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YANGGE DANCE: THE RHYTHM OF LIABILITY FOR MEDICAL MALPRACTICE IN THE PEOPLE'S REPUBLIC OF CHINA

ZHU WANG & KEN OLIPHANT*

INTRODUCTION

Yangge Dance is a popular folk dance in rural China. Its basic pattern is three paces forwards, followed by two paces back; then a step to the right, followed by a step to the left. In our view, Yangge Dance is an apt simile for the process of legal development relating to liability for medical malpractice in the People's Republic of China (P. R. China).¹ The three paces forward refer to successive reforms furthering the interests of patients, following an initial period—dating from the foundation of P.R. China in 1949 until 1987—during which medical malpractice was handled by an administrative system without formal liability rules. The first of these advances came in 1987, when the existing administrative system was formalized by an administrative regulation,² the Rules on the Handling of Medical Accidents,³ which provided not only for administrative sanctions

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In this article, Chinese names are rendered with the given name preceding the family name except in Chinese-language citations, where the order is reversed. Unless otherwise indicated, all translations are by Zhu Wang, and were revised with the assistance of Ken Oliphant.

1. The account presented below relies primarily on Chinese-language materials. For discussion of compensation for medical injuries in P.R. China in English, see Chunyan Ding, *Medical Negligence Law in Transitional China: A patient in need of a cure* (July 2009) (unpublished PhD thesis, University of Hong Kong) (on file with the authors); Liming Liu, *Medical Professional Liability in the Chinese Tort Law Reform Act 2010*, 26 PN 224 (2010); Chao Xi & Lixin Yang, *Medical Liability Laws in China: The Tale of Two Regimes*, 19 Tort L. Rev. 65 (2011).

2. Administrative regulations issued by the State Council have effect as legislation under the Legislation Law of 2000. *Zhong hua ren min gong he guo li fa fa* [Legislation Law of the People's Republic of China] (promulgated by the Standing Comm. Nat'l People's Cong., Mar. 15, 2000, effective Sept. 1, 2000), available at gov.cn (last visited Oct. 23, 2011). They are subordinate to the legislation enacted by the National People's Congress (NPC), the supreme legislative organ of P.R. China, and by its Standing Committee, but have priority over departmental rules issued by central government ministries and agencies, and over local regulations issued by provincial and municipal people's congresses and their standing committees.

3. Rules on the Handling of Medical Accidents, (promulgated by the State Council, June 29, 1987) [hereinafter *Medical Accident Rules 1987*].

in the event of malpractice but also for a (limited) liability to pay compensation for resultant injury. A further advance came in 2002 with the amendment of this system of administrative liability by the Regulations on the Handling of Medical Accidents.⁴ The third and final advance, consolidated by rulings of the Supreme People's Court (SPC)⁵ in 2002–2003, was to recognize that liability could be established—independently of the administrative system—under the ordinary rules of tort⁶ liability, then embodied in the General Principles of the Civil Law of the People's Republic of China (GPCL).⁷ Conversely, the enactment of the new Tort Liability Law (TLL) in 2009, taking effect on July 1, 2010, arguably marks a step backwards, subordinating the interests of patients in favor of the interests of the medical community. A second backwards step, through the prospective enactment of additional rules relating to liability for medical malpractice

4. Dui chuli yiliao shigu de guiding [Regulations on Handling Medical Accidents] (promulgated by the St. Council, Apr. 4, 2002, effective Sept. 1, 2002), available at gov.cn (last visited Oct. 23, 2011) [hereinafter Medical Accident Regulations 2002].

5. The SPC is P.R. China's highest court. In addition to its role as P.R. China's final court of appeal, the SPC also has the power to issue quasi-legislative "judicial interpretations" on specific issues concerning the application of law in the adjudicative work of the people's courts. Depending on the circumstances, judicial interpretations are issued as an "interpretation," "provision," "reply," or "decision." See Zui gao ren min fa yuan guan yu si fa jie shi gong zuo de gui ding [Provisions of the Supreme People's Court on its Work Relating to Judicial Interpretations] art. 6 (promulgated Mar. 23, 2007, effective Apr. 1, 2007), available at <http://www.eastlaw.net/chineselaws/judicial/JudicialInterpretation2007.htm> (last visited Oct. 26, 2011). Such rulings have played a vital role in the area of compensation for medical injuries (and indeed in compensation for personal injury generally). See *infra* Part III.

P.R. China's lower courts include people's courts at various local levels: basic people's courts, intermediate people's courts, and higher people's courts. See Zhong hua ren min gong he guo ren min fa yuan zu zhi fa [Organization Law of the People's Courts of the People's Republic of China] (adopted by the Nat'l People's Cong., Jul. 1, 1979, revised Sept. 2, 1983, Dec. 2, 1986, and Oct. 31, 2006), available at http://www.china.org.cn/china/LegislationsForm2001-2010/2011-02/12/content_21907420.htm (last visited Oct. 26, 2011).

6. An aggrieved party is entitled to proceed in tort even where the conduct complained of is both a tort and a breach of contract. Zhong hua ren min gong he guo he tong fa [Contract Law of the People's Republic of China] art. 122 (adopted by the Nat'l People's Cong., Mar. 15, 1999, effective Oct. 1, 1999), available at <http://en.chinacourt.org/public/detail.php?id=97> (last visited Oct. 24, 2011). In practice, claims for medical injuries under general civil law are normally brought on the basis of tort rather than contractual liability.

7. Xing tian ren zhong hua ren min gong he guo de min shi fa lu de yi ban yuan ze [General Principles of the Civil Law of the People's Republic of China] (adopted by the Nat'l People's Cong., Apr. 12, 1986, effective Jan. 1, 1987), available at <http://en.chinacourt.org/public/detail.php?id=2696> (last visited Oct. 24, 2011) [hereinafter GPCL]. The GPCL was the first legislation in P.R. China to deal comprehensively with general civil law, including the law of tort (which was addressed in Section 3 of Chapter 6). For an English translation, see Whitmore Grey & Henry Ruiheng Zheng, *General Principles of Civil Law of the People's Republic of China*, 34 *Am. J. Comp. L.* 715 (1986). For analysis in English of its tort law provisions, see Lin Ye, *The Tort System in China*, 52 *L. & Contemp. Probs.* 143 (Xiaoming Li & Henry Pitney, trans. 1989); Kui-Hua Wang & Danuta Mendelson, *An Overview of Liability and Compensation for Personal Injury in China under the General Principles of Civil Law*, 4 *Torts L. J.* 137 (1996) (Austl.).

that further advantage healthcare providers, may also be anticipated in the future.

The sideways steps of Yangge Dance—first to the right, then to the left—may be taken to refer to the constant interplay (at least since 1992) between the two concurrent systems of liability for medical malpractice—one administrative, broadly favoring the interests of the medical community, and the other tortious, broadly favoring the interests of patients.

To compare the two liability regimes (administrative and tortious), and to show their development over time, the analysis below addresses four common dimensions of the parallel systems, namely, the basis of the cause of action, the burden of proof, the process of (technical or judicial) “identification”⁸ used to establish that a compensable medical injury has been suffered, and the assessment of damages.

I. THE WIDER HEALTHCARE CONTEXT⁹

P.R. China was founded in 1949. In the early years of the Communist regime, healthcare—and social welfare provision in general—was organized on a commune or workplace basis, with free basic healthcare for all. All medical facilities were publicly owned and operated; doctors were employees of the State; there was no private medicine. The system achieved significant success against a range of health indicators (e.g., life expectancy, infant mortality), with its performance matching or exceeding that of many countries with superior economic resources.¹⁰

With the reform and opening-up policy adopted in 1978,¹¹ the commune system was dismantled as private enterprise was encouraged. Many state-owned enterprises closed. The social safety net the communes and public-sector employment provided was abruptly swept away. The proportion of the population covered by health insurance declined sharply. Though some doctors (especially doctors in rural areas and practitioners of traditional Chinese medicine) began to practice privately, most healthcare

8. Also translated as “authentication” by some authors. See, e.g., Ding, *supra* note 1, *passim*; Xi & Yang, *supra* note 1, *passim*.

9. For general accounts in English, see David Blumenthal & William Hsiao, *Privatization and Its Discontents—The Evolving Chinese Health Care System*, 353 *New Eng. J. Med.* 1165 (2005); Sarah L Barber & Lan Yao, *Health Insurance Systems in China: A briefing note*, World Health Report (2010), Background Paper No. 37 (2010), available at http://www.who.int/healthsystems/topics/financing/healthreport/37ChinaB_YFINAL.pdf (last visited Oct. 3, 2011); R.E. Ling et al., *Emerging Issues in Public Health: A Perspective on China's Healthcare System*, 125 *Pub. Health* 9 (2011).

10. Blumenthal & Hsiao, *supra* note 9, at 1166.

11. On the reform and opening-up, and in particular their impact on the role of law in P.R. China, see Stanley B. Lubman, *Bird in a Cage: Legal Reform in China After Mao* ch. 5 (1999).

facilities remained under state ownership. But user fees were introduced even for public healthcare and providers were generally encouraged to operate as businesses.¹² Substantial disparities arose in the quality of care provided, reflecting widely divergent levels of investment. The resultant problems were particularly acute in rural areas.¹³

Since 1997, China has striven to address inequalities in healthcare provision with successive reform programs supported by significant investment.¹⁴ The voluntary medical insurance schemes previously applying to urban workers and rural residents have been replaced, and contributions are now subsidized to a significant degree by central and local government. A medical assistance program (Medicare) has been introduced for the poor. A network of community health centers, dependent on State financing rather than user fees, has been created. Efforts have been made to address skill shortages—in particular, in remote areas and in primary care—through education and training. New initiatives have sought to secure the maintenance of appropriate quality standards, with an emphasis on better record keeping and the reporting of adverse events¹⁵ to supplement the traditional forms of government oversight (licensing and accreditation of practitioners and facilities, approval of drugs, etc.). The “Health China” initiative adopted in 2009 aspires to universal basic healthcare coverage by

12. Qingyue Meng and Shenglan Tang, *Universal Coverage of Health Care in China: Challenges and Opportunities*, World Health Report (2010), Background Paper No. 7 para. 3.2 (2010), available at http://www.who.int/healthsystems/topics/financing/healthreport/7ChinaM_T.pdf (last visited Oct. 3, 2011).

13. See Adam Wagstaff et al., *The Int'l Bank for Reconstruction & Dev./The World Bank, Reforming China's Rural Health System* (2009), available at http://siteresources.worldbank.org/CHINAEXTN/Resources/318949-1248160372290/rural_health_full_report_en.pdf (last visited Oct. 3, 2011).

14. For general accounts in English, see Shenglan Tang et al., *Tackling the Challenges to Health Equity in China*, 372 *Lancet* 1493 (2008); Shanlian Hu et al., *Reform of How Health Care is Paid for in China: Challenges and Opportunities*, 372 *Lancet* 1846 (2008).

15. The Medical Accident Regulations 2002 impose a reporting obligation on medical workers who, in the course of their medical activities, cause or discover a medical accident, or medical fault that might result in a medical accident; such reports are investigated internally and entail an obligation to inform and provide an appropriate explanation to the patient concerned. *Yi liao shi gu chu li tiao li* [Regulations on Handling Medical Accidents] art. 13 (promulgated by the St. Council, Feb. 20, 2002, effective Sept. 1, 2002), available at http://www.gov.cn/english/laws/2005-07/25/content_16885.htm (last visited Oct. 25, 2011). Where a medical accident actually occurs, the medical institution is also obliged to report it to the health administration. *Id.* at art. 14. By Article 10, item 9 of the Government Information Publicity Regulations, the government has an obligation to make such information available to the public. *Zheng fu xin xi gong kai tiao li* [Regulation on Open Government Information] (promulgated by the St. Council, Apr. 24, 2007, effective May 1, 2008), available at http://www.law.yale.edu/documents/pdf/Intellectual_Life/Ch_OGI_Regualtions_Eng_Final_051607.pdf (last visited Oct. 25, 2011).

2020.¹⁶ Problems remain, however. China's health system performs unevenly, doing well on some indicators and poorly on others.¹⁷ Three underlying problems in particular have proved hard to solve, notwithstanding the increased investment: (1) high levels of out-of-pocket expenditure on medicines and medical services, including a high proportion of catastrophic expenditure (i.e., more than 30 percent of income), with potentially devastating effects on those affected;¹⁸ (2) a geographical imbalance in healthcare spending, with greater expenditure on urban as compared with rural areas; and (3) the commercialization of healthcare without adequate attention to cost control, which has led to escalation of prices and decreased efficiency.¹⁹

According to World Health Organization statistics, China's total expenditure on health as a percentage of gross domestic product was 4.3% in 2007 (as compared with a global average of 9.7%, and 15.7% and 8.8% for the United States and European Region respectively).²⁰ Of the total, 44.7% was general government expenditure and 55.3% private expenditure. General government expenditure on health was 9.9% of total government expenditure.²¹ Reflecting the high levels of direct (out-of-pocket) payment for medicines and medical services, noted above, only 7.1% of private expenditure on health was on private prepaid plans.²² Per capita total expenditure on health was equivalent to just USD \$ 43, far below not just Europe and the United States (USD \$ 2,035 and USD \$ 7,285 respectively) but also the global average of USD \$ 802. Just to give these figures is to

16. Communist Party of China Central Committee and State Council, Opinions of the CPC Central Committee and State Council on Deepening the Health Care System Reform (Mar. 17, 2009), available at http://www.china.org.cn/government/scio-press-conferences/2009-04/09/content_17575378.htm (last visited Oct. 3, 2011).

17. Yuanli Liu et al., China's Health System Performance, 372 *Lancet* 1914 (2008).

18. As exemplified by the "Harbin scandal" of 2005, in which the family of an elderly patient hospitalized in an intensive care unit for over two months were required to pay in excess of RMB 6 million (approx. US\$ 660,000). See Edwin C. Hui, The Contemporary Healthcare Crisis in China and the Role of Medical Professionalism, 35 *J. Med. Philos.* 477, 479-80 (2010).

19. Ling et al., *supra* note 9.

20. World Health Organization, World Health Statistics 2010 127-39 tbl. 7 (2010), available at http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf.

21. *Id.* at 130. Global average: 15.4%; United States: 19.5%; Europe Region: 15.3%. *Id.* at 136, 138.

22. *Id.* at 131. Global average: 45.0%; United States: 63.5%; Europe Region: 24.3%. *Id.* at 137, 139. In considering the interaction between health insurance and the liability system, it is material to note that an insurer who pays insurance moneys to an injured insured has no right to recover those sums from the third party who caused the injury, though the latter's liability to the insured is unaffected. *Zhong hua ren min gong he guo bao xian fa* [Insurance Law of the People's Republic of China] art. 46 (promulgated by the Standing Comm. Nat'l People's Cong., Jun. 30, 1995, amended Oct. 28, 2002 and Feb. 28, 2009), available at <http://www.china.org.cn/english/DAT/214788.htm> (last visited Oct. 25, 2011).

make clear the nature of the challenge facing Chinese healthcare in the coming years.

II. THE EARLY P.R. CHINA: MEDICAL SERVICES AS SOCIAL WELFARE (1949–1987)

As detailed above, medical services were treated as a matter of social welfare in the early years of P.R. China after its foundation in 1949. There was no legislation on liability or compensation for medical malpractice,²³ and disputes were normally settled on an informal basis within the administrative framework. As early as 1953, the central government investigated and reported improper acts on the part of medical institutions and personnel; these acts included serious accidents that caused death or deterioration of patients' conditions as a result of negligence on the part of hospitals and major fault in nursing.²⁴ At that time, judges believed dispute settlement through mediation served judicial policy better than litigation, and declined to impose civil liability.²⁵ A Reply by the Supreme People's Court, dated January 18, 1964, states:

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 disability or loss of income as a result of medical accidents. Therefore, you may advise the department of public health of

23. All laws dating from before 1949 were repealed on the foundation of P.R. China. Although there were periodic attempts thereafter to legislate a civil code, none has yet been successful, though a first concrete step was taken in that direction with the enactment of the GPCL in 1986. See GPCL, *supra* note 7. The enactment of a Tort Liability Law in 2009, following the Contract Law of 1999 and Property Law of 2007, can be seen as a further step towards a complete civil code. See *Qin quan ze ren fa di zhong guo ren min gong huo guo*, [Tort Law of the People's Republic of China] (promulgated by the Standing Comm. Nat'l People's Cong., Dec. 26, 2009, effective Jul. 1, 2010); *Zhong hua ren min gong he guo he tong fa* [Contract Law of the People's Republic of China] (promulgated by the Standing Comm. Nat'l People's Cong., Mar. 15, 1999, effective October 1, 1999), available at <http://en.chinacourt.org/public/detail.php?id=97> (last visited Oct. 25, 2011); *Zhong hua ren min gong he guo wu quan fa* [Property Law of the People's Republic of China] (promulgated by the Standing Comm. Nat'l People's Cong., Mar. 13, 2007, effective Oct. 1, 2007) available at http://www.china.org.cn/china/LegislationsForm2001-2010/2011-02/11/content_21897791.htm (last visited Oct. 25, 2011).

24. *Zhong Yang Ren Min Zheng Fu Zheng Wu Yuan Guan Yu Zheng Wu Yuan Ren Min Jian Cha Wei Yuan Hui Guan Yu Chu Li Ruo Gan Yuan Zhong De Yi Liao Shi Gu He Yi Wu Ren Yuan Bu Liang Zuo Feng An Jian De Tong Bao*, *Shan Xi Zheng Bao* 1954 nian di 10 qi, di 70-72 ye. (《中央人民政府政务院关于政务院人民监察委员会关于处理若干院中的医疗事故和医务人员不良作风案件的通报》，《山西政报》1954年第10期，第70—72页。) [A Circular on Dealing with Medical Accidents in Hospitals and Improper Acts of Medical Personnel by the Supervisory Commission of Government Administration Council of the Central People's Government, 10 *Shanxi Pol. J.* 70, 70-72 (1954)].

25. Xie Guisheng (谢桂生), *Cong Yi Jian Yi Liao Shi Gu An Jian de Chu Li Kan Shen Pan Si Xiang*, *Fa Xue* 1958 nian di 9 qi, di 26-28 ye. (《从一件医疗事故案件的处理看审判思想》) [《法学》1958年第9期，第26—28页。] [A Study on Trial Thoughts Through the Judgment of A Medical Accident, 9 *Legal Sci.* 26, 26-28 (1958)].

your province to seek remedies through joint efforts with labor, personnel and civil administration departments, and execute them.²⁶

Few claims of medical malpractice were litigated at this time, and little attention was given to compensation for harm caused by medical treatment.

In 1978, the Central Committee of the Communist Party of China (CPC) adopted a policy of reform and opening-up, and China began a transformation from a planned to a market economy. As Chinese society underwent a remarkable change, the foundations of the established medical system began to shake (as detailed above). With the progress of medical reform, more medical disputes arose, requiring the improvement of relevant legal mechanisms. But, generally speaking, most workers still enjoyed free medical services at this time, and medical institutions remained part of the social welfare system, funded by government, and it seems from the very few civil cases discussed in the secondary literature at this time (in contrast with the number of criminal cases discussed there) that few disputes actually went to court. In practice, the main focus as regards medical malpractice was on criminal liability, even though the then-effective Criminal Law, promulgated by the National People's Congress in 1979, did not criminalize medical malpractice as such.²⁷ Doctors were charged with various crimes of general application, such as negligent killing, negligently causing a serious accident, or neglect of duty, or sometimes with crimes specifically relating to medical malpractice (e.g., negligently causing a serious medical accident or criminal medical fault) without any express basis in the legislative text.²⁸ Shortly after the enactment of the 1979 Criminal Law,²⁹ scholars began to suggest that medical malpractice should itself be recognized as a crime.³⁰ This controversial issue was finally settled in 1997 when Article

26. Zui Gao Ren Min Fa Yuan Guan Yu Chu Li Yi Liao Shi Gu An Jian Bu Ying Pan Gei Jing Ji Bu Chang Wen Ti De Pi Fu, 1964 nian 1 yue 18 ri. (《最高人民法院关于处理医疗事故案件不应判给经济补偿问题的批复》(1964年1月18日)) [Reply by the Sup. People's Ct. as to Not Granting Economic Compensation in Medical Accidents (Sup. People's Ct. 1964)].

27. Criminal Law of the People's Republic of China (promulgated by the Second Session of the Fifth Nat'l People's Cong, July 1, 1979) [hereinafter 1979 Criminal Law].

28. Chan Zhang, (张赞宁), Yi Liao Shi Gu Xing Shi An Jian Liu Shi Si Li Fa Li Pou Xi, Fa Lv Yu Yi Xue Za Zhi 1994 nian di 2 qi, di 74 ye. (《医疗事故刑事案件64例法理剖析》, 《法律与医学杂志》1994年第2期, 第74页。) [An Analysis of 64 Criminal Cases of Medical Accidents, 2 L. & Med. 74 (1994)].

29. 1979 Criminal Law, supra note 27.

30. Wu Shimin, (吴仕民), Zhong Da Yi Liao Shi Gu Ru He Ding Zui, Xian Dai Fa Xue 1982 nian di 1 qi, di 30-31 ye. (《重大医疗事故如何定罪?》, 《现代法学》1982年第1期, 第30-31页。) [How to Establish Criminal Liability for Serious Medical Accidents, 1 Mod. Sci. of L. 30, 30-31 (1982)]; Wang Xiaojuan & Chen Haibo, (王晓娟、陈海波), Guan Yu Ren Ding Yi Liao Shi Gu Fan Zui de Ji Ge Wen Ti, Fa Zhi Cong Lun 1992 nian di yi qi, di 42-46 ye.

335 of the newly amended Criminal Law established a crime of serious medical malpractice resulting in death or serious harm: “[m]edical 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.”³¹

It should be noted that Chinese law allows a person injured by a criminal act to recover compensation through the criminal courts. Under the Criminal Procedure Law,³² if a victim has suffered material losses as a result of the defendant’s criminal act, he has the right to file an “incidental civil action” during the course of the criminal proceeding.³³ The incidental civil action is generally heard together with the criminal trial, but may be continued after the criminal trial has ended if necessary to prevent it being excessively delayed.³⁴ So far as can be ascertained, however, criminal prosecutions of doctors are rare.

III. THE ADMINISTRATIVE LIABILITY REGIME

A national regime of administrative liability for medical accidents was established by the Medical Accident Rules of 1987,³⁵ and reformed by the Medical Accident Regulations of 2002. Both enactments were administrative regulations drafted by the Ministry of Health and promulgated by the central government (State Council), and were applicable to both public and private healthcare.

A. *The Medical Accident Rules 1987*

1. Context

The Medical Accident Rules 1987 were enacted when the provision of free medical services, including medical treatment by a healthcare institu-

(《关于认定医疗事故犯罪的几个问题》，《法治论丛》1992年第1期，第42—46页。) [Several Problems Concerning the Establishment of Medical Accidents, 1 Collection of Papers on Rule of Law 42, 42-46 (1992)]; Hou Guoyun(侯国云), *You Guan Yi Liao Shi Gu Zui de Ji Ge Wen Ti*, *Zhong Guo Wei Sheng Fa Zhi* 1995 nian di 2 qi, di 7-10 ye. (《有关医疗事故罪的几个问题》，《中国卫生法制》1995年第2期，第7—10页。)

[Guoyun Hou, *Several Questions on Convictions in Respect of Medical Accidents*, 2 *Rule of Law in China's Pub. Health*, 7-10 (1995)].

31. Criminal Law of the People’s Republic of China (promulgated by the Nat’l People’s Cong., Mar. 14, 1997) [hereinafter 1997 Criminal Law].

32. Criminal Procedure Law of the People’s Republic of China (promulgated by the Nat’l People’s Cong., July 1, 1979, amended Mar. 17, 1996).

33. *Id.* at art. 77 para. 1.

34. *Id.* at art. 78.

35. The 1987 Rules were preceded by local administrative regulations adopted in Shanghai and Shanxi Province in 1985. See Ding, *supra* note 1, at 70-71, 178-80.

tion, was part of social welfare policy. Most hospitals were still state-owned at the time. As a result, it was thought desirable to place a strict limit on the liability of medical institutions that did harm to their patients when performing medical treatment. The 1987 Rules created a formal system of administrative liability in cases of medical accident in which claims for compensation were submitted in the first instance to the health administration (for adjudication or mediation), with the option of a new hearing before a court if either party was unsatisfied with the outcome.³⁶ In hearing such a claim, the court would apply the 1987 Rules rather than the ordinary principles of tortious liability. The enactment of the Rules immediately after the GPCL strongly suggests that their intention was to exclude the GPCL's application to medical accidents so as to limit the circumstances giving rise to liability and the amount of compensation to be paid when liability was established.

2. Main Features of the Administrative Liability Regime, 1987–2002

a. Basis of the Cause of Action

Under the Rules, the basic component of the cause of action was a dispute about compensation for harm caused by a medical accident.³⁷ The term “medical accident” referred to a situation where the patient suffered death, disability, or organ damage resulting in dysfunction, as a direct result of fault in diagnosis, medical treatment, or nursing on the part of medical personnel.³⁸ Medical accidents included “malpractice accidents” and “technical accidents.” A medical malpractice accident was an accident caused by medical personnel due to a breach of duty as a result of the violation of rules or regulations, or of procedures for diagnosis, cure or nursing. A technical medical accident was an accident caused by medical personnel due to negligent treatment not involving the violation of any such rule or procedure. Accidents involving malpractice were regarded as more serious than those involving mere negligence in treatment,³⁹ with administrative sanctions (e.g., dismissal, demotion or warning) attaching to the responsible personnel, while such sanctions applied to technical accidents only where a seriousness threshold was crossed, and even then the sanctions applied were less severe.⁴⁰

36. Rules on the Handling of Medical Accidents art. 11 (promulgated by the St. Council, June 29, 1987) [hereinafter Medical Accidents Rules 1987].

37. As affirmed by the Regulation on Causes of Action for Civil Cases (for Trial Implementation) (promulgated by the SPC, effective Jan. 1, 2001).

38. Medical Accident Rules 1987, *supra* note 36, at art. 2.

39. *Id.* at art. 5.

40. *Id.* at arts. 20, 21.

b. Burden of Proof

Under the Rules of 1987, the burden of proof lay on the patient. The Rules required that, when a medical accident (or an incident which might later be recognized as a medical accident) occurred, the medical institution should assign a specific person to properly keep such original materials as were relevant.⁴¹ In reality, however, it was possible for the medical institution to alter, forge, conceal, or even destroy the original materials. Consequently, it seems to have been difficult for patients—who were further disadvantaged by their own lack of medical knowledge—to satisfy the burden of proof lying on them. So they had to apply for “technical identification” (see below), which itself tended to favor the hospital.⁴²

c. The Identification Process

A central feature of the administrative liability regime established by the 1987 Rules was the process of “technical identification.” This was the procedure by which a committee of medical experts, selected by the health administration (i.e., the responsible provincial, regional or municipal department of health),⁴³ would investigate the circumstances giving rise to a claim and report their conclusions to the appropriate tribunal. A decision of a local committee could be appealed to a higher level (e.g., a provincial committee) but the outcome of the process was in practice binding on the tribunal (whether the health administration or a court), except to the extent that the court could remit the case to be reviewed either by the original committee or a higher-level committee. Technical identification could be carried out at the level of the province, city, county or municipal district;⁴⁴ there was no nationwide organization undertaking the process. Since most hospitals were still state-owned at the time, technical identification organized by the local health administration was just a case of (in the common parlance) “making the father the judge of the son.” Hospitals were favored with the excuse that medical malpractice did not amount to a “medical accident” but merely a “medical error” giving rise to no liability to pay compensation.

41. *Id.* at art. 8.

42. Yang Lixin (杨立新), *Yi Liao Qin Quan Yu Fa Lv Shi Yong*, *Fa Lv Chu Ban She 2008 nian ban*, di 4 ye. (《医疗侵权法律与适用》, 法律出版社2008年版, 第4页。) [The Law and Its Application for Medical Torts 4 (2008)].

43. *Medical Accident Rules 1987*, *supra* note 36, at art. 11.

44. *Id.* at art. 12.

d. Assessment of Damages

Where an occurrence was identified as a medical accident, the patient was to be awarded a lump sum payment of compensation according to the accident's grade of severity on a scale of 1–3 (see below), its circumstances and the patient's pre-existing condition. The Rules provided that the level of compensation should be formulated by the provincial, regional or municipal government in whose area the accident occurred.⁴⁵ The sums awarded were small, and reflected the grade of the accident rather than the loss actually suffered by the patient. As an example, we may consider the levels of compensation prescribed in Tianjin, a municipality directly under the central government near Beijing:⁴⁶

Grade I medical accidents (causing death): compensation in the range of RMB 3,000 to 4,000;⁴⁷ compensation for infants under the age of three was RMB 1,000; compensation for neonates was RMB 700.

Grade II medical accidents (causing serious disability or severe dysfunction): RMB 3,000 to 5,000.

Grade III medical accidents (causing disability or dysfunction): RMB 2,000 to 3,000; compensation for infants under the age of three was RMB 700; compensation for neonates was RMB 500.

These compensation levels were actually very low even when they were introduced (1988), and they did not change in the fourteen years until the enactment of a new set of Regulations in 2002.

*B. The Medical Accident Regulations 2002*⁴⁸

1. Context

A new set of administrative regulations replaced the previously enacted rules in 2002, though they maintained the basic features of the previous regime, at least in broad outline. The Medical Accident Regulations 2002 were intended to respond to widespread criticism of the strict limits on liability in the previous regime and they may thus be considered to have made some progress towards the better protection of patients' interests.

45. *Id.* at art. 18.

46. Detailed Rules on the Implementation of the Regulations on Handling Medical Accidents in Tianjin art. 19 (1988).

47. In 1988, the exchange rate for the US dollar: Chinese Renminbi (or yuan) was USD 1 : RMB 3.712. U.S. Dep't Treasury, Fin. Mgmt. Serv., Treasury Reporting Rates of Exchange (1988–1991) 3 (1991).

48. For analysis in English, see Dean M. Harris & Chien-Chang Wu, Medical Malpractice in the People's Republic of China: The 2002 Regulation on the Handling of Medical Accidents, 33 *J. L. Med. & Ethics* 456 (2005).

However, there was still a big gap between the medical and legal community's estimations of the proper extent of liability.

2. Main Features of the Administrative Liability Regime, 2002 onwards

a. Basis of the Cause of Action

The 2002 Regulations defined "medical accident" as an accident caused by a medical institution or its medical personnel resulting in personal injuries to a patient due to negligence in medical activities as a result of the violation of laws, administrative regulations or departmental rules on medical and health administration, or of standards or procedures for diagnosis, cure and nursing.⁴⁹ Compared with the Rules of 1987, the new Regulations expanded the scope of medical accident in two aspects. First, harm was no longer limited to death, disability or functional dysfunction: any physical injury caused by negligent medical treatment was covered. Four grades of accident were now recognized (instead of the previous three): death and serious disability (Grade I); moderate disability (Grade II); mild disability (Grade III); and other obvious injury (Grade IV).⁵⁰ Second, causality was no longer limited to direct causation: indirect causation was also included.

b. Burden of Proof

Though the burden of proof was still on the patient, the 2002 Regulations imposed a more onerous recordkeeping obligation on medical institutions, who were to compile and properly preserve medical records as required by the health administration department of the State Council. In the case of emergency treatment to save the patient's life, where timely record keeping might not be possible, the medical person concerned had an obligation to update the record within six hours of the treatment being given.⁵¹ Alteration, forgery, concealment, destruction, and seizure of medical records were strictly forbidden,⁵² on penalty of administrative or disciplinary sanction or, in prescribed circumstances, criminal punishment.⁵³ Patients were entitled to a copy of their record on request.⁵⁴

49. Regulations on Handling of Medical Accidents art. 2 (promulgated by the St. Council, Apr. 4, 2002, effective Sept. 1, 2002) [hereinafter Medical Accident Regulations 2002].

50. *Id.* at art. 4.

51. *Id.* at art. 8.

52. *Id.* at art. 9.

53. *Id.* at arts 58-59.

54. *Id.* at art. 10.

c. Technical Identification

There were two significant changes as regards the process of technical identification.⁵⁵ First, the responsibility for organizing the process was shifted from the health administration to the medical associations (i.e., the professional bodies representing healthcare practitioners). In the 1987 Rules, the technical identification was organized by the health administration itself, which was also the administrative authority of the hospital that was being sued, and this created a very obvious conflict of interests. To address this unsatisfactory situation, the 2002 Regulations required the health administration department concerned to forward any report of serious medical fault from a medical institution, and every application to settle a medical accident dispute from a party to it, to the responsible medical association for the purposes of organizing the necessary technical identification.⁵⁶

Second, technical identification at a national level became available. In addition to the technical identifications organized by local medical associations, the 2002 Regulations provided for the Chinese Medical Association⁵⁷ to organize technical identification of difficult and complicated medical accident disputes having significant national importance.⁵⁸

In spite of these major changes, the new system attracted criticism because the medical associations had such close links with the health administration. Though formally independent, in reality the medical associations perform a semi-official role and are closely linked with and dependent upon government at all levels, with leading positions in them being taken by leaders of health administration departments. Consequently, the new identification system was perceived to involve medical institutions “shielding” one another, and still tended to protect hospitals from liability.⁵⁹

55. In departmental rules issued shortly after the Medical Accident Regulations 2002, the aim of technical identification was described as being to reach a conclusion as to the following issues (amongst others): (1) whether the medical treatment violated a law, administrative regulation or departmental rule or the applicable standards and procedures for diagnosis, cure or nursing; (2) the causal relationship between the medical fault (if any) and the personal injury; (3) the extent of responsibility to be attributed to the medical fault for causing injury in the medical accident; and (4) the grade of severity of the medical accident. See Temporary Rules on Technical Identification of Medical Accidents (coming into force on Sept. 1, 2002), at item 4-7, para. 1, arts. 35-36.

56. Medical Accident Regulations 2002, *supra* note 49, at art. 20.

57. See Chinese Med. Ass'n, About the CMA, <http://www.cma.org.cn/ensite/>.

58. Medical Accident Regulations 2002, *supra* note 49, at art. 21.

59. See Xi & Yang, *supra* note 1, at 70-71 (citing evidence from a number of local surveys to report that the percentage of medical accident claims upheld by identification panels under the 2002 Regulations was in many places less than 10 percent).

d. Assessment of Damages

In contrast with the 1987 Rules, which left the amount of compensation payable for each grade of medical accident to be determined by provincial, regional or municipal administrative rules, the 2002 Regulations treated the loss suffered by the patient—rather than the grade of the accident—as decisive, and stipulated in some detail the heads of loss in respect of which compensation would be awarded. Eleven items were listed: (1) medical expenses; (2) loss of income (subject to a cap of three times annual earnings in the place the medical accident occurred); (3) a food allowance during hospitalization; (4) expenses incurred looking after the patient; (5) a living allowance in the event of disability; (6) a disability allowance for the purchase of appliances; (7) funeral expenses; (8) the living expenses of a dependent; (9) a traffic allowance; (10) a lodging allowance; and (11) a solatium for emotional harm, capped by reference to annual living expenses in the place of the accident.⁶⁰ Conspicuous because of its absence from this list is compensation for death itself, in contrast with the ordinary rules of tortious liability where such compensation is expressly allowed (in addition to compensation for the living expenses of dependents and a solatium for emotional harm resulting from the bereavement).⁶¹ This is the principal reason why the legal community has taken comprehensive measures to sideline the Medical Accident Regulations 2002 when proceedings are brought in court.

A significant feature of the administrative liability scheme as amended in 2002 was the requirement to apportion liability to reflect not only the grade of the accident but also both the extent of responsibility to be attributed to the medical fault and the role played by the patient's underlying condition.⁶² For example, where a fifty-one-year-old man was treated in hospital for an abdominal injury and died, the main cause of death being the hospital's medical mistakes, and a contributing cause being the man's previous liver problems, this constituted a Grade I medical accident where the hospital had to bear the main responsibility, but, taking account of the

60. Medical Accident Regulations 2002, *supra* note 49, at art. 50. The solatium for emotional harm is calculated by reference to annual average living expenses in the place where the medical accident occurs. In the case of death, a maximum of six times the annual amount may be paid; in the case of non-fatal disability, the maximum is three times the annual amount. See *id.* at art. 50(11).

61. See *infra* Part V(IV).B.4.

62. Medical Accident Regulations 2002, *supra* note 49, at art. 49.

patient's pre-surgery medical conditions, the defendant's liability was determined to be only 80 percent.⁶³

IV. THE TORT LIABILITY REGIME

A. Recourse to the General Principles of Civil Liability

Responding to dissatisfaction about the low levels of compensation paid under the administrative liability regime (at that time governed by the Rules of 1987), the SPC began unobtrusively to allow injured patients access to higher compensation awards by recognizing their ability to bring their claim on the basis of tortious liability arising under the GPCL; if successful, the compensation would be calculated under the more generous damages rules of the GPCL rather than those of the administrative liability regime. In a formal Reply to the High Court of Tianjin in 1992, the SPC stated that the local court could properly handle medical accident cases in accordance with either the relevant provisions of the GPCL, or the State Council's Medical Accident Regulations (combined with the local rules implementing the Regulations), according to the specific conditions of the case.⁶⁴ The SPC's Reply thus allowed the court in Tianjin to make a compensatory award under the GPCL that was much higher than would have been possible under the administrative liability regime. Even though the medical community insisted that the GPCL should not be applied so indiscriminately that it came to replace the administrative regime,⁶⁵ the courts began to show a preference for the GPCL from this time on. This move towards tort liability was consolidated in 2003—just one year after the administrative liability regime was reformed—when the SPC issued a Notice on the Trial of Civil Cases Involving Medical Disputes with Reference to the Medical Accident Regulations, which explicitly established a dual

63. [Yang v Unnamed County Hospital] (People's Court of Sheyang County, Jiangsu Province May 19 2006). The authors are very grateful to Benjamin Liebman for pointing them towards this decision and providing them an English translation.

64. Zui Gao Ren Min Fa Yuan Guan Yu Li Xinrong Su Tian Jin Shi Di'er Yi Xue Yuan Fu Shu Yi Yuan Yi Liao Shi Gu Pei Chang Yi An Ru He Shi Yong Fa lv Wen Ti de Fu Han, 1992 nian 3 yue 24 ri.

(《最高人民法院关于李新荣诉天津市第二医学院附属医院医疗事故赔偿一案如何适用法律问题的复函》(1992年3月24日)) [Reply of Supreme People's Court to the Question of How to Apply Laws of the Medical Accident Compensation Case "Li Xinrong vs. Tianjin Second Medical College Subsidiary Hospital" (Mar. 24, 1992)].

65. Hu Xiaoxiang (胡晓翔), Zai Lun Dui "Yi Liao Shi Gu Chu Li Ban Fa" de Ping Jia—Bu Ke Lan Yong "Min Fa Tong Ze", Zhong Guo Wei Sheng Shi Ye Guan Li 1998 nian di 7 qi, di 364-367 ye. (再论对《医疗事故处理办法》的评价——不可滥用《民法通则》,《中国卫生事业管理》1998年第7期,第364—367页。) [Xiaoxiang Hu, Reevaluation of Medical Accident Rules 1987—GPCL Should Not Be Applied Indiscriminately, 7 Admin. of Pub. Health China, 364–367 (1998)].

system of liability for medical malpractice.⁶⁶ The relationship of the two liability regimes to each other, and the differences between them, may now be considered with reference to the four criteria proposed above: the cause of action, the burden of proof, the identification process, and the assessment of damages.

B. Elements of the Tort Liability Regime

1. Cause of Action

The SPC Notice provided that, where a lawsuit is brought before any court⁶⁷ regarding a dispute over compensation for medical malpractice which occurred after the 2002 Regulations came into force, it is to be resolved by referring to the relevant provisions in the Regulations; for disputes over compensation for patient injury attributed to factors other than medical malpractice, the provisions of the GPCL apply.⁶⁸ Thus, if a patient sued the hospital on the basis of a medical accident, the court would decide the case under the administrative liability regime. If the patient chose to sue the hospital on the basis of fault sufficient to establish ordinary civil liability (commonly termed “medical fault,” though the GPCL laid down no special rule for fault in a medical context), the court would decide the case according to the GPCL and, most importantly, would calculate the damages according to the SPC Interpretation dealing with compensation for personal injury in civil cases.⁶⁹ We consider below the huge difference this made to the quantum of compensation. In practice, the courts allowed patients the freedom to sue hospitals on the basis of medical fault rather than medical accident, and most patients chose to proceed on this basis in view of the advantages of the tort liability regime.

66. Zui Gao Ren Min Fa Yuan “Guan Yu Can Zhao ‘Yi Liao Shi Gu Chu Li Tiao Li’ Shen Li Yi Liao Jiu Fen Min Shi An Jian de Tong Zhi,” 2003 nian 1 yue 6 ri, fa [2003] 20 hao. (最高人民法院《关于参照〈医疗事故处理条例〉审理医疗纠纷民事案件的通知》，2003年1月6日，法[2003]20号) [Notice of the Supreme People’s Court on “The Trial of Civil Cases Involving Medical Disputes with Reference to the ‘Medical Accident Regulations’”] Jan. 6, 2003 [hereinafter SPC Notice on the Medical Accident Regulations].

67. Cases for medical malpractice are usually brought in a basic people’s court or intermediate people’s court.

68. SPC Notice on the Medical Accident Regulations, *supra* note 66, § 1 para. 1.

69. “Zui Gao Ren Min Fa Yuan Guan Yu Shen Li Ren Shen Sun Hai Pei Chang An Jian Shi Yong Fa lv Ruo Gan Wen Ti de Jie Shi,” 2003 nian 12 yue 4 ri You Zui Gao Ren Min Fa Yuan Shen Pan Wei Yuan Hui di 1299 ci Hui Yi Tong Guo, Zi 2004 nian 5 yue 1 ri Shi Xing. (《最高人民法院关于审理人身损害赔偿案件适用法律若干问题的解释》，2003年12月4日由最高人民法院审判委员会第1299次会议通过，自2004年5月1日起施行。) [“Interpretation of the Supreme People’s Court of Some Issues Concerning the Application of the Law on the Trial of Cases to Compensation for Personal Injury,” adopted at the 1,299th meeting of the Judicial Committee of the Supreme People’s Court on Dec. 4, 2003, coming into force on May 1, 2004] Dec. 26, 2003 [hereinafter SPC Interpretation on Compensation for Personal Injury].

2. Burden of Proof

Though the burden of proof in civil litigation normally lies on the plaintiff, in 2002 a Judicial Interpretation of the SPC introduced a reversal in the burden of proving causation and fault in claims alleging medical fault.⁷⁰ This was a crucial feature of the tort liability regime applying to medical injuries as developed at this time by the courts in parallel to the administrative liability regime. The relevant passage stipulates: “In tort actions relating to medical practice, medical institutions shall bear the burden of proving both the lack of a causal relationship between the medical practice and the harmful consequences, and the absence of medical fault.”⁷¹ In short, causation and fault were presumed and had to be disproved by the hospital. This contrasted with the administrative liability regime where the burden of proof was always on the plaintiff.

3. The Identification Process

The SPC also decided that a dual system should apply to the process of identification, depending on whether administrative or tortious liability was at stake.⁷² If, in civil proceedings pursued on the basis of medical accident, the court decided—upon application by either party concerned or in the exercise of its own powers—that there should be a technical identification, this would be conducted by a medical association prescribed by regulation. However, where an identification procedure was required in a dispute over compensation for patient injury not attributed to a medical accident (i.e., in an action brought under the tort liability regime), a “judicial identification” would be organized by the court itself, rather than by the health administration (as under the 1987 Rules) or a medical association (as under the 2002 Regulations).⁷³ This was important because, under the

70. “Zui Gao Ren Min Fa Yuan Guan Yu Min Shi Su Song Zheng Ju de Ruo Gan Gui Ding,” 2001 nian 12 yue 6 ri You Zui Gao Ren Min Fa Yuan Shen Pan Wei Yuan Hui di 1201 ci Hui Yi Tong Guo, Zi 2002 nian 4 yue 1 ri qi Shi Xing. (《最高人民法院关于民事诉讼证据的若干规定》，2001年12月6日由最高人民法院审判委员会第1201次会议通过，自2002年4月1日起施行) [“Several Stipulations of the Supreme People’s Court on Evidence in Civil Actions,” adopted on Dec. 6, 2001 at the 1,201st meeting of the Judicial Committee of the Supreme People’s Court, effective Apr. 1, 2002] Dec. 21, 2001, at art. 4(8).

71. *Id.*

72. SPC Notice on the Medical Accident Regulations, *supra* note 66, § II para. 1.

73. Ren Min Fa Yuan Dui Wai Wei Tuo Si Fa Jian Ding Guan Li Gui Ding, 2002 nian 2 yue 22 ri You Zui Gao Ren Min Fa Yuan Shen Pan Wei Yuan Hui di 1214 ci Hui Yi Tong Guo, Zi 2002 nian 4 yue 1 ri qi Shi Xing. (《人民法院对外委托司法鉴定管理规定》，2002年2月22日由最高人民法院审判委员会第1214次会议通过，自2002年4月1日起施行。) [“Provisions on the Administration of Judicial Identification upon Entrustment by the People’s Court,” adopted on Feb. 22, 2002 at the 1,214th meeting of the Judicial Committee of the Supreme People’s Court, effective Apr. 1, 2002] Mar. 27, 2002.

administrative liability system, most technical identifications concluded that there had been no medical accident,⁷⁴ and medical institutions were consequently exempted from liability to a large extent. *Judicial* identifications proved more likely to find in favor of the patient and consequently to allow the latter to obtain compensation.⁷⁵

4. Assessment of Damages

The most important difference between administrative and tort liability regimes lay in the assessment of compensation. For medical accidents, assessment was under the framework established by the Regulations of 2002⁷⁶ though the amounts payable were stipulated by reference to local conditions.⁷⁷ Taking Beijing as an example, the maximum sum of compensation payable in respect of a medical accident was approximately 100,000 RMB in 2010.⁷⁸ But if the patient chose to sue the hospital on the basis of medical fault, the compensation was calculated in accordance with the principles ordinarily applicable to tort liability,⁷⁹ and the maximum compensation payable was much higher—about 400,000 RMB in 2010. The big differential of 300,000 RMB was mainly attributable to the award of compensation for death⁸⁰ that is made where the claim is brought in tort but not where it is brought under the administrative regulations.

The medical community argued that the general approach to the assessment of compensation for tortious personal injury should not apply to medical accidents, which should be governed exclusively by the 2002 Regulations.⁸¹ However, it proved to be another story in practice, and at least

74. See Xi & Yang, *supra* note 59 and accompanying text.

75. See *id.* (reporting that judicial identifications conducted by one certified institution in Beijing found in favor of the patient in over 60 percent of cases, as compared with less than 10 percent reported in respect of technical identifications in several areas).

76. In such cases, Section III of the SPC Notice on the Medical Accident Regulations provides for the application of the provisions on compensation (Articles 49, 50, 51 and 52) in the 2002 Regulations themselves. SPC Notice on the Medical Accident Regulations, *supra* note 66, § III.

77. Medical Accident Regulations 2002, *supra* note 49, at items 2-5,7,10, 11, art. 50.

78. In 2010, the average monthly exchange rate fluctuated between approximately \$1=RMB6.6 and \$1=RMB 6.8.

79. Specifically, SPC Interpretation on Compensation for Personal Injury, *supra* note 69, at art. 17.

80. *Id.* at art. 29 (providing that compensation for death shall be payable at the rate of twenty times the per capita disposable income of urban residents, or per capita net income in the case of rural residents, at the locality of the court accepting the case (based on the previous year's income figures)). However, if the victim is age sixty or over, the period is reduced by one year for each year of age added; if the victim is age seventy-five or over, the period is calculated as five years. *Id.*

81. Chou Yonggui (仇永贵), Yi Liao Shi Gu Sun Hai Pei Chang Bu Shi Yong "Ren Shen Sun Hai Pei Chang Si Fa Jie Shi," *Zhong Hua Yi Yuan Guan Li Za Zhi* 2004 nian di 12 qi, di 737-738 ye. ("医疗事故损害赔偿不适用《人身损害赔偿司法解释》", 《中华医院管理杂志》2004年第12期,

one local court (the Beijing Higher People's Court) provided for the toping-up of compensation for medical accidents with reference to the GPCL and any relevant judicial interpretation where the sum assessed under the 2002 Regulations left the patient under-compensated.⁸² This effectively unified the measure of compensation irrespective of the cause of action the patient chose.

C. Effect on the Administrative Liability Regime

The increasing recourse to the ordinary principles of tortious liability had dramatic effects on the utilization of the administrative liability regime. Just three years after the 2002 Regulations were implemented, there were significantly fewer applications for technical identification as both medical institutions and patients sought to avoid the attribution of patient injury to a medical accident: the administrative liability regime was "left in the cold" by the parties concerned.⁸³ Patients turned to the GPCL because they wanted more compensation; hospitals, on the other hand, thought the administrative sanctions they faced under the 2002 Regulations too harsh because they might entail, in serious cases, an order by the health administration to suspend activities or the revocation of their practicing licenses, while the medical workers responsible for the accident would be subject to criminal investigation or, in less serious cases, disciplinary measures, as well as mandatory suspension of their activities and revocation of their practicing certificates.⁸⁴ To avoid these administrative sanctions, hospitals were often prepared to admit civil liability voluntarily, even if this meant paying more

第737—738页。) [Yonggui Chou, Interpretation of the Supreme People's Court of Some Issues Concerning the Application of Law for the Trial of Cases on Compensation for Personal Injury Should Not Be Applied in Compensation for Medical Accidents, 12 Chinese Hosp. Mgmt 737, 737-38 (2004)].

82. Bei Jing Shi Gao Ji Ren Min Fa Yuan Guan Yu Yin Fa "Bei Jing Shi Gao Ji Ren Min Fa Yuan Guan Yu Shen Li Yi Liao Sun Hai Pei Chang Jiu Fen An Jian Ruo Gan Wen Ti de Yi Jian (Shi Xing)" de Tong Zhi. (北京市高级人民法院关于印发《北京市高级人民法院关于审理医疗损害赔偿纠纷案件若干问题的意见(试行)》的通知) [Notice of Beijing Higher People's Court on Several Problems Concerning the Trial of Disputes Arising from Medical Malpractice (for Trial Implementation)] Jul. 13, 2005, at art. 21] ["To determine the compensation standard for medical malpractice, provisions from Article 49 to 52 of the Regulations for the Handling of Medical Accidents should be applied; if by following the Regulations the patient is left uncompensated, the GPCL and any relevant judicial interpretation shall be applied to increase the compensation."].

83. Liu Hong (刘虹), "Yi Liao Shi Gu Chu Li Tiao Li" Shi Shi San nian Yuan He Bei Leng Luo, Yi Yuan Ling Dao Jue Ce Can kao 2006 nian di 9 qi di 39-41 ye. (《医疗事故处理条例》实施三年缘何被冷落, 《医院领导决策参考》2006年第9期, 第39—41页。) [Hong Liu, Why are the Regulations on Handling Medical Accidents Left in the Cold Three Years After Their Implementation, 9 Decision-Making Assistant for Hosp. Superintendents 39, 39-41 (2006)].

84. Medical Accident Regulations 2002, *supra* note 49, at art. 55.

compensation. The courts also preferred to rely on the GPCL and to determine the sum of compensation according to the general principles established by the SPC. The 2002 Regulations thus became increasingly marginalized.⁸⁵

V. REFORM OF MEDICAL LIABILITY UNDER THE TORT LIABILITY LAW OF 2009

A. Antecedents

The dual system of liability and compensation for medical injury created chaos in practice, at a time when pressure for reform also came from the increasing number of disputes between doctors and patients, and widespread concerns about defensive medicine.

1. Increasing Disputes between Doctors and Patients

According to a survey by the Chinese Medical Association in 2003, among 326 medical institutions investigated, 321 (98 percent) were involved in medical disputes of one type or another.⁸⁶ A further survey in 2005 by the China Hospital Management Association looked at the incidence of disputes in 270 hospitals. Even in high-rated (Grade 3-A)⁸⁷ hospitals, there were on average over thirty lawsuits every year, and more than one million RMB was paid as compensation in them. Doctors were assaulted, threatened, and abused in 73 percent of all hospitals; in 60 percent of hospitals patients besieged and threatened hospital superintendents out of dissatisfaction with the outcomes of their treatment; in 77 percent of hospitals patients and their families refused to leave the premises or to pay their bill after treatment; in 62 percent of hospitals patients' families laid wreaths

85. See Wang Lianggang, (王良钢), "Yi Liao Shi Gu Chu Li Tiao Li" Zai Yi Liao Jiu Fen Min Shi Su Song Zhong de Bian Yuan Hua, *Dang Dai Yi Xue* 2005 nian di 10 qi, di 26 ye. (《医疗事故处理条例》在医疗纠纷民事诉讼中的边缘化》，《当代医学》2005年第10期，第26页。) [Lianggang Wang, Medical Accident Regulations 2002 Marginalized in Dealing With Medical Civil Disputes, 10 *Modern Med.* 26 (2005)].

86. Fan Jing & Jiang Chao (樊静、姜潮), *Yi Liao Jiu Fen de Xian Zhuang Ji Dui Yi Yuan He Yi Wu Ren Yuan de Ying Xiang*, *Zhong Guo Yi Yuan Guan Li* 2003 nian di 1 qi, di 29-30 ye. (《医疗纠纷的现状及对医院和医务人员的影响》，《中国医院管理》2003年第1期，第29-30页。) [Jing Fan & Chao Jiang, Status Quo of Medical Disputes and Their Influence on Hospitals and Medical Personnel, 1 *Mgmt. of China's Hospitals* 29, 29-30 (2003)].

87. According to Articles 4 and 5 of the Administrative Rules for Hospital Grading (for Implementation) (1989), hospitals are divided into ten grades (from highest to lowest): 3-Top, 3-A, 3-B, 3-C, 2-A, 2-B, 2-C, 1-A, 1-B and 1-C. *Yi Liao Shi Gu Fen Ji Biao Zhun* (Shi Xing), *Zhong Hua Ren Min Gong He Guo Wei Sheng Bu Ling* di 32 hao. (《医疗事故分级标准(试行)》，中华人民共和国卫生部令第32号) [Administrative Rules for Hospital Grading (for Trial Implementation), Ministry of Health Order No. 32] (Jul. 19, 2002), arts. 4, 5]. At the time of writing, there are no 3-Top rated hospitals in China, so 3-A is actually the highest grade.

and created mourning halls on the premises following the patient's death.⁸⁸ Increasing numbers of these disputes resulted in litigation. Taking the Haidian district court in Beijing as an example, eighty-nine medical disputes were tried in 2003, 103 in 2004, 124 in 2005, 138 in 2006, and 160 in 2007.⁸⁹

2. Concerns about Defensive Medical Treatments

The increasing number of hospital-related disputes raised concerns that medical personnel might be induced to carry out defensive and passive medical treatments to avoid liability,⁹⁰ though reliable empirical evidence that this in fact occurred is lacking.

According to a questionnaire survey of 487 clinicians shortly after the 2002 Regulations were implemented, 76 percent felt psychologically pressured; 42 percent said they were losing self-confidence.⁹¹ It has also been claimed (though without reliable supporting data) that, to avoid lawsuits and compensation awards, medical institutions require patients as a matter of course to undergo excessive or unnecessary examinations, and that medical personnel also avoid offering or refuse to undertake risky interventions, and instead carry out only passive treatments which, though less likely to

88. Fu Zhongyu (傅忠宇), Gou Jian He Xie Yi Huan Guan Xi de Dui Ce Si Kao, *Yi Xue Yu She Hui* 2007 nian di 7 qi. (《构建和谐医患关系的对策思考》, 《医学与社会》2007年第7期。) [Zhongyu Fu, Thoughts on Measures That Aim at Building a Harmonious Hospital-Patient Relationship, 7 *Med. & Soc'y* 11, 11 (2007)]. On the role played by entrepreneurial "hospital chaos makers," see Ding, *supra* note 1, at 2-3.

89. Bei Jing Shi Hai Dian Qu Ren Min Fa Yuan Ke Ti Zu. (北京市海淀区人民法院课题组), Guan Yu Yi Liao Jiu Fen An Jian Fa lv Shi Yong Qing Kuang de Diao Yan Bao Gao, *Fa lv Shi Yong* 2008 nian di 7 qi, di 62 ye. (《关于医疗纠纷案件法律适用情况的调研报告》, 《法律适用》2008年第7期, 第62页。) [Research Team of the Haidian District Court of Beijing, An Investigative Report on the Application of the Law in Medical Disputes, 7 *Legal Application* 62 (2008)]. Unfortunately, there are no reliable national estimates of the number of medical injury claims pursued in Chinese courts. It should however be noted that the "loser pays" rule applying to court fees (but not lawyers' fees, which are always borne by the client unless there is a contingent fee contract) acts as some disincentive to meritless claims.

90. Xu Ping, Wang Shuhui & Wang Yunling (徐萍、王书会、王云玲), Shi Lun "Yi Liao Shi Gu Chu Li Tiao Li" Yu Yi Sheng de Zi Wei Yi Xue Xing Wei, *Zhong Guo Yi Xue Lun Li Xue* 2006 nian di 1 qi, di 59 ye. (试论《医疗事故处理条例》与医生的自卫医学行为》, 《中国医学伦理学》2006年第1期, 第59页。) [Ping Xu, Shuhui Wang & Yunling Wang, On the Relationship between Medical Accident Regulations 2002 and Defensive Medical Treatment by Medical Personnel, 1 *Ethics in Med.* 59, 59 (2006)].

91. Qin Hong, Zou Xiaoping & Yang Hui (秦红、邹晓平、杨会), "Yi Liao Shi Gu Chu Li Tiao Li" Dui Si Bai Ba Shi Qi Ming Lin Chuang Yi Sheng Xin Li Zhuang Kuang de Ying Xiang Ji Dui Ce, *Zhong Guo Quan Ke Yi Xue* 2004 nian di 7 qi, di 475 ye. (《医疗事故处理条例》对487名临床医生心理状况的影响及对策》, 《中国全科医学》2004年第7期, 第475页。) [Hong Qin, Xiaoping Zou & Hui Yang, The Influence of the Medical Accident Regulations 2002 on 487 Clinicians' Psychology and Countermeasures Against It, 7 *China Gen. Med.* 475, 475 (2004)].

lead to iatrogenic injury, may not be in the patient's best interests.⁹² Such attitudes may also have affected medical education and training. In 2002, in another questionnaire about the new Regulations' influence in this area, 35 percent of respondents said that they were unwilling to supervise interns, and 59 percent said that they were reluctant to instruct students in how to operate.⁹³

3. The Chaos Resulting from the Dual System of Medical Liability⁹⁴

The emergence of the dual liability system for medical malpractice can be attributed to three basic factors: first, the health administration's excessive emphasis on the uniqueness of medical institutions and its determination to give special protection to them; second, patients were forced to seek a more favorable compensation system to overcome the limits prescribed in the Regulations; and third, the court system tolerated a situation in which medical accident and medical fault were alternative causes of action, and even went so far as to create parallel systems for "identification" and the assessment of compensation. The disadvantages of such a state of affairs are obvious. The creation of a dual system under which limits on liability under the administrative regulations could easily be circumvented by recourse to the more favorable rules (so far as the patient was concerned) of ordinary tortious liability aggravated disputes between doctors and patients. Defensive and passive medical treatment—to the extent (if any) that it stemmed from the increased liabilities—harmed the interests of all patients, who could be obliged to pay for unnecessary examinations while at the same time being denied treatments which, though risky, were in their best interests. Lastly the disunity of judicial approaches harmed the authority of justice itself. This chaotic state of affairs was calling out for further reform by the time of the Tort Liability Law (TLL) of 2009.⁹⁵

92. See also the evidence of a number of other local surveys cited by Xi and Yang, *supra* note 1, at 71-72.

93. Qin, Zou & Yang, *supra* note 91.

94. Yang Lixin (杨立新), *Zhong Guo Yi Liao Sun Hai Ze Ren Zhi du Gai Ge, Fa Xue Yan Jiu* 2009 nian di 4 qi, di 84-85 ye. (《中国医疗损害责任制度改革》, 《法学研究》2009年第4期, 第84-85页。) [Lixing Yang, Reform of the Liability System Relating to Medical Harm in China, 4 Chinese J. Law, 84-85 (2009)].

95. *Zhong Hua Ren Min Gong He Guo Qin Quan Ze Ren Fa* (《中华人民共和国侵权责任法》) [promulgated by the Standing Comm. Nat'l People's Cong., Dec. 26, 2009, effective July 1, 2010] [P.R.C. Presidential Decree], available at http://www.gov.cn/flfg/2009-12/26/content_1497435.htm (last visited Nov. 6, 2011) [hereinafter TLL]. For analysis in English, see Helmut Koziol & Yan Zhu, Background and Key Contents of the New Chinese Tort Liability Law, 1 J. Eur. Tort L. 328 (2010); Surya Deva, The PRC Tort Law: A Big Step Forward, 2 City U. H.K. L. Rev. 383 (2010).

B. Legislative History

The TLL was the outcome of a long history of unsuccessful attempts at codification in P.R. China. Following previous failed attempts to introduce a Civil Code, it was decided to proceed incrementally by way of a series of enactments dealing with particular areas of civil law.⁹⁶ The first draft of the TLL was actually the title on tort liability (Title VIII) in a new draft Civil Code of 2002.⁹⁷ This made no specific provision for medical liability. It was in the second draft of December 21, 2008, that a new chapter on Liability for Injury in Medical Treatment was added, reflecting the legislature's conclusion that a specific provision was necessary in view of the chaos that had arisen in practice. Apart from one significant amendment (relating to the burden of proof),⁹⁸ this was the regime introduced in the final version of the Law adopted on December 26, 2009.

The TLL had three basic goals in reforming the medical liability system: (1) to establish a single cause of action for medical malpractice to unify the application of law; (2) to seek a balance between the interests of the patient and the medical institution; and (3) to promote the sound development of state-funded medical services (Medicare).⁹⁹ Its approach may be evaluated by reference to the four basic elements which we have highlighted with respect to the preexisting liability regimes: namely, the basis of the cause of action, the burden of proof, the identification process, and the assessment of damages.

C. Four Dimensions of the TLL

1. Basis of the Cause of Action

The TLL adopts the term "liability for injury in medical treatment" to denote the field of its application. The language can be traced back to a Regulation issued by the Supreme People's Court in 2008, which used the

96. The legislature of P.R. China attempted to introduce a Civil Code on three previous occasions (1954–1958, 1962–1966 and 1979–1982), but failed each time—for primarily political reasons. The first effort was halted by the Great Leap Forward and Movement of People's Commune in 1958, the second was halted by the Great Cultural Revolution begun in 1966, and the third was delayed because of the political belief that a civil code would be premature with economic reform underway. See Gu angrān (顾昂然), *Xin Zhong Guo Min Shi Li Fa Gai Shu, Fa lv Chu Ban She 2000 nian Ban, di 1-3, 9 ye.* (《新中国民事立法概述》, 法律出版社2000年版, 第1–3, 9页。) [Angrān Gu, A Brief Introduction to the Civil Law Legislation of the New China 1–3, 9 (2000)].

97. George W. Conk, Translation: A New Tort Code Emerges in China: An Introduction to the Discussion with a Translation of Chapter 8–Tort Liability, of the Official Discussion Draft of the Proposed Revised Civil Code of the People's Republic of China, 30 *Fordham Int'l L.J.* 935 (2007).

98. See *infra* Part V.C.2.

99. Yang, *supra* note 94, at 84–85.

phrase “dispute relating to compensation for injury in medical treatment.”¹⁰⁰ The term “medical accident” was deliberately avoided because of its use under the administrative liability regime.¹⁰¹ The aim was to mark a clear break between the TLL and the 2002 Regulations in the area of medical liability. The 2002 Regulations are still binding on the health administration in its adjudications on administrative liability, but the courts are no longer bound by them.

The relevant chapter of the TLL begins with a general statement of the responsibility of the medical institution both for its own fault and for that of its medical staff. Article 54 of the TLL provides: “If a patient suffers injury in the course of medical diagnosis or treatment, and the medical institution or medical personnel are at fault, the medical institution shall bear compensatory liability.”

This umbrella clause subsumes two specific liabilities for medical fault that the Law goes on to specify, dealing respectively with the breach of medical ethical duties and the breach of medical technical duties. As the provision makes clear, the medical institution’s liability in each case may be either personal (i.e., for its own fault) or vicarious.¹⁰² Additionally, the same chapter of the TLL specifies a separate strict liability for the medical institution as the supplier of medical products. In all, then, the TLL provides for three basic types of liability for injury resulting from medical treatment, and these are now addressed in more detail in the sections below.¹⁰³

100. “Min Shi An Jian An You Gui Ding”, 2007 nian 10 yue 29 ri You Zui Gao Ren Min Fa Yuan Shen Pan Wei Yuan Hui di 1438 ci Hui Yi Tao Lun Tong Guo, Zi 2008 nian 4 yue 1 ri qi Shi Xing. (《民事案件案由规定》, 2007年10月29日由最高人民法院审判委员会第1438次会议讨论通过, 自2008年4月1日起施行) [Regulation on Causes of Action in Civil Cases, promulgated by the Judicial Committee of the SPC on Oct. 29, 2007, effective Apr. 1, 2008]. Following amendment by the SPC on February 18, 2011, Section 351 of the Regulation now treats a dispute relating to compensation for injury in medical treatment as a “tort liability dispute”, with specific recognition of both “disputes relating to liability for infringement of a patient’s right to be informed and to consent” and “disputes relating to liability for medical products.” Both discussed further *infra* Parts V.C.1.a, V.C.1.c.

101. Ai Erken(艾尔肯), Lun Yi Liao Sun Hai, Bei Fang Fa Xue 2008 nian di er qi, di 49 ye. (《论医疗损害》, 《北方法学》2008年第2期, 第49页。) [Erken Ai, On Medical Malpractice, 2 N. Legal Sci.46, 49 (2008)].

102. There is therefore no need to rely on the general provision on vicarious liability in Article 34 of the TLL. On the medical institution’s liability under the TLL for organizational fault, see Gert Brüggemeier, *European Civil Liability Law Outside Europe. The Example of the Big Three: China, Brazil, Russia*, 2 J. Eur. Tort L. 1, 7-8 (2011).

103. Yang, *supra* note 94, at 89.

a. Liability for Breaching Medical Ethical Duties

The first form of medical fault addressed in the TLL is the breach of medical ethical duties. In effect, this recognizes a liability for injury resulting from the failure to obtain informed consent to treatment. Article 55(1) of the TLL establishes the medical ethical duties in the following terms:

In the course of diagnosis and medical treatment, medical personnel shall give the patient an explanation of the nature of his illness and the medical measures proposed. If surgery, special examination, or special therapy needs to be carried out, the medical personnel shall give the patient a timely explanation of the medical treatment risks, alternative medical treatment plans, and other relevant considerations, and get his written permission. If it is not appropriate to give the explanation to the patient, the medical personnel shall give the explanation to the close relatives of the patient and get their written permission.¹⁰⁴

The second paragraph of Article 55 of the TLL provides for liability for breach of the specified duties: “[i]f the medical personnel fail to fulfill the duties in the preceding paragraph, and cause injury to the patient, their medical institution shall bear compensatory liability.” It may be noted that the liability is for “injury,” and not merely the violation of the patient’s civil rights or interests, and that there appears therefore to be no right to compensation for infringement of the patient’s autonomy or dignity in the absence of physical harm or serious emotional harm.¹⁰⁵

b. Liability for Breaching Medical Technical Duties

Article 57 of the TLL is about liability for breaching medical technical duties: “[i]f, in the course of diagnosis or medical treatment, medical personnel fail to fulfill the duty of diagnosis and medical treatment corresponding to the state of medical treatment then and there, and cause injury to the patient, their medical institution shall bear compensatory liability.” As the content of the applicable standard of care (“the duty of diagnosis and medical treatment corresponding to the state of medical treatment then and there,” i.e., at the time and place the treatment was given) is not speci-

104. There is an exception to the above-mentioned information duties in Article 56 when it is impossible to seek the consent of the patient or his or her close relatives: “If, due to an emergency such as saving a patient on the verge of death, it is impossible to seek the consent of the patient or his close relatives, appropriate medical measures can be taken immediately upon approval by the principal of the medical institution or any authorized person.” It should be emphasized that there is no duty on the principal of the medical institution or any authorized person to approve emergency medical measures. So this exception is just a privilege and does not entail a duty to act.

105. See also Wang Zhu (王竹), *Jie Shi Lun Shi Ye Xia de Qin Hai Huan Zhe Zhi Qing Tong Yi Quan Qin Quan Ze Ren, Fa Xue 2011 nian di 12 qi ji jiang fabiao.* [《解释论视野下的侵害患者知情同意权侵权责任》, 《法学》2011年第12期即将发表。] [Zhu Wang, Tort Liability for Infringement on the Right of Informed Consent of Patients under the Framework of Heurematic Law, 12 Legal Sci. __ (forthcoming 2011, 12th Issue)].

fied in the TLL or in other legislation, it becomes a further question for the courts to decide.

c. Liability for Medical Products

The third type of medical liability covered by the TLL is with respect to injuries caused by medical products. Here the liability is strict rather than fault-based—even so far as the medical institution is concerned. However, where the patient claims compensation from the medical institution rather than the manufacturer of the product—or, as the case may be, a supplier of blood for transfusion—it has the right to indemnity from the liable manufacturer or supplier of blood. The reason for what (in international perspective) is a rather unusual strict liability on the medical institution as supplier is the special role played by hospitals in China as suppliers of pharmaceutical products. It is commonly recognized that Chinese hospitals derive a significant proportion of their income from the sale of drugs, and indeed that they profit from excessive and unnecessary sales. This is quite different from the situation in other countries. In fact, drug sales make up about 50 percent of the revenues of most hospitals in China. Taking Shanghai as an example, the total revenue of state-owned hospitals in 2007 was 39 billion RMB, which consisted of: (1) government subsidy of 3.64 billion RMB (9.5%); (2) income from the provision of medical services amounting to 16.94 billion RMB (43%); (3) drug sales amounting to 17.51 billion RMB (45%); and (4) income from other sources of 950 million RMB (2.5%).¹⁰⁶ The percentage of drug sales in the revenues of private hospitals is even higher than that in state-owned hospitals. Overall, the hospital system is the major outlet for the sale of medicines in China. In Shanghai, from 2002 to 2007, hospitals accounted for 79 percent of the drug market, compared with 21 percent comprised by drugstores.¹⁰⁷ In 2009, the market for medicines in China as a whole was 580 billion RMB, of which hospitals accounted for 430 billion RMB (74%) and drugstores only 150 billion RMB (26%).¹⁰⁸ Driven by mutual financial interest with the drug companies, hospitals have become the only sellers of some drugs in China.

106. Wang Shiling(王世玲), Hu Gong Li Yi Yuan Shou Zhi Bao Gao Chu Lu Zhi Xing Yao Pin Ling Cha Jia Que Kou San Shi Yi, 21 Shi Ji Jing Ji Bao Dao 2010 nian 4 yue 14 ri. (《沪公立医院收支报告出炉执行药品零差价缺口30亿》, 《21世纪经济报道》2010年4月14日。)[Shiling Wang, Financial Reports of Public Hospitals in Shanghai: 3 Billion Yuan Government Subsidy Needed to Cover Deficit, 21st Century Rep. (Apr. 14, 2010)], available at <http://health.sohu.com/20100414/n271494256.shtml> (last visited Nov. 9, 2011).

107. *Id.*

108. Shi Chang Gui Mo Zhan Bi Bai Fen Zhi Qi Shi Si Yi Yuan Reng Wei Yao Pin Xiao Shou Zhu Qu Dao, Di Yi Cai Jing Ri Bao 2010 nian 8 yue 30 ri. (《市场规模占比74% 医院仍为药品销售主渠道》, 《第一财经日报》, 2010年8月30日。)[Taking up 74% of the

Article 59 of the TLL accordingly provides for medical institutions to bear liability for defective pharmaceutical products:

If a defect in a drug, sterilizing agent or medical device, or a substandard blood transfusion, causes injury to a patient, the patient may claim compensation from the manufacturer or the blood supplying institution, or may claim compensation from the medical institution. If the patient claims compensation from the medical institution, after the medical institution has paid the compensation, it has the right to claim indemnity from the liable manufacturer or blood supplying institution.

2. Burden of Proof

The new law does not explicitly deal with proof of causation,¹⁰⁹ but makes significant changes in the principles applicable to the proof of fault. The burden of proving fault, or (as the case may be) the absence of fault, on the part of the medical institution is no longer on the hospital or doctor (as it was under the SPC Stipulations on Evidence in Civil Litigation)¹¹⁰ but primarily on the patient. According to the new law, if a patient suffers injury in the course of diagnosis or medical treatment, and the medical institution or its medical personnel are at fault, the medical institution shall bear compensatory liability.¹¹¹ On the other hand, fault on the part of the medical institution is presumed in special circumstances. If a patient is injured, and any of the following circumstances apply, fault on the part of the medical institution is taken to be established unless the medical institution proves the contrary: (1) violation of provisions of laws, administrative regulations, ministerial rules, or other standards regarding diagnosis and medical treatment; (2) concealing or refusing to provide medical record materials related to the dispute; and (3) falsifying, distorting, or destroying medical record materials.¹¹²

Market, Hospitals are still the Main Channel for the Sale of Drugs, First Financial Daily (Aug. 30, 2010)], available at <http://money.163.com/10/0830/01/6FA2PBLC002541TK.html> (last visited Nov. 9, 2011).

109. The concept of cause is left undefined in the TLL, but specific provision is made for cases of causal uncertainty as between alternative defendants (Article 10) and multiple sufficient causal contributions (Article 11). TLL, *supra* note 95. The TLL gives no indication whether the basic notion of cause embraces legal as well as factual causation, nor as to how the line is to be drawn between consequences attributable to the tort and those which are too remote or outside the scope of the risk attributable to the defendant. Chinese scholarship has not yet given significant consideration to the recognition of liability for loss of chance as a means of circumventing difficulties of proof. See also Ken Oliphant, *Uncertain Causes: the Chinese Tort Liability Act in Comparative Perspective*, in *Towards A Chinese Civil Code: Historical and Comparative Perspective* (Chen Lei & C.H. van Rhee eds., forthcoming 2011 or 2012).

110. Several Stipulations of Supreme People's Court on Evidence in Civil Litigation, *supra* note 70, at art. 4(8); see also *supra* Part V.B.2.

111. TLL, *supra* note 95, at art. 54.

112. *Id.* at art. 58.

In fact, this provision is a significantly watered-down version of what was proposed when the reform of tort law was revived in 2008 with the publication of a second draft of the Tort Liability Law (building on the first draft included in the proposal for a Civil Code of 2002). The second draft included a reversal of the burden of proof by which, if a patient's injury appeared to be caused by a diagnosis or medical treatment by medical personnel, a causal relationship between such diagnosis or treatment and the harm suffered by the patient would be presumed unless the medical personnel provided proof to the contrary.¹¹³ This provision was deleted in the third draft of November 6, 2009¹¹⁴ and does not appear in the TLL as enacted. This may be understood as the implicit rejection of presumed causation in the area of medical malpractice. So far as patients are concerned, the new law thus marks a step backwards not only from the presumption of both fault and causation under the approach previously adopted by the SPC, but also (insofar as proof of causation is concerned) from the second draft of 2008.

3. The Identification Procedure

Unfortunately, the TLL does not resolve the controversial question of who should act as the organizer of the identification process it requires. However, just one day before the TLL was to enter into force, the SPC issued a Notice Addressing Several Issues Relating to the Application of the Tort Liability Law¹¹⁵ according to Article 3 of which a people's court applying the TLL in a case where technical identification is required shall itself take responsibility for organizing the process.¹¹⁶ In other words, there should be a judicial identification, not an identification by a committee appointed by the health administration.

4. Assessment of Damages

There is no special provision in the TLL dealing with compensation for injury arising from medical treatment. Consequently, the general approach applicable to compensation for tortious personal injury, found in

113. See Tort Liability Law of P. R. China (second officially discussed edition/Dec. 21, 2008), translated by Zhu Wang and George W. Conk, unpublished [hereinafter Tort Liability Law, second draft Dec. 2008].

114. See Tort Liability Law of P. R. China (third officially discussed edition/Nov. 6, 2009), available at official website of NPC: http://www.npc.gov.cn/npc/xinwen/lfgz/flca/2009-11/06/content_1525914.htm.

115. Notice of Supreme People's Court Addressing Several Issues Relating to the Application of the Tort Liability Law of P. R. China, (promulgated by the SPC, June 30, 2010). (A "Notice" is an informal but binding direction by the SPC to the lower courts.)

116. *Id.* at § III.

Articles 16 to 23 of the Law, is to be followed. Article 16 of the TLL provides:¹¹⁷

One who infringes on the rights or interests of another, and causes physical injury, shall compensate for the reasonable expenses of medical care, nursing, and transportation, etc., for the purposes of therapy and restoring good health, as well as for reduced income due to loss of working time. One who causes disability shall also pay for the cost of prostheses and compensation for disability. One who causes death shall also pay funeral expenses and death benefits.¹¹⁸

The succeeding Articles of the TLL deal (*inter alia*) with compensation on death (Article 18) and compensation for serious emotional damage (Article 22).¹¹⁹

VI. ANOTHER STEP BACKWARDS ON ITS WAY?

The reform of tort liability for medical malpractice in China is still a work in progress, and it seems certain that there will be further reform, whether by incorporation of the rules of tortious liability for medical malpractice in a Civil Code, or a specific enactment on medical treatment or medical malpractice,¹²⁰ or by a comprehensive SPC interpretation that directly addresses all unresolved questions. Whether the direction of such reform will be “forwards” or “backwards” remains to be seen, but our inclination is to think that it will be the latter, if only because the TLL fails to resolve a number of disputed issues related to the four dimensions highlighted for analysis in this paper and, by default, seems to validate solutions favoring the medical community’s interests over those of patients. We now briefly address each of the four in turn, highlighting possible options for further reform.

First, in considering the basis of the cause of action, it seems likely that clarification will be required of the standard of care to which doctors are held in performing their technical duties. The “then and there”¹²¹ medi-

117. *Id.* at § 4.

118. TLL, *supra* note 95, at art. 16.

119. On the damages that may be awarded under the TLL, see Koziol & Zhu, *supra* note 95, at 343-344.

120. Ai Erken & Fang Bo(艾尔肯、方博), *Wo Guo Yi Liao Sun Hai Pei Chang An Jian Fa lv Shi Yong Wen Ti Yan Jiu Bao Gao, He Bei Fa Xue 2010 nian di 2 qi, di 130-131 ye.* (《我国医疗损害赔偿案件法律适用问题研究报告》, 《河北法学》2010年第2期, 第130-131页。) [Erken Ai & Bo Fang, *The Research Report Concerning the Application of Law for the Medical Malpractice Compensation Cases of China*, 2 *Hebei L. Sci.* 121, 130-131 (2010)].

121. See TLL, *supra* note 95, at art. 57; *supra* Part IV.C.1.b. In their translation of the TLL, Yan Zhu and Helmut Koziol use the expression “at the time,” which is the direct translation of the Chinese word. Yan Zhu & Helmut Koziol, *Tort Liability Law of the People’s Republic of China*, 1 *J. Eur. Tort. L.* 362, 370 (Yan Zhu & Helmut Koziol trans., 2010). But in Chinese, “at the time”, usually refers to a given place as well as a given time. The standard is therefore to be understood as

cal standard adopted as the criterion to judge medical misconduct is arguably too imprecise, and should be supplemented with reference to specific factors. In fact, the second draft of the TLL contained a provision (deleted in the final version) which expressly required the court to consider the location of the medical institution, its accreditation, and the qualifications of its medical personnel.¹²² An almost identical provision has now found its way into guidance issued to the local courts in Beijing by the city's Higher People's Court.¹²³ In a country so large and with such substantial differences in healthcare delivery between different areas—especially between urban and rural areas—it is easy to see that such a provision might be considered desirable. However, insofar as it rubber-stamps local practice even if it fails to attain reasonable quality standards, such reform could well be seen as contrary to the interests of patients. Another possible reform adverse to such interests would be the introduction of limits on the liability of medical institutions for defective pharmaceutical products. Arguably, it is unfair to treat medical institutions as sellers (and, as such, strictly liable for defects) in cases of all types. At the least, since blood suppliers in China are non-profit institutions who act in the public interest, there seems to be a case for introducing a cap on their liability in damages. From the patient's perspective, the best that could be said for such a reform is that it would serve to ensure the continued supply of blood for transfusion in the interests of all patients.

Secondly, regarding the burden of proof, the major open question is proof of causation. Under the pre-TLL approach of the SPC, the burden of proving the absence of a causal relationship between the medical treatment and the patient's injury, as well as the absence of medical fault, fell on the hospital.¹²⁴ The TLL puts the burden of proving fault on the patient in most cases—though Article 59 prescribes a set (albeit limited) of factors whose presence raises a presumption of fault—but it does not deal explicitly with the burden of causation, which is not unimportant in medical cases. It seems likely that, in the absence of a specific provision in the TLL, the

referring to local practice, and does not mean (for example) imposing the standards of the big cities on practitioners in remote rural localities.

122. See Tort Liability Law, second draft Dec. 2008, *supra* note 113.

123. Bei Jing Shi Gao Ji Ren Min Fa Yuan Guan Yu Yin Fa "Bei Jing Shi Gao Ji Ren Min Fa Yuan Guan Yu Shen Li Yi Liao Sun Hai Pei Chang Jiu Fen An Jian Ruo Gan Wen Ti de Zhi Dao Yi Jian Shi Xing".

(北京市高级人民法院关于印发《北京市高级人民法院关于审理医疗损害赔偿纠纷案件若干问题的指导意见(试行)》) [Guiding Notice of Beijing Higher People's Court on Several Problems Concerning the Trial of Disputes Arising from Medical Malpractice (for Trial Implementation)] (promulgated by the Judicial Comm. of Beijing Higher People's Court, Nov. 18, 2010).

124. Several Stipulations of the SPC on Evidence in Civil Actions, *supra* note 70, at art. 4(8).

burden of proving causation will follow the ordinary rule, and therefore fall on the plaintiff. It is arguable, however, that a more nuanced approach is necessary to balance the interests of the competing parties, and in particular to make allowance for the information and resource asymmetry that very often obstructs proof of causation. We therefore take the liberty of suggesting that Chinese law should follow the German approach of shifting the burden of proving causation to the hospital in cases of gross negligence in medical treatment.¹²⁵ The serious character of the treatment error provides a reason for moving the risk of causal uncertainty from the patient to the hospital.

Thirdly, we come to the identification process, which is likely to be the most important practical problem relating to medical malpractice suits to arise in the immediate future.¹²⁶ As patients do not trust technical identifications conducted by the health administration, and hospitals do not trust judicial identifications, scholars have suggested the adoption of a combined system.¹²⁷ Judicial identification under the charge of a specified person would be maintained and carried out in a different jurisdiction from that in which the injury occurred in order to avoid any conflict of interest on the part of the local medical association, and any perception that it might be deliberately protecting its members. At the same time, technical identification would be conducted by clinical professionals together with medico-legal experts to guarantee an objective and just identification result. Although such a process involves a duplication of resources, the hope is that it would ultimately command more respect—at least in cases where the two processes come to the same result.

Turning lastly to the assessment of compensation, the principal question awaiting resolution is whether the general approach adopted in the TLL with respect to personal injury leaves room for special rules in the area of medical malpractice. It is quite conceivable that pressure could mount to enact rules limiting the damages recoverable in tort by reference to existing provisions of the Medical Accident Regulations, for example,

125. See Marc Stauch, *The Law of Medical Negligence in England and Germany: A Comparative Analysis* 87–92 (2008).

126. Wang Cheng(王成), Yi Liao Qin Quan Xing Wei Fa lv Gui Zhi de Shi Zheng Fen Xi—Jian Ping “Qin Quan Ze Ren Fa” Di Qi Zhang, *Zhong Guo Fa Xue* 2010 nian di 5 qi, di 116-118 ye. (医疗侵权行为法律规制的实证分析——兼评《侵权责任法》第七章, 《中国法学》2010年第5期, 第116—118页。) [Cheng Wang, *Analysis of Legal Regulation of Medical Tort and Evaluation of Chapter Seven of Tort Law*, 5 *China L.* 113, 116–18 (2010)].

127. Ai Erken & Fang Bo(艾尔肯·方博), Lun Yi Liao Sun Hai Jian Ding Zhi Du, Shi Dai Fa Xue 2009 nian di 5 qi, di 25 ye. (《论医疗损害鉴定制度》, 《时代法学》2009年第5期, 第25页。) [Erken Ai & Bo Fang, *Discussion of the Appraisal System of Medical Malpractice*, 5 *Presentday L. Sci.* 20, 25–26 (2009)].

the apportionment of liability by reference to the respective roles played by the medical fault and the patient's preexisting condition.¹²⁸ As a cap currently applies to compensation for emotional harm in medical malpractice claims brought under the administrative liability regime,¹²⁹ this too could conceivably be adopted for the purposes of liability in tort, if it is considered useful to limit the liability of medical institutions. Neither of these possible reforms would be in the interests of patients.

CONCLUSION

P.R. China faces numerous healthcare challenges in the coming years as it strives to develop an equitable system of universal health care for its citizens. Relative to the magnitude of that task, the development of appropriate mechanisms to provide compensation and accountability with respect to medical injuries is a rather small matter. Yet it is not unimportant. The popular unrest provoked by the perceived unfairness of the liability system in the early years of the present century sat ill with the commitment to "social harmony and stability" that is proclaimed in the opening Article of the new Tort Liability Law.¹³⁰ It is still too early to assess, however, whether the steps taken forwards and backwards, to the left and to the right, as the "dance pattern" of the reform process has slowly unfolded, have adequately balanced the rights and interests of the dancing partners, or to predict what new steps they will be required to learn in the future.

128. See *infra* Part III.B.2.d.

129. *Id.*

130. TLL, *supra* note 95, at art. 1.