hospitals. In response to complaints about the administrative legal procedure for handling medical malpractice cases, the Supreme People’s Court began to gradually allow courts to handle medical liability claims under the General Principles of Civil Law as an alternative to the 2002 Medical Accident Regulations, depending on the details of the case. This flexibility was initially suggested in a “Reply” to the High Court of Tianjin in 1992, but was further clarified and formalized with a series of decisions made between 2001 and 2003, which established the precedent for a “dual track” system for medical liability arbitration—one using the Medical Accident Regulations and one using the General Principles of Civil Law.<sup>46</sup> The Chief Justice of the Supreme People’s Court explained in an interview a year after the dual track system was enabled, that cases in which the patient was injured by a negligent act, but unable to gain compensation because the instance was not one of “medical fault ... violates our constitutional principle of equity before law.”<sup>47</sup>

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<sup>46</sup> The General Principles of Civil Law were promulgated in 1986. The most important of these decisions were *Several Regulations on Evidence in Civil Proceedings* in 2002; *Measures on the Administration of Judicial Authentication Entrusted by the People’s Courts* in 2002; *Circular Regarding Adjudicating Civil Lawsuits Involving Medical Disputes with Reference to the Regulations on the Handling of Medical Accidents* in 2003; and, *Interpretations on Several Issues Regarding the Application of Laws in the Adjudication of Personal Injury Compensation Proceedings* in 2003. See Xi and Yang, 68. The General Principles of Civil Law are available at [http://www.npc.gov.cn/englishnpc/Law/2007-12/12/content\\_1383941.htm](http://www.npc.gov.cn/englishnpc/Law/2007-12/12/content_1383941.htm).

<sup>47</sup> Interview with the Chief Justice of the First Civil Division of the Supreme People’s Court on Issues Concerning the Application of Law in Adjudicating Medical Dispute Cases” [in Chinese] in First Civil



The difference between the two tracks largely boiled down to the specific cause of action which the plaintiff chose to accuse the hospital and healthcare practitioners of committing. If the healthcare providers were accused of a “medical accident,” the case would be handled by the administrative legal system. If “medical fault” was the charge, the case could—depending somewhat on the discretion of the local judicial authorities—be brought under the general laws of tort. Before the series of decisions rendered by Supreme People’s Court, for cases in which “medical accident” had not been established, plaintiffs had little ground to proceed. Under the new interpretations, plaintiffs could claim compensation for negligence in cases outside of the rules of “medical accident.”

The creation of a “dual track” system had important implications for the Chinese civil legal system and for the healthcare system.<sup>48</sup> Under the General Principles of Civil Law, plaintiffs could claim much higher damages because they were entitled to claim recourse for death itself. Under the Chinese General Principles of Civil Law, compensation for death can be claimed for up to twenty years times the disposable income per capita of the victim’s city for urban residents.<sup>49</sup> For example, in 2010, a citizen in Beijing would be able to claim a maximum of 100,000 RMB of compensation for claims brought under the “medical accident” administrative track, but could claim up to 400,000 RMB for charges of “medical fault resulting in death” under the General Principles of Civil Law. In official surveys, conducted in the Shanghai and Jiangxi

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Division of the Supreme People’s Court (ed), *Guide on Civil Trial*. China Legal Press, 2004: 5-6, cited in Xi and Yang, “Medical Liability Law,” 67.

<sup>48</sup> It must be noted here that not all municipalities allow plaintiffs to freely choose which track their case will proceed along. Beijing, for example, generally did allow plaintiffs to choose. Liebman, Benjamin L. “Malpractice Mobs: Medical Dispute Resolution in China,” *Columbia Law Review* 113: 200.

<sup>49</sup> Rural citizens were entitled to claim per capita net income at the locality of the court where the charge was brought. See Article 29, “SPC Interpretation on Compensation for Personal Injury,” Adopted December 4, 2003. A translated copy is available at: <[http://209.200.107.14/english/law2\\_disp.asp?sublawcode=SUB83611511815161414&lawcode=LAW462667131210161611&country=China](http://209.200.107.14/english/law2_disp.asp?sublawcode=SUB83611511815161414&lawcode=LAW462667131210161611&country=China)> .

Appellate Courts for comparable cases, medical liability cases brought under the judicial track received significantly higher rates of compensation.<sup>50</sup>

The standards for the burden of proof were different for the two tracks with the “judicial” track placing patients under a lower burden of proof. According to certain rules established by the Supreme People’s Court for tort cases involving “medical fault,” the relevant medical institutions were charged with proving the absence of medical fault and the lack of a causal link between the harm sustained and the treatment provided.<sup>51</sup> Further, while both tracks of the dual system used “appraisal panels,” under the judicial track, the court had the right to resolve any disputes created by the medical expert’s evaluation with a “judicial appraisal panel,” under the aegis of the court itself.

Many scholars have accused the variability between the two tracks and the perceived bias of the “administrative panels” as leading to “forum shopping” by plaintiffs and “defensive medicine” on the part of doctors. After the series of Supreme People’s Court’s decisions took effect, in some provinces, the number of medical liability cases heard by courts increased dramatically. In an official survey of the Higher People’s Court of Jiangsu Province, the court experienced a 26.4 percent increase in cases of medical liability in the quarter immediately following the Supreme People’s Court’s decision which reversed the burden of proof.<sup>52</sup> The dramatic rise in medical lawsuits noted in statistics circulated by popular media frequently draw on this period during the

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<sup>50</sup> Xi and Yang, “Tale of Two Tracks,” 70; Zhu and Oliphant, “Yangge Dance,” 38.

<sup>51</sup> Actually, the plaintiff had to prove the patient had received treatment at the medical institution. After that, the burden shifted onto hospitals. See, Lixin Yang, *A Study of Medical Injury Liability*. China Legal Press, 2009: 258-260 [In Chinese]; and, Zhu and Oliphant, “Yangge Dance,” 37, ft. 70,71.

<sup>52</sup> The number of filed cases increased from 128 in the previous quarter to 158 in the quarter after April 1, 2003, when the decision took effect. See First Civil Division, Higher People’s Court of Jiangsu Province, “Survey Report on Cases Involving Medical Injury Compensation Disputes” *People’s Judicature* 10.21 (2002) [in Chinese]; and, Xi and Yang, 71.

2000s to make this point.<sup>53</sup> Whether this period is truly representative should be treated with skepticism.

The “dual track” system was ended by the 2009 Tort Liability Law, which came into effect in 2010, which established that “medical fault” was the basis of medical liability (adopting the language used in the General Principles of Civil Law).<sup>54</sup> However, under Article 54 and Article 58 of the new law, the burden of proof was still upon the plaintiff to prove causation, but not if the practice of the healthcare provider had clearly violated any laws, regulations, or guidelines for standards of care.<sup>55</sup> This clarification also enabled plaintiffs to claim compensation for death, but maintain certain caps on damages. The 2009 Tort Laws also made clear that medical institutions are liable for their staff.<sup>56</sup>

Perhaps the most important clarification in the stipulations of the 2009 Tort Liability Law was an increased attention to the “standard of care.” Courts no longer have the power to interpret the reasonableness of the care provided by doctors; instead, they are tasked merely with examining whether the doctor upheld the standards of care practiced within his or her specialty.<sup>57</sup> Interestingly, the original draft of the bill included a clause about doctors being held to the standard of care within their locality, as doctors are in American law, but this was dropped in the revision process. The question of

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<sup>53</sup> For example, see Jiang, Jessie. ““In Some Chinese Hospitals, Violence Is Out of Control and It’s Doctors Who Are at Risk,.” *Time Magazine*. 11/10/2011. Web. <<http://www.time.com/time/world/article/0,8599,2096630,00.html>>.

<sup>54</sup> See 2009 Tort Liability Law of the People’s Republic of China, Adopted December 26, 2009. A translated copy is available at: <[http://www.procedurallaw.cn/english/law/201001/t20100110\\_300173.html](http://www.procedurallaw.cn/english/law/201001/t20100110_300173.html)>. For more general notes on an earlier draft of the code, see: Conk, George. “A New Tort Code Emerges in China: An Introduction to the Discussion and a Translation of Chapter 8-Tort Law of the Official Discussion Draft of the Proposed Revised Civil Code.” *Fordham International Law Journal* 30.935-999 (2007).

<sup>55</sup> There are a few other exceptions articulated in Article 58.

<sup>56</sup> Article 54, 2009 Tort Liability Law of the P.R.C.

<sup>57</sup> Wang S, *Annotations of the Tort Liability Law of the People’s Republic of China*. China Legal Press, 2010: 274-268.[In Chinese]; Xi and Yang, “Medical Liability Laws,” 72.

degree to which upholding the standards of care within a doctor's specialty and geographic locality—even if they have been found to be risky—is an interesting topic of debate within comparative law. In Britain, the *Bolam* test functions very similarly to the new stipulations of the 2009 Tort Liability Law; whereas, in America, doctors are even more specifically judged in accordance with the standards of practice within their geographic locality.<sup>58</sup> In short, this particular clarification affirmed the right of the medical profession in China to set its own professional standards of care.

It is not yet clear what the ultimate effects of the 2009 Tort Law upon the handling of plaintiffs' medical treatment complaints will be. As I have noted earlier, most available statistics are from before the Tort Liability Law took effect and thus do not help us assess China's present conditions. Early, preliminary evidence has shown that the case loads of some courts remain unchanged. A survey of Jinan's malpractice cases from 2008 to 2011, witnessed a consistent number of cases brought each year, and similar conviction rates.<sup>59</sup> In his research on medical malpractice, Benjamin Liebman has suggested that, in part due to some uncertainty over whether or not the previous Regulations remained valid, in many locations, the new laws do not seem to have had significant effects.<sup>60</sup>

As some have suggested, one of the major issues facing the system of Chinese tort law is the irregularity of its enforcement. Patients frequently feel disenfranchised by the system, so protests and publicity appear to be one of the greatest weapons wronged parties feel they can wield against their accused wrongdoers. Yet, publicity to resolve

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<sup>58</sup> Xi and Yang, "Medical Liability Laws," 72.

<sup>59</sup> Du Peng, Wang Libo, Li Feicheng, Zhang Donghang, Deng Hongyan, Liu Hongbing, "An Analysis of the Causes and Circumstances of Complaints Within Different Systems For A Hospital In Jinan," *Jilin Medical Studies* 33.34 (2012): 7616-7617 [In Chinese].

<sup>60</sup> Benjamin Liebman, "Malpractice Mobs," 201-203.

medical disputes fuels the very public distrust in doctors that increases the disputes. In his work on Chinese civil liability compensation, Ben Liebman has criticized the Chinese tort legal system as being overresponsive only in select instances, and otherwise being generally underresponsive to civil liability complaints.<sup>61</sup> Despite the appearance of greater formalism, Liebman argues that courts “exist in the shadow of protests and violence,” and that media attention remains one of the best routes for plaintiffs to secure higher compensation. Thus, he posits, despite moves towards increased formalization and professionalism, the reach of Chinese legal institutions—such as the courts in cases of medical liability—remains limited and erratic.<sup>62</sup>

The way forward lies within guaranteeing a more consistent, meaningful levels of compensation issued by the courts, and, in turn, improving the public image of China’s civil legal institutions. Greater consistency and predictability from the legal system in the adjudication of medical malpractice complaints would also likely work to manage patient expectations, curb “defensive medicine,” and, in turn, increase the likelihood of medical malpractice becoming a self-reported event. Consistency and predictability in compensation can also work to reduce the incentives for patients to protest and attack doctors. Yet, as Benjamin Liebman has argued, the wide ranges in compensation rewards seems to stem less from a lack of legal specificity in the written law and more from a desire on the part of local judges to mediate conflicts on a relatively subjective basis.<sup>63</sup> In the cases he studied, plaintiffs received some compensation in 80 percent of first instance cases, even if they did not win the case. Though some evidence suggests that appellate

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<sup>61</sup> Liebman, Benjamin L. “Watchdog or demagogue? The media in the Chinese legal system.” *Columbia Law Review* (2005): 1-157.

<sup>62</sup> Liebman, “Malpractice Mobs,” 237-250.

<sup>63</sup> *Ibid.*, 237-242.

courts tend to undo some of this variability, it is possible that a desire to reduce social conflict, rather than consistency, on the part of Chinese judges will make achieving these goals more difficult.<sup>64</sup>

Most municipalities have also launched policy experiments with different forms of mediation panels and third-party arbiters, in an effort to correct the perception continuing that existent mediation paths are biased towards hospitals. In a work report at the 2013 National Health Conference in January, former Minister of Health, Chen Zhu, announced that such panels had “a mediation success rate of 85% and a satisfaction rate of 93%.”<sup>65</sup>

## Conclusion

While improving the legal institutions for adjudicating medical complaints will bring greater clarity to patient-doctor conflicts and will likely reduce incidents of violence, the road forward for China’s doctor-patient relationship cannot be fixed by legal reforms alone. In addition to legal reforms, it is imperative to study new policies to combat economic, institutional, and interpersonal causes of doctor-patient conflict. First, as many scholars have noted, China must continue to manage the inherent, continuing tension between efforts to expand the access to basic health services while simultaneously enabling the market to drive demand for supplementary services. It is hoped that government attempts to improve basic care at rural and tertiary hospitals will

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<sup>64</sup> Ibid., 30. This high number should not necessarily be seen as nationally representative; however, as all other studies I have found only list who was found to hold responsibility—but not how compensation was allocated—it is difficult to evaluate.

<sup>65</sup>“A Notification Issues By the Ministry of Health at the 2013 National Health Conference,” Available: <<http://www.moh.gov.cn/mohzcfgs/s7847/201302/8c7d17426a754bb78dd33757a9d3892a.shtml>> [In Chinese]. Dr. Chen was replaced in March 2013 by Dr. Li Bin, as part of the merging of the National Population and Family Planning Commission and the Ministry of Health.

result in a better allocation of medical services. Next, government efforts to reduce the out-of-pocket costs of essential medicine and basic procedures continue to be a crucial aspect of reducing the cost burden felt by patients.<sup>66</sup> Such processes will take time, money, and pragmatism, as the government attempts to “cross the river by the feel of the stones.” However, reducing the cost burden on patients is one crucial way to manage the high “expectations” they place upon health care providers.

On the professional level, a greater degree of autonomy for medical professional associations and an increased focus on promoting self-conscious medical professionalism could produce great benefits for the entire healthcare system. Doctors frequently complain about the perceived “low social status” of healthcare providers. Strengthening the ability for quasi-public groups—such as quality control non-government organizations and medical professional groups—to regulate the medical marketplace, in combination with existent government regulation, could also provide greater incentives for hospitals to focus on the quality of medical services.

Towards this goal, there is reason for optimism. Recently, the Chinese Medical Association (*Zhongguo Yishi Xiehui*) has announced it will hold periodic assessments for all doctors, every two years, with tests on medical treatment standards and legal regulations.<sup>67</sup> The current chairman of the Chinese Medical Association’s Department of

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<sup>66</sup> Zhang, Lufa, and Nan Liu, “Health Reform and Out-of-Pocket Payments: Lessons from China.” *Health Policy and Planning* (2013): 1-10.

<sup>67</sup> Accreditation is a particularly promising area for medical professional organizations to take a more autonomous role. While the 1999 Law on Physicians and the 2005 laws on hospital accreditation and Village Doctor Practice Regulation have increased the required level of training for practicing medical professionals and required the certification of “village doctors” (often under-qualified rural medical practitioners), these regulations allowed a great degree of flexibility for local government enforcement. As a recent scandal over a leaked government “black list” of uncertified, practicing medical professional revealed, local governments have known about several unqualified doctors. According to reporters from Southern Weekend, government health administrations failed to make the existence of these unqualified doctors public, nor subjected offenders to criminal charges; instead, many offenders were provided

Legal Affairs, Deng Liqiang, has stressed in several recent interviews that self-imposed stricter regulations upon medical practitioners will help to correct “problems with doctors morals and manners (*yidao yifeng wenti*).”<sup>68</sup> Those physicians who fail are given a second chance before being “blacklisted” from future medical employment. As of the end of 2012, over 1.5 million doctors had been tested.<sup>69</sup> Deng and other advocates have also called for lifetime bans for unqualified or noncompliant doctors.<sup>70</sup>

In line with establishing a greater sense of professional ethics, hospitals can work towards creating better “hospital culture.” Some hospitals have taken steps towards explicitly refusing bribes—called “red envelopes (*hongbao*)”—by making all of its physicians refuse to accept them.<sup>71</sup> Some scholars have suggested that easier access to patient medical records and greater transparency in the early stages of medical complaints could also reduce the escalation of conflict.<sup>72</sup>

Lastly, professional development courses and hospital training sessions to improve communication between healthcare practitioners and patients is another important area for study and implementation. Elite hospitals, such as the Peking Union Medical College Hospital, have stressed these “social” dimensions of care for a while, but broader attention to such aspects of doctor-patient encounters could do much to

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opportunities for fraudulent practitioners to get certified and continue practicing. See: Chai, Kuaiqun, “Fake Doctor Blacklist Not Made Public.” *Southern Weekend* 13 Jun 2013. <<http://www.infzm.com/content/91408>>. [In Chinese].

<sup>68</sup> “China Proposes A Doctor Blacklist, Starting Regular Assessments of 200 Million Doctors,” *Beijing Times*, 11 Aug 2013. <[http://news.xinhuanet.com/health/2013-08/11/c\\_125148620.htm](http://news.xinhuanet.com/health/2013-08/11/c_125148620.htm)>. [In Chinese].

<sup>69</sup> Han Lu, “How Does The Medical Profession View The Doctor ‘Black List’?” *Health News* 15 Aug 2013. <<http://www.jkb.com.cn/htmlpage/38/380759.htm?docid=380759&cat=null&sKeyWord=null>>. [In Chinese].

<sup>70</sup> Ibid.

<sup>71</sup> Hui, Edwin C., “The Contemporary Healthcare Crisis in China and the Role of Medical Professionalism.” *Journal of Medicine and Philosophy* 35.4 (2010): 477-492.

<sup>72</sup> An Shan, “For a Harmonious Doctor-Patient Relationship, [We Must] Raise The Standards of Medical Records Services,” Presentation at the Eleventh Annual Meeting of the Chinese Medical Associations Committee on Patient Medical Records Management, 2012. [In Chinese].



improve public trust in doctors. Most Chinese-language studies of medical liability lawsuits found that “poor communication” or patient dissatisfaction with hospital workers’ “demeanor” are the predominant complaints.<sup>73</sup> Several researchers and scholars have called attention to the lack of “humanistic” courses and the low quality of “medical ethics education” in many Chinese medical hospitals.<sup>74</sup> While access inequalities still incentivizes tiered medical education and creation of medical practitioners with lower levels of training to serve in rural areas, professional and government leaders must continue to strive to improve the quality of medical education. In short, increased attention to the “social” aspects of medical care must be stressed to lower levels of public distrust and improve the overall quality of care.

The most recent government healthcare reforms have taken important first steps towards increasing access to basic healthcare, while legal reforms have permitted greater access to redress for medical complaints. However, these reforms likely will not be enough to remedy the tensions between patients and health care providers. As I have suggested, (a) reducing out-of-pocket expenses, (b) strengthening institutional and professional standards for medical providers, and (c) improving the quality of communication and social interaction skills of medical providers are all crucial areas for further study and experimental implementation. Only through promoting increased attention to these areas can “trust” in China’s legal and healthcare institutions be

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<sup>73</sup> Du Peng, et al., “An Analysis of the Causes and Circumstances of Complaints,” 7616-7617 [In Chinese]; Zhao Bin, Wu Qihong, “An Analysis of 40 Cases of Medical Complaints and an Examination of Countermeasures,” *Chongqing Medical Studies* 4.2 (2011) [In Chinese]: 403-404 [In Chinese]; Nanjing Drumtower Hospital, “Analysis of Medical Conflicts and Prevention Methods—Using An Analysis of 524 Medical Complaint Cases” *Jiangsu Public Health Management*, March (1999): 12-14 [In Chinese]; and Zhou Guifen, “A Suggestion for My Hospital’s Management of Medical Complaints,” *Goods and Quality*, August (2012): 48-49. [In Chinese].

<sup>74</sup> Xu, Dong, Sun, B., Wan, X., & Ke, Y., “Reformation of medical education in China.” *The Lancet* 375.9725 (2010): 1502-1504.

increased and incentives that drive plaintiffs to violent protests and violent attacks against medical practitioners be reduced.