

2024

Taiwan's Medical Injury Law in Action

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Recommended Citation

Chih-Ming Liang, Robert B Leflar & Chih-Cheng Wu, *Taiwan's Medical Injury Law in Action*, 38 Emory Int'l L. Rev. 1 (2024).

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TAIWAN'S MEDICAL INJURY LAW IN ACTION

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INTRODUCTION

Medical injury compensation systems in East Asia have only recently received significant attention in the comparative health law literature.¹ Taiwan's systems, for example, are addressed in only a few English-language papers.²

This Article examines Taiwan's medical injury compensation systems in action.³ Part I of this Article sets out Taiwan's current law on the books by introducing statutory grounds for, and a procedural overview of, Taiwan's medical malpractice litigation—both criminal and civil.⁴ Part II presents numerical litigation trends since the late twentieth century.

Part III introduces five key aspects of Taiwan's medical injury compensation systems in action: (a) the connection between criminal and civil claims, a structure giving criminal complainants various advantages to the dismay of the medical profession; (b) informed consent doctrine and practice; (c) third-party expert assessments as key evidence; (d) the burgeoning use of alternative dispute

¹ A number of helpful works are available, however, e.g., *MEDICAL LIABILITY IN ASIA AND AUSTRALASIA* (Vera Lúcia Raposo & Roy G. Beran eds., 2022), https://doi.org/10.1007/978-981-16-4855-7_17 (chapters on China, Hong Kong, Indonesia, Japan, Macao, Malaysia, Singapore, South Korea, Taiwan, other countries in the region); Chunyan Ding & Pei Zhi, *An Empirical Study of Pain and Suffering Awards in Chinese Personal Injury Cases*, 52(3) H.K. L.J. 1194 (2022); Robert B Leflar, *The Law of Medical Misadventure in Japan*, in *MEDICAL MALPRACTICE AND COMPENSATION IN A GLOBAL PERSPECTIVE* 239-273 (Ken Oliphant & Richard W. Wright eds. 2013); Benjamin L. Liebman, *Malpractice Mobs: Medical Dispute Resolution in China*, 113 COLUM. L. REV. 181 (2013); J. Mark Ramseyer, *The Effect of Universal Health Insurance on Malpractice Claims: The Japanese Experience*, 2 J. LEGAL ANALYSIS 621 (2010); Robert B Leflar, "Unnatural Deaths," *Criminal Sanctions, and Medical Quality Improvement in Japan*, 9 YALE J. HEALTH POL'Y L. & ETHICS 1 (2009) [hereinafter *Unnatural Deaths*].

² See, e.g., Kevin Chien-Chang Wu & Ching-Ting Liu, *Medical Malpractice in Taiwan*, in *MEDICAL LIABILITY IN ASIA AND AUSTRALASIA*, *supra* note 1, at 283-308; Ming-Ta Hsieh et al., *Correlation Between Malpractice Litigation and Legislation Reform in Taiwan over a 30-Year Period*, 14 INT'L J. GEN. MED. 1889 (2021); Robert B Leflar, *Discerning Why Patients Die: Legal and Political Controversies in Japan, the United States, and Taiwan*, 22 MICH. ST. INT'L L. REV. 777 (2014); Kuan-Yu Chen et al., *Medical Malpractice in Taiwan: Injury Types, Compensation, and Specialty Risk*, 19 ACAD. EMERGENCY MED. 598 (2012).

³ Information presented in this paper comes from literature reviews, government statistics, secondary sources (e.g., statistical analyses of court decisions conducted by individual scholars), and face-to-face interviews with Taiwan's health minister, judges, prosecutors, attorneys, physicians, scholars, and other citizens.

⁴ English translations of Taiwanese statutes are those employed in the Laws & Regulations Database of the Republic of China (Taiwan) (全國法規資料庫, *quan guo fa gui zi liao ku*), <https://law.moj.gov.tw/ENG/Index.aspx>, unless otherwise noted. Where the official translation is flawed, we offer our preferred translation, adding an explanatory parenthetical.

Taiwanese court cases are available on the Judicial Yuan Legal Data Search System (司法院法學資料檢索系統, *si fa yuan fa xue zi liao jian suo xi tong*), <https://judgment.judicial.gov.tw/FJUD/default.aspx>. Except for constitutional interpretations, no official English translations exist for court judgments; all translations are ours. We employ an exchange rate of thirty New Taiwan Dollars = one U.S. Dollar, a rate typical of the time period covered.

resolution to avoid litigation; and (e) the role of no-fault administrative injury compensation funds. Part IV examines the system's economics: how lawyers are paid and how payments of compensation are made. Part V discusses the politics behind major reform efforts regarding medical liability, such as the 2017 amendments to Article 82 of the Medical Law and the 2022 law reforming the medical dispute resolution system. Part VI summarizes and concludes.

I. MALPRACTICE LAW, CRIMINAL AND CIVIL: ON THE BOOKS AND IN ACTION

Part I first addresses Taiwan's judicial structure as a civil law nation, perhaps unfamiliar to readers with a common-law background, and the statutory criminal and civil grounds for medical injury liability. Next, Part I explains the elements of "negligence" in both criminal and civil law, a perplexing and controverted field. Finally, Part I sets out the procedures of Taiwanese law in both civil and criminal litigation.

A. *Judicial Structure and the Law on the Books*

Taiwan's judicial branch, the Judicial Yuan (司法院, *si fa yuan*), has three components: the Constitutional Court, the Supreme Court that oversees civil and criminal matters, and the Supreme Administrative Court that hears appeals from administrative agencies. The court structure overseen by the Supreme Court is most relevant to the doctrine and practice of medical injury law. This court structure has three levels: the district courts (地區法院, *di qu fa yuan*), a single High Court (高等法院, *gao deng fa yuan*) with regional branches, and the Supreme Court (最高法院, *zui gao fa yuan*).⁵

⁵ Taiwan, like many civil law nations, does not have an American-style precedent system. Opinions of higher courts do not have binding effect on lower court judges, and the only court that has precedential power is the Constitutional Court of the Judicial Yuan (司法院憲法法庭, *si fa yuan xian fa fa ting*), which performs the function of judicial review. For an overview of the development of the Constitutional Court's judicial review power in the late twentieth century, see generally Tom Ginsburg, *Confucian Constitutionalism? The Emergence of Constitutional Review in Korea and Taiwan*, 27 *LAW & SOC. INQUIRY* 763, 768-778 (2002).

Taiwan's legal system until recently operated under the *pan-li* system. The characters *pan-li* (判例) are usually translated as "precedent." However, "*pan-li*" actually refers to excerpts of judgments selected by the Supreme Court only on questions of law, without accompanying facts. A *pan-li* was not legally binding but had a *de facto* effect. For example, parties could use a lower court's deviation from a *pan-li* as a basis for appeal.

Due to concern that *pan-li* violate judicial independence, the system was recently abolished. In its place, in 2019, Taiwan established the Grand Chamber system, which allows the Supreme Court and the Supreme Administrative Court to hold special sessions called the Grand Chamber to settle inconsistencies of opinions among different divisions within both Courts. The new system, however, still is legally binding only for the case in dispute, without having general precedential effect. See Fayuan Zuzhi Fa (法院組織法) [Court Organization Act] art. 51-1 & 51-10 (Taiwan), translated in FAWUBU FAGUI ZILIAOKU (Laws and Regulations Database of

Three features of this structure are noteworthy. First, unlike the United States, where medical malpractice litigation (with uncommon exceptions) takes place in civil courts, in Taiwan medical malpractice complainants often turn to both criminal and civil law since both criminal and civil codes sanction “negligence” causing death or injury. Second, most criminal cases involving injuries due to medical negligence may be appealed only to the High Court, while those involving death may be further appealed to the Supreme Court.⁶ Third, unlike appellate procedure in the United States but comparable to that in Japan,⁷ the High Court is allowed to review new evidence in both civil and criminal cases. The appellate process is essentially viewed as a retrial, and parties may submit new evidence for the appellate court’s review.⁸

Taiwan is a civil law nation; as a formal matter, common-law judges’ law-making powers do not come into play.⁹ So legal analysis must begin with the applicable provisions of the criminal and civil codes. In significant respects, Taiwanese medical injury compensation law draws on Japanese and European law.¹⁰

the Republic of China (Taiwan)), <https://law.moj.gov.tw/ENG/Index.aspx>; Xingzheng Fayuan Zuzhi Fa (行政院組織法) [Administrative Court Organization Act] art. 15-1 (Taiwan), translated in FAWUBU FAGUI ZILIAOKU (Laws and Regulations Database of the Republic of China (Taiwan)), <https://law.moj.gov.tw/ENG/Index.aspx>.

⁶ Code of Criminal Procedure art. 376 (Taiwan). Article 376 does provide an exception to the appealability limitation when “the judgment of the first instance court was not-guilty, exempt-from-prosecution, dismissal-from-prosecution, or jurisdictional error, and is revoked by the second instance court and a guilty ruling is pronounced.” *Id.* This exception rarely comes into play. From 2004 to 2019, only four defendants used this exception to appeal to the Supreme Court. See Tongji Nianbao (統計年報) [Annual Statistical Report], JUDICIAL YUAN, <https://www.judicial.gov.tw/tw/np-1260-1.html> (last visited Oct. 20, 2023).

⁷ MINJI SOSHŌHŌ [MINSHŌHŌ] [C. CIV. PRO.] 1996, art. 297–298 (Japan) (providing that the provisions for first instance (trial) procedure are applicable in the appellate procedure as well).

⁸ Code of Criminal Procedure art. 373 (Taiwan). Although prosecutors usually rely on the evidence used at the district court trial, this procedural design increases the possibility of reversal and remand and contributes to the prolongation of medical malpractice litigation. A 2000 Taipei District Court criminal case, for example, was reversed and remanded by the High Court five times. Taipei Difang Fayuan 89 Niandu Su Zi Di 358 Hao Xingshi Panjue (臺北地方法院89年度訴字第358號刑事判決) [Taipei District Court Su Zi No. 358 Criminal Decision of 2000] (Taipei Dist. Ct. 2002) (Taiwan).

⁹ In the interpretation of ambiguous statutes and the filling of statutory gaps, Taiwanese judges do exercise law-making functions. For instance, in the context of medical negligence, key concepts such as “medical norm,” “medical standard,” and “reasonable professional clinical discretion” all originated from judicial practice without clear statutory bases. The evolution of these concepts is discussed in Part I.B *infra*.

¹⁰ The criminal aspect of Taiwanese medical injury compensation law bears a resemblance to German criminal law. *E.g.*, STRAFGESETZBUCH [STGB] [PENAL CODE] §§ 222, 229, https://www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html (Ger.) (negligent homicide and negligent bodily injury); see generally Marc S. Stauch, *Medical Malpractice and Compensation in Germany*, 86 CHI. KENT. L. REV. 1139 (2011). As for the civil side, the Civil Code was first enacted before the Kuomintang (the Nationalist Party) regime lost the Chinese civil war and relocated to Taiwan in 1949. The original Civil Code was heavily

The chief statutory grounds for criminal medical liability are the crimes of negligence causing death (過失致死, *guo shi zhi si*) and negligence causing injury (過失致傷, *guo shi zhi shang*), governed by Articles 276 and 284 of the Criminal Code (刑法, *xing fa*).¹¹

In civil cases, both delivery of substandard healthcare and failure to obtain legally sufficient informed consent are available causes of action, and either can be based on both tort and contract grounds.¹² The main statutory grounds for tort liability are Articles 184 (against individual providers as tortfeasors) and 188 (against healthcare institutions as employers) of the Civil Code (民法, *min fa*), while Articles 227 (against healthcare institutions as contracting parties) and 224 (healthcare institutions as contracting parties shall be responsible for the intentional or negligent acts of their employees to the same extent as they are responsible for their own intentional or negligent acts) provide contract law grounds for civil medical liability.¹³ The doctrinal structure of the civil causes of action is displayed in Diagram 1.¹⁴

influenced by Japanese law, which in turn was modeled on European law. For the historical background, see Tai-Sheng Wang (王泰升), *Taiwan de Ji Shou Oulu Minfa: Cong Jingyou Ri Zhong Liang Guo Dao Zizhu Caize (臺灣的繼受歐陸民法：從經由日中兩國到自主採擇)* [*Legal Transplantation of European Civil Law in Taiwan—From Indirect Influence by China and Japan to Autonomous Incorporation*], 68 L. MONTHLY (法令月刊) 1, 7–8 (2017) (discussing the influence of Japanese and European law on the original Civil Code enacted by the Kuomintang government).

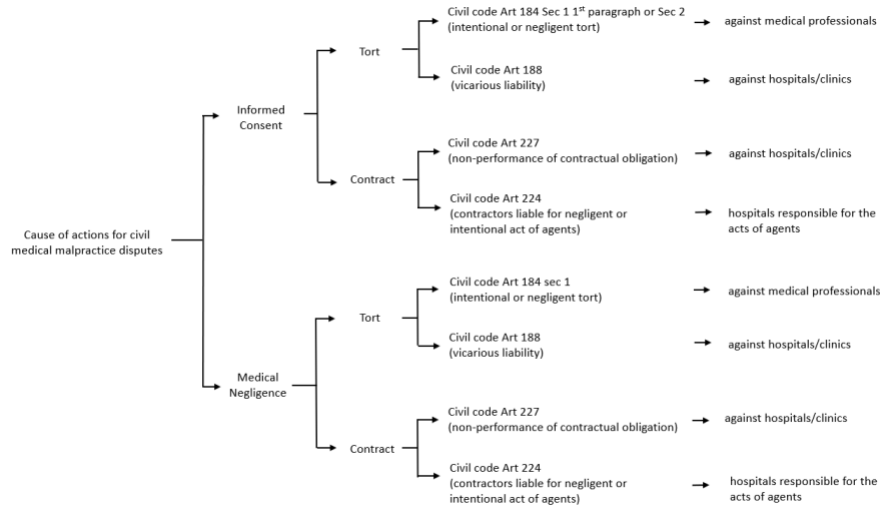
¹¹ See Crim. Code art. 276, 284 (FAWUBU FAGUI ZILIAOKU) (Taiwan). These provisions have been central to medical professionals' dissatisfaction with the state of the law.

These provisions used to contain a subcategory of “professional negligence” (業務過失, *yewu guoshi*) that applied to medical malpractice cases. In 2019, the legislature abolished the concept of professional negligence, and the same negligence concept, at least formally, now applies to all defendants.

¹² Taiwanese courts conventionally hold that medical contracts exist between patients and healthcare institutions, which include hospitals and clinics. The idea can be traced back to at least around the millennium. For example, in *Zuigao Fayuan 90 Niandu Tai Shang Zi Di 468 Hao Minshi Panjue* (最高法院90年度台上字第468號民事判決) [Supreme Court No. 486 Civil Decision of 2001] (Taiwan S. Ct. March 22, 2001), the Court held that the patient and the defendant hospital had entered into a medical contract, and the defendant was held liable on the basis of contractual non-performance.

¹³ In some cases, courts seemed to adopt a concept of corporate negligence by holding hospitals independently liable, regardless of whether individuals committed negligence. In *Zuigao Fayuan 107 Niandu Tai Shang Zi Di 1593 Hao Minshi Panjue* (最高法院107年度台上字第1593號民事判) [Supreme Court No. 1593 Civil Decision of 2018] (Taiwan S. Ct. Oct. 9, 2018), for example, the hospital was held independently liable for failing to meet its contractual obligation to establish proper policies and procedures to inform patients of potentially dangerous test results or diagnoses even after they were discharged from the hospital. The predominant judicial practice, however, remains that the existence of individual negligence is a prerequisite to organizational liability.

¹⁴ Civil Code art. 184, 188, 227, 224 (FAWUBU FAGUI ZILIAOKU) (Taiwan).

Diagram 1: Doctrinal structure of civil causes of action

B. The Elements of “Negligence”

To establish negligence in both criminal and civil law, two key elements are a deviation from the duty of care¹⁵ and the existence of legal causation.¹⁶ In

¹⁵ In criminal law, the role of duty of care in establishing negligence is provided in Article 14 of the Criminal Code. The Civil Code provides no direct definition of negligence, instead relying on judicial and scholarly interpretation to draw its connection with duty of care. The definition of negligence in both criminal and civil law is discussed below.

¹⁶ The dominant theory of causation in Taiwan is the “adequate causation” theory (相當因果關係, *xiang dang yin guo guan xi*). The theory’s origin is often traced to Zuigao Fayuan 76 Niandu Tai Shang Zi Di 192 Hao Xingshi Panjue (最高法院76年度台上字第192號刑事判決) [Supreme Court No. 192 Criminal Judgment of 1987] (Taiwan S. Ct. Jan. 16, 1987), in which the Court explained that adequate causation exists when “the court, based on the rule of experience and considering all facts existing at the time of the action . . . believes that in ordinary situations, the same circumstances with similar factual conditions will lead to the same result.” *Id.* In the context of medical malpractice law, courts predominantly rely on the Medical Review Committee (MRC) assessment report to determine whether medical interventions “under the same circumstances with similar factual conditions will lead to the same result.” See *infra* Part III.C for a discussion of how MRCs work. One experienced prosecutor suggested that judges require stricter proof of causation in criminal than in civil cases. Interview with Prosecutor Fang-Yu Lin, Taichung, Jan. 5, 2023.

The adequate causation theory is binary in the sense that the court can only decide whether adequate causation exists or not. Recently in the field of medical malpractice law, debate has arisen on whether more proportional

principle, the burden is on the plaintiff to prove that these elements exist.¹⁷ As exceptions, Article 277 of Taiwan’s Code of Civil Procedure states that when “the law provides otherwise” or when “the circumstances render it manifestly unfair,” courts have the authority to reduce or shift the burden of proof.¹⁸ In the context of medical malpractice cases, courts have modified the burden of proof in a small but meaningful number of cases, including some that are high-profile.¹⁹ In Shen and Chuang’s study, courts in thirty-three out of 657 (5%) district court cases and eleven out of 299 (4%) High Court civil cases from 2000

theories of causation, such as the loss-of-chance theory in American law and the significant possibility of survival theory in Japan (相当程度の生存の可能性), should be allowed. *Zuigao Fayuan 107 Niandu Tai Shang Zi Di 624 Hao Minshi Panjue* (最高法院107年度台上字第624號民事判決) [Supreme Court No. 624 Civil Judgment of 2018] (Taiwan S. Ct. May 11, 2018), for example, held that the plaintiff’s ten-year survival rate dropped seventeen percent due to the defendant physician’s misdiagnosis of malignant thymoma, which in turn served as the basis for calculating the size of plaintiff’s economic damages. The Court’s reasoning in that case may be influenced by Taiwanese scholars introducing the loss-of-chance theory in recent years. *See, e.g.,* Tsung-Fu Chen (陳聰富), ‘Cunhuo Jihui Sangshi’ zhi Sunhai Peichang (「存活機會喪失」之損害賠償) [*Damage Compensation from Loss-of-Chance*], 8 CHUNG YUAN FIN. ECON. L. REV. (中原財經法學) 65, 112 (2002) (arguing that lost chance of survival should be compensable).

¹⁷ Code of Civil Procedure art. 277 (FAWUBO FAGUI ZILIAOKU) (Taiwan) (“A party bears the burden of proof with regard to the facts which he/she alleges in his/her favor, except either where the law provides otherwise or where the circumstances render it manifestly unfair.”).

¹⁸ *Id.*

¹⁹ Courts in applying Article 277 often interpret it as a response to modern tort cases. Examples include toxic torts, traffic incidents, product liability, and medical malpractice litigation. In some of these cases, courts have viewed that the general principle that plaintiffs are responsible for proving facts advantageous to them may lead to unfair and unjust outcomes due to the complexity and high-tech nature of these cases. *See, e.g.,* *Zuigao Fayuan 103 Niandu Tai Shang Zi Di 1311 Hao Minshi Panjue* (最高法院103年度台上字第1311號民事判決) [Supreme Court No. 1311 Civil Judgment of 2014] (Taiwan S. Ct. July 2, 2014); *Zuigao Fayuan 101 Niandu Tai Shang Zi Di 1809 Hao Minshi Panjue* (最高法院101年度台上字第1809號民事判決) [Supreme Court No. 1809 Civil Judgment 2012] (Taiwan S. Ct. Nov. 7, 2012).

For example, the court switched the burden of proof to the defendant in Supreme Court No. 227 Civil Judgment of 2017, in which the wife of a retired High Court judge fell, hit her head, and later died while under hospital observation. *Zuigao Fayuan 106 Niandu Tai Shang Zi Di 227 Hao Minshi Panjue* (最高法院106年度台上字第227號民事判決) [Supreme Court No. 227 Civil Judgment of 2017] (Taiwan S. Ct. March 29, 2017). In that highly publicized case, the Court did not refer to Article 227 but seemingly adopted the German theory of “gross treatment error” (*großer Behandlungsfehler*) as the basis for the shift. *Id.* The Court stated that the personnel in the hospital, a top-rated medical center, did not properly keep records of the patient’s vital signs, which the Court viewed as a gross treatment error. *Id.* The Court held that such an error was the key reason that the cause of death later became “ensnarled and difficult to discern” (糾結而難以釐清, *jiu jie er nan yi li qing*), and that it should not be the plaintiffs who bear the consequence of this flaw. *Id.* The German theory of “gross treatment error” was introduced by Justice Sheng-Lin Jan of the Constitutional Court in his early career as a civil law scholar. *See* Sheng-Lin Jan (詹森林), *Deguo Yiliao Guoshi Juzheng Zeren Zhi Yanjiu* (德國醫療過失舉證責任之研究) [*Burden of Proof in German Medical Malpractice*], 63 TAIPEI U. L. REV. (臺北大學法學論叢) 47, 70–74 (2007).

to 2009 explicitly switched the burden to defendants to prove no deviation from the duty of care; the burden shift on the causation issue was even less frequent.²⁰

Among the elements of proof of negligence, criteria for determining a deviation from the duty of care have long occupied the center stage of scholarly and policy debate on medical malpractice. The only statutory definition of negligence is provided in the Criminal Code.²¹ Article 14 § 1 stipulates that “[a] conduct is committed negligently if the actor fails, although not intentionally, to exercise his duty of care that he should and could have exercised in the circumstances.”²² This definition is often shortened into the phrase “should’ve cared, could’ve cared, but didn’t care” (應注意，能注意而不注意, *ying zhu yi*, *neng zhu yi er bu zhu yi*).²³

The wording of Criminal Code Article 14 § 1 does not distinguish among different levels of negligence. Accordingly, many criminal law scholars believe that there is little interpretive space for a more stringent standard, such as gross negligence. In practice, however, Chih-Cheng Wu and Mei-Chun Yeh found that more than ninety percent of criminal cases in which medical defendants were held criminally liable involved medical interventions that, from the perspective of physician reviewers recruited by the study, could be characterized as involving *zhong da guo shi* (重大過失), which roughly translates as gross negligence.²⁴ Many background factors may have contributed to this

²⁰ See Kuan-Ling Shen (沈冠伶) & Ching-Hsiu Chuang (莊錦秀), *Minshi Yiliao Susong Zhi Zhengming Faze Yu Shiwu Yunzuo* (民事醫療訴訟之證明法則與實務運作) [*Evidence Law and Empirical Study in Medical Malpractice Litigation*], 127 CHENGCHI U. L. REV. (政大法學評論) 165, 205–209 (2012).

²¹ Crim. Code art. 14 § 1 (FAWUBU FAGUI ZILIAOKU) (Taiwan). See Part VII, the Statutory Appendix for English translations.

²² *Id.*

²³ For example, a High Court decision in 2012 found a defendant physician guilty for failing to conduct a transvaginal ultrasonography to detect ectopic pregnancy. Taiwan Gaodeng Fayuan Gaoxiong Fenyuan 101 Niandu Yi Shangsuzi Di 1 Hao Xingshi Panjue (臺灣高等法院高雄分院101年度醫上訴字第1號刑事判決) [Taiwan High Court Kaohsiung Branch Court Yi Shang Su Zi No. 1 Criminal Judgment of 2012] (Taiwan High Ct. Apr. 27, 2012). The court stated that one of the defendant physicians “displayed negligence in his medical practice in that he should have cared, could have cared, but did not care.” *Id.*

²⁴ See Chih-Cheng Wu (吳志正) & Mei-Chun Yeh (葉眉君), *Yiliao Xing Ze Guoshi Chengdu Zhi Fa Shizheng Fenxi: Dui Yiliao Xing Ze Helihua Zhi Xing Si* (醫療刑責過失程度之法實證分析：對醫療刑責合理化之省思) [*Evidence-Based Study on the Pattern of Negligence in Medical Crimes: With Special Reference to the Amendment Draft of the Medical Care Act*], 47 NAT’L TAIWAN U. L. J. (臺大法學論叢) 1125, 1137–40 (2018). Wu & Yeh’s research design asked physician reviewers to decide whether physician behaviors in each case constituted an intentional offense, a reckless offense, gross negligence, or ordinary negligence. *Id.* Because the Taiwanese criminal code does not incorporate the concept of gross negligence, the research further asked reviewers to choose among three possible definitions of this concept, so as to understand how this concept is commonly perceived by the Taiwanese medical community. *Id.* These definitions included (1) mistakes that physicians who have passed the national exam can easily avoid by paying just slight attention; (2) mistakes that

development. Among them, Wu and Yeh surmised that the doctrine requiring strict evidence (嚴格證據法則, *yan ge zheng ju fa ze*) in criminal law may nudge judges toward hesitancy in finding that the evidence presented proved the existence of negligence.²⁵ Wu and Yeh also suggested that outside experts offering expert assessment often are much more conservative in criminal cases. Since Taiwanese courts when determining physician negligence usually defer to such expert opinions, the overall result has arguably tilted toward a standard similar to gross negligence in criminal cases, despite the lack of statutory basis for such a heightened standard.²⁶

Unlike the Criminal Code, the Civil Code lacks a specific statutory definition of negligence.²⁷ Instead, civil law jurisprudence through judicial interpretation and scholarly debate has developed various levels of duty of care.²⁸ The duty in medical malpractice cases is commonly associated with *the duty of care of a good administrator* (善良管理人注意義務, *shan liang guan li ren zhu yi yi wu*), which in turn is somewhat ambiguously defined as the level of care that, according to ordinary business customs, a person with “certain knowledge, experience, and sincerity” (相當知識經驗及誠意, *xiang dang zhi shi jing yan ji cheng yi*) should be able to meet.²⁹

physicians in the same specialty almost never make or physician behaviors that seriously deviate from the medical norm; and (3) mistakes the seriousness of which clearly exceeds the supposed scope of clinical physician discretion. *Id.*

²⁵ *Id.* at 1154. Wu & Yeh view the doctrine as requiring proof of a higher level of probability in criminal cases. *Id.* They suggest that judges require a 90% probability of guilt—comparable to the “beyond reasonable doubt” standard. *Id.*

²⁶ *Id.* at 1159.

²⁷ The basic doctrinal framework for negligence was laid out as early as 1953 by the Supreme Court in a *pan-li* (判例) excerpted from *Zuigao Fayuan 42 Niandu Tai Shang Zi Di 865 Hao Minshi Panjue* (最高法院42年度台上字第865號民事判決) [Supreme Court No. 865 Civil Judgment of 1953] (Taiwan S. Ct. July 31, 1953), which stated that “[i]n civil law, negligence is categorized based on the degree of lack of care, which can be divided into abstract negligence (抽象輕過失, *chou xiang qing guo shi*), specific negligence (具體輕過失, *ju ti qing guo shi*), and gross negligence (重大過失, *zhong da guo shi*).” On the difference between the *pan-li* system and U.S.-style precedents, *see supra* note 5.

Among these categories, abstract negligence is further defined as the duty of care of a good administrator, while specific negligence is defined as the duty of care to handle one’s own affairs. The term “the duty of care of a good administrator” appears seven times in the Civil Code, “the duty of care to handle one’s own affairs” appears five times, while “gross negligence” appears eighteen times. However, no statutory definition is given for these concepts.

²⁸ *Id.*

²⁹ *Id.* A medical contract is generally viewed as a contract of mandate (委任契約, *wei ren qi yue*). Under Civil Code Article 535, the party “who deals with the affair commissioned, shall [act] in accordance with the instructions of the principal and with the same care as he would deal with his own affairs. If he has received remuneration, he shall do so with *the care of a good administrator*.” Civil Code art. 535 (FAWUBU FAGUI ZILIAOKU) (Taiwan) (emphasis added).

Regardless of statutory or jurisprudential definitions, in practice, Taiwanese courts in both criminal and civil cases have mainly relied on the judicially developed concepts of “medical norm” (醫療常規, *yi liao chang gui*) and “medical standard” (醫療水準, *yi liao shui zhun*) as the key criteria to determine whether the duty of care has been breached in specific cases.³⁰ Originally “medical norm” was the master concept that attempted to capture widely accepted best medical practice.³¹ The Official Handbook for Physicians Conducting Preliminary Assessment for Medical Disputes (醫事糾紛鑑定初鑑醫師指引手冊) (hereinafter the “Preliminary Assessment Handbook”) defines “medical norm” as the “common norm formulated in clinical care through medical custom, logic, or experience.”³² The Preliminary Assessment Handbook further lists four elements of a “medical norm”: whether the healthcare service in dispute is accepted (適應性, *shi ying xing*), appropriate (適正性, *shi zheng xing*), practical (實踐性, *shi jian xing*), and ethical (倫理性, *lun li xing*).³³

“Medical standard,” on the other hand, was originally intended to be a concept subordinate or supplementary to “medical norm.” The term “medical standard” is a legal transplant from Japan that attempts to capture the different levels of personnel, skill, and equipment capacity possessed by different levels of hospitals.³⁴ The Preliminary Assessment Handbook states that “[w]hether the

³⁰ In the Judicial Yuan Court Judgment database, which contains all court decisions since the mid-1990s, the use of “medical norm” as part of court reasoning began as early as 1997. Judicial Yuan Legal Data Search System, *supra* note 4. In the Supreme Court No. 1731 Civil Judgment of 1997, for example, the Court mentioned that “according to the medical norm at the time, for cataract surgery, it is common to combine extracapsular excision with implantation of posterior chamber intraocular lens to reduce post-surgery complications.” *Zuigao Fayuan 86 Niandu Tai Shang Zi Di 1731 Hao Minshi Panjue* (最高法院86年度台上字第1731號民事判決) [Supreme Court No. 1731 Civil Judgment of 1997] (Taiwan S. Ct. May 30, 1997). Similarly, the term “medical standard” can also be observed in the 1990s. However, the terms “medical norm” and “medical standard” appeared nowhere in the statutes until Article 82 of the Medical Care Act was amended in 2017, as discussed below.

³¹ TAIWAN JOINT COMMISSION ON HOSPITAL ACCREDITATION, THE OFFICIAL HANDBOOK FOR PHYSICIANS CONDUCTING PRELIMINARY ASSESSMENT FOR MEDICAL DISPUTES 11 (4th ed. 2013).

³² *Id.*

³³ *Id.* at 11–12. The Preliminary Assessment Handbook further defines each of these four conditions. “Accepted” means the medical interventions are necessary and adequate for the purpose of maintaining or improving patient health. *Id.* “Appropriate” means the interventions are conducted in ways ordinarily recognized by medical sciences that meet the medical standard at the time and location. *Id.* “Practical” means the interventions are generally recognized by clinical medical practice in the same level of hospitals and same class of specialty physicians. *Id.* Finally, “ethical” means the interventions must be consistent with the four universally embraced principles of medical ethics: respect for autonomy, non-maleficence, beneficence, and justice. *Id.*

³⁴ Common reasoning when the court applies the term “medical standard” is as follows: “Due to the special nature of medical practice, a certain degree of risk should be tolerated. Therefore, the determination of breach of duty of care should be made against the medical standard displayed by the practice of clinical medicine at the time of the disputed behaviors. In principle, medical centers should be held to a higher medical standard than

medical practice being assessed adheres to the medical norm should mainly be judged by the medical standard at the time and location of the healthcare delivery.”³⁵ In evaluating the medical standard, the physician “should take into account, in a comprehensive way, the differences in healthcare institutions, facilities, professional knowledge, clinical experience, and feasibility of consulting other physicians.”³⁶

In recent years, courts have attempted to clarify the concepts of “medical norm” and “medical standard,” sometimes in ways that deviate from the Preliminary Assessment Handbook. For example, two Supreme Court civil cases in 2017 rejected the traditional construction of “medical norm” as the master concept and instead adopted the dichotomy of local custom versus national standard, analogous to the dichotomy developed in the U.S. in *Hall v. Hilbun*³⁷ and similar decisions. In both 2017 cases, the Court equated “medical norm” to medical custom (醫療慣習, *yi liao guan xi*), comparable to the concept of local custom in the U.S., and concluded that meeting the medical norm (i.e., medical custom) does not necessarily qualify the medical intervention as non-

regional hospitals, which in turn should be held to a higher medical standard than local hospitals, with clinics subject to a still lower standard . . . The medical standard of medical centers should not be treated as a universal criterion.” Zuigao Fayuan 97 Niandu Tai Shang Zi Di 2346 Hao Xingshi Panjue (最高法院97年度台上字第2346號刑事判決) [Supreme Court No. 2346 Criminal Judgment of 2008] (Taiwan S. Ct. May 30, 2008). This reasoning is consistent with how the Preliminary Assessment Handbook describes “medical standard.” TAIWAN JOINT COMMISSION ON HOSPITAL ACCREDITATION, *supra* note 31, at 11.

Scholars often connect this reasoning with the opinion of the Japanese Supreme Court in the 高山日赤事件 (*gao shan ri chi shi jian*) decision in 1982 and the 姫路日赤事件 (*ji lu ri chi shi jian*) decision in 1995. See Chien-Yu Liao (廖建瑜), *Yiliao Shuizhu Yu Yiliao Guanxing Zhi Zhuyi Yiwu* (醫療水準與醫療慣行之注意義務) [Medical Standards and Customary Medical Duty of Care], 10 ANGLE HEALTH L. REV. (月旦醫事法報告) 86, 88–90 (2017) (arguing that the way “medical standard” is being interpreted in court judgments and relevant regulations in Taiwan is consistent with the view developed by the Japanese Supreme Court in these two cases); TSUNG-FU CHEN (陳聰富), *Yiliao Zeren de Xingcheng Yu Zhankai* (醫療責任的形成與展開) [FORMATION AND EVOLUTION OF MEDICAL LIABILITY], 337–40 (2014) (pointing to the 1982 decision as the origin of the medical standard concept in Japan); Saikō Saibansho [Sup. Ct.] March 30, 1982, 135 SAIBANSHO MINJI HANREISHŪ [MINSHŪ] 563, 468 HANREI TAIMUZU [HANTA] 76 (Japan) (holding that 医療水準 *iryō suijun* (“medical standard”) at the time of care delivery is the proper standard for determining the duty of care); Saikō Saibansho [Sup. Ct.] June 9, 1995, 49 SAIBANSHO MINJI HANREISHŪ [MINSHŪ] 1499, 883 HANREI TAIMUZU [HANTA] 92 (Japan) (explaining “medical standard”).

³⁵ TAIWAN JOINT COMMISSION ON HOSPITAL ACCREDITATION, *supra* note 31. The same page also mentions that courts should look into the professional ability of individual providers. *Id.* Compared to “medical norm” and “medical standard,” however, this criterion is rarely mentioned in court judgments.

³⁶ *Id.*

³⁷ *Hall v. Hilbun*, 466 So.2d 856 (Miss. 1985). The case challenged the then-dominant reliance on local custom in U.S. medical malpractice cases and developed the concept of a national standard regarding medical education and training, opening up the courtroom for expert testimony from outside the local community.

negligent.³⁸ Rather, providers must also meet the higher threshold of “medical standard,” comparable to the national standard for education and training laid out in cases such as *Hall v. Hilbun*, to avoid liability.³⁹

The Court in these two 2017 civil cases also attempted to clarify “medical standard” by listing numerous factors that judges should consider such as medical knowledge at the time; the benefit and risk of the intervention and the cost of preventing the damage; levels, facilities, and capacities of the hospital; professional training of the personnel and scheduling of work; the number of patients awaiting treatment, etc.⁴⁰ The ambiguity inherent in these attempts at clarifying what constitutes “negligence” served as a major factor in the Legislative Yuan’s December 2017 amendment to Article 82 of the Medical Care Act, discussed below.⁴¹

C. Procedures in Civil and Criminal Medical Malpractice Litigation

Diagram 2 simplifies the civil and criminal procedures of medical malpractice litigation.⁴² We highlight several procedural points. First, when cases have reached judges and prosecutors, represented by the three star signs in the diagram, judges and prosecutors routinely request expert assessment opinions (鑑定意見, *jian ding yi jian*) from outside medical experts, usually by the Medical Review Committee (MRC, 醫事審議委員會, *yi shi shen yi wei yuan hui*) under the Ministry of Health and Welfare.⁴³ These reviews of medical records by outside experts typically constitute the key evidence in the case.

³⁸ Supreme Court No. 227 Civil Judgment of 2017, *supra* note 19; Zuigao Fayuan 106 Niandu Tai Shang Zi Di 1048 Hao Minshi Panjue (最高法院106年度台上字第1048號民事判決) [Supreme Court No. 1048 Civil Judgment of 2017] (Taiwan S. Ct. Aug. 8, 2017).

³⁹ In Supreme Court No. 227 Civil Judgment of 2017, *supra* note 19, for instance, the Court reasoned that “[m]edical norm’ is the lowest bar that medical practices need to clear. Physician practices that follow the medical norm do not always meet the (legally required) duty of care set by the medical standard.” (parenthesis added)

⁴⁰ *Id.*

⁴¹ *See infra* Part V.C.1.

⁴² The option for private criminal prosecutions used to allow self-representation. However, a 2003 revision of the Code of Criminal Procedure added Article 319 § 2, stating that “[a]n attorney shall be retained to file a private prosecution . . .” Code of Criminal Procedure art. 319 § 2 (FAWUBO FAGUI ZILIAOKU) (Taiwan). Legal representation, therefore, is now legally required for filing private criminal prosecutions. There is no such requirement for filing civil complaints, whether preceded by criminal complaints or not. However, considering the complexity of medical malpractice cases, the plaintiff’s best interest in civil cases is generally to seek legal counsel.

⁴³ Physicians account for about two-thirds of the committee members. The remaining third are professionals from other backgrounds, usually legal scholars. Article 100 of the Medical Care Act states: “Members of the medical review committee . . . shall include medical experts, legal experts, scholars, and social

Second, in the United States, if the prosecutor decides not to file an indictment, that is usually the last step in the criminal process.⁴⁴ In Taiwan, however, if the prosecutor does not indict the defendant, patients or families have the procedural options first to seek superior prosecutors to reconsider (再議, *zai yi*) and, if that fails, to request the court to take up the case as a criminal matter (交付審判, *jiao fu shen pan*).⁴⁵ The number of medical malpractice cases reaching trials through this procedural route is relatively small but by no means negligible.

Third, as in some other civil code nations such as France⁴⁶ and Germany,⁴⁷ complainants seeking redress under the Criminal Code may also bring an ancillary civil action (附帶民事訴訟, *fu dai min shi su song*).⁴⁸ Even if a criminal complaint does not reach trial, complainants still have the option to file an independent civil suit.

personages, excluding legislators/councilors and representatives of medical juridical persons, of which legal experts and social personages shall account for at least one-third of the number of members.” Medical Care Act, art. 100 (Taiwan).

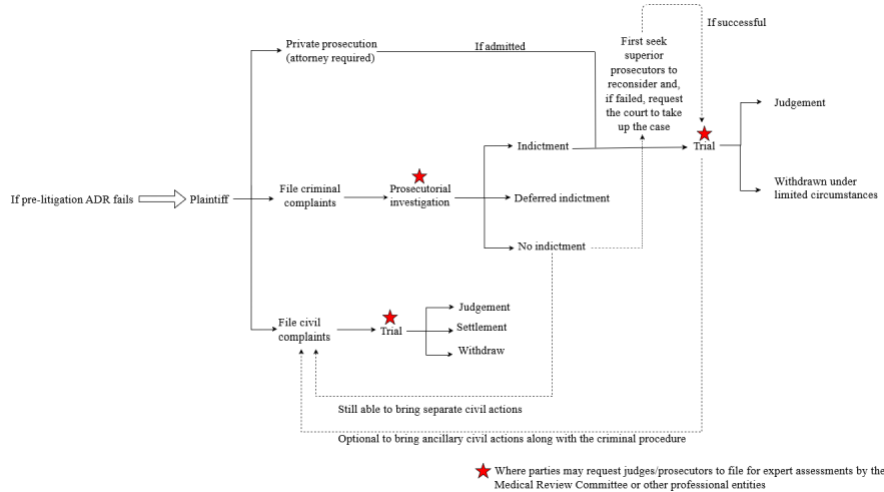
⁴⁴ See, e.g., David Alan Sklansky, *The Nature and Function of Prosecutorial Power*, 106 J. CRIM. L. & CRIMINOLOGY 473, 480–81 (2016) (“The American prosecutor rules the criminal justice system, exercising almost limitless discretion and virtually absolute power.”) (internal citations omitted).

⁴⁵ Crim. Code art. 258-4, 259 (FAWUBU FAGUI ZILIAOKU) (Taiwan).

⁴⁶ CODE PÉNAL [PENAL CODE] art. 121-3 (Fr.); see Danielle Griffiths, Melinee Kazarian & Margaret Brazier, *Criminal Responsibility for Medical Malpractice in France*, 27 J. PRO. NEGL. 188, 191–196 (2011).

⁴⁷ STRAFGESETZBUCH [STGB] [PENAL CODE] §§ 222, 229 (Ger.) (negligent killing and negligent bodily harm); see generally Stauch, *supra* note 10, at 1141–42.

⁴⁸ The Code of Criminal Procedure states that “[t]hose who injured [*sic*] by an offence may bring an ancillary civil action along with the criminal procedure, to request compensation from the defendant and those who may be liable under the Civil Code.” Code of Criminal Procedure art. 487 § 1 (FAWUBO FAGUI ZILIAOKU) (Taiwan).

Diagram 2: *Civil and criminal procedure of medical malpractice litigation*

II. TRENDS IN MEDICAL MALPRACTICE LITIGATION⁴⁹

The number of prosecutorial investigations of alleged medical negligence, relatively constant during the 1980s and 1990s, climbed steadily from 2002 to its peak in 2015,⁵⁰ but has diminished in subsequent years. The proportion of investigations resulting in criminal indictments of medical professionals (the “indictment rate”)⁵¹ fluctuated between one-sixth to one-quarter from 1988 to

⁴⁹ This discussion is based on three sources of statistical data: (1) official statistics on prosecutorial investigations and court judgments compiled by the Ministry of Justice (法務部, *fa wu bu*) and the Judicial Yuan; (2) official statistics compiled by the MRC on judicial and prosecutorial requests for MRC expert assessment; and (3) statistics compiled by individual scholars, typically derived from analysis of court cases in a specific time frame and level of court. (1) and (2) offer more basic information across a longer time span, while (3), depending on research design, may engage in more sophisticated coding and statistical analyses.

⁵⁰ In 2001, prosecutors finalized fifty-eight investigations of death due to professional medical negligence. The number of finalized investigations rose to 204 in 2015 and declined to 146 in 2018 (the last year for which this statistic is available). Statistics from 2001 are based on Kuo-Hua Hong’s Master’s thesis. See Kuo-Hua Hong, Taiwan Yiliao Xingshi Zhuisu Zhi Xianzhuang Yu Zhengce Zouxiang (台灣醫療刑事追訴之現狀與政策走向) [The Current State and Policy Direction of Taiwan Medical Criminal Prosecution] 84 (unpublished Masters thesis, Graduate Institute of Interdisciplinary Legal Studies, National Taiwan University). The data from 2015 and 2018 are drawn from the Taiwan Legal Affairs Statistical Report (臺灣法務統計專輯) compiled by the Taiwan High Prosecutors Office (台灣高等檢察署). See *Electronic Publication*, Taiwan High Prosecutors Office, <https://www.tph.moj.gov.tw/4421/4599/4621/Lpsimplelist> (last visited Nov. 2, 2023).

2011—a yearly total ranging from ten to thirty-two—but from 2013 onward plunged to one in fifty⁵¹ (Chart A and Table A).⁵²

The drop in the indictment rate resulted in a gradual decline in the number of criminal filings since 2012 (Chart B).⁵³ The proportion of guilty verdicts, however, trended in the opposite direction. The percentage of indicted medical defendants found guilty in both district courts and the High Court increased from 19% in 2002-2004 to 29% in 2017-2019 (Chart C).⁵⁴

The rise and subsequent decline in the indictment rate and criminal filings are consistent with annual statistics on the number of Medical Review Committee expert assessments initiated by judges and prosecutors (Chart D).⁵⁵ The number of MRC assessments confirming medical errors has fluctuated widely—from around ten in the 1980s to about sixty or more in 2007-2009, and back down to about twenty or fewer in 2012-2020 (Chart E).⁵⁶

Medical defendants convicted of criminal negligence typically receive sentences of probation—usually for two years or less—or a fine, and rarely serve time in prison.⁵⁷ Virtually all sentences result in probation for two years

⁵¹ The indictment rate of medical professionals for death due to professional negligence is far lower than the corresponding rate for other professionals. In 2010, for example, the indictment rate for physicians was eleven percent, contrasted with seventy-four percent for drivers and forty-eight percent for other types of professional negligence. See Hong, *supra* note 50, at 109. The Criminal Code was revised in 2018 to abolish the separate category of “professional negligence,” so it is no longer possible to draw this contrast for recent years.

⁵² Statistics before 2010 in Chart A are based on Kuo-Hua Hong’s Master’s thesis. Hong, *supra* note 50, at 84–85. The remaining data in Chart A and in Table A, provided in the text below, are drawn from the Taiwan Legal Affairs Statistical Report, *supra* note 50.

⁵³ Data in Chart B are from the Judicial Yuan Annual Statistical Report. See Judicial Yuan website, *supra* note 6.

⁵⁴ *Id.*

⁵⁵ Data in Chart D are from the official statistics on the MRC compiled by the Ministry of Health and Welfare (衛生福利部). See Ministry of Health and Welfare, Yishi Zhengyi Chuli, Jianding Deng Xiangguan Yewu (醫事爭議處理、鑑定等相關業務) [*Matters Related to Medical Dispute Resolution and Assessment*] [hereinafter *Matters Related to Medical Dispute Resolution and Assessment*], <https://dep.mohw.gov.tw/doma/cp-2712-7681-106.html> (last visited Nov. 2, 2023). One must be careful in using official MRC data as a proxy for the overall trend of medical malpractice litigation for at least two reasons. First, a single incident may lead to multiple judgments at different levels of court, with each judgment involving multiple rounds of expert assessment. Additionally, the number of requests for criminal cases has been consistently higher than those for civil cases. The trend, however, is opposite to the distribution of actual court cases. A likely reason for the discrepancy is plaintiffs’ common litigation strategy of attempting to force civil compensation by filing criminal charges. See *infra* Part III.A.

⁵⁶ *Matters Related to Medical Dispute Resolution and Assessment*, *supra* note 55.

⁵⁷ The Criminal Code provides for probationary suspension of imprisonment for not more than two years if the defendant meets various mitigating conditions in the sentencing judge’s discretion. Among these mitigating considerations are whether the defendant has apologized to the victim, written a “statement of repentance,” and

or less. Even for cases of death due to negligence, from 2002 to 2019, only five defendants received sentences longer than two years (Chart F).⁵⁸

As discussed below (Part V), the medical community has expressed strong dissatisfaction with the law's treatment of medical practice. While the major target of dissatisfaction has been the criminal justice system's involvement, civil malpractice claims are also a source of concern.

The number of civil malpractice claims increased substantially during the early years of this century. Although official statistics on the annual number of civil medical malpractice case filings are not compiled by the Judicial Yuan, estimates can be constructed from private databases employing Judicial Yuan data. According to the LawBank (法源法律網, *fa yuan falu wang*) database, for example, malpractice case filings (excluding cases subject to summary proceedings) increased from 2006 (seventy-four) to 2013 (159) (Chart G),⁵⁹

paid an "appropriate amount of compensation." Crim. Code art. 74 § 2(1)-(3) (FAWUBU FAGUI ZILIAOKU) (Taiwan).

Judicial Yuan official statistics indicate that in no case of death due to criminal negligence, appealed to the Supreme Court from 2002 to 2019, was a defendant physician sentenced to more than two years. Technically, therefore, defendants in criminal medical malpractice cases almost always qualify for probation. See *Annual Statistical Report*, *supra* note 6. Sentences of less than six months are typically commuted to penalty fines.

However, even if given a sentence of two years (or perhaps even less), a defendant physician in rare cases may still face the danger of prison time. These situations typically involve an unwritten requirement developed by the Court that reaching a settlement with patients and families is a precondition for probation. When the defendant has failed to do so, or when the court determines that the defendant was not sincere in the settlement agreement, the court may refuse to issue probation.

For example, in a 2018 Supreme Court decision, the defendant physician had been sentenced to two years without probation. In that case, the physician was accused of failing to properly monitor and record vital signs, thereby missing the deterioration of the patient's health condition. The Court agreed with the lower courts that the physician's practice had deviated from the medical norm. The Court affirmed the lower courts' sentencing decision of two years, rendering the defendant ineligible for probation. *Zuigao Fayuan 107 Niandu Taishangzi Di 4259 Hao Xingshi Panjue*, (最高法院107年度台上字第4259號刑事判決) [Supreme Court No. 4259 Criminal Judgment of 2018] (Taiwan S. Ct. March 6, 2018). The High Court had specifically concluded that the defendant had showed no remorse and had failed to reach a settlement with the victim's family. *Taiwan Gaodeng Fayuan Gaoxiong Fayuan 106 Niandu Yishang Shangsuzi Di 4 Hao Xingshi Panjue*, (臺灣高等法院高雄分院106年度醫上訴字第4號刑事判決) [Taiwan High Court Yi Shang Su Zi No. 4 Criminal Judgment of 2017] (Taiwan High Ct. March 21, 2017).

Another case where the defendant did not receive probation involved an Ob-Gyn who failed to notice and take proper precautions against the possibility of an ectopic pregnancy. The Supreme Court agreed with the lower court that the defendant chose to blame others and failed to reach settlement with the victim's family. *ZuiGao Fayuan 108 Niandu Taishangzi Di 1768 Hao Xingshi Panjue*, (最高法院108年度台上字第1768號刑事判決) [Supreme Court No. 1768 Criminal Judgment of 2019] (Taiwan S. Ct. July 3, 2019).

⁵⁸ Data are from the Judicial Yuan Annual Statistical Report. See *Annual Statistical Report*, *supra* note 6.

⁵⁹ LawBank Database, *Judgment Search*, <https://fyjud.lawbank.com.tw/index.aspx> (last visited Nov. 2, 2023). Chart G displays the yearly number of district court civil judgments using the docket title *yizi* (醫字, literally "medical serial #") from 2006 to 2021. Courts sometimes assign *yizi* to medical disputes not involving

similar to trends found by other scholars (Chart H).⁶⁰ This substantially surpassed the number of criminal cases and put significant pressure on medical practitioners.

The causes of rising medical malpractice litigation during those years are unclear. For civil disputes, the growth in this area may merely mirror the overall growth of all civil cases. Chart I compares the number of district court medical malpractice cases with the number of all district court cases from 2000 to 2009, displaying a similar growth pattern.⁶¹ Possibly, the growth in civil medical malpractice cases is simply a result of a more accessible civil court system after Taiwan's democratization in the 1990s.

In addition to the mental pressure inflicted on physicians, the growing number of malpractice disputes in this century's early years had financial implications. In general, however, the financial pressure of medical malpractice disputes on Taiwanese healthcare providers has been relatively manageable compared to their U.S. counterparts. Yun-Tzu Chang analyzed 372 civil cases in district courts from 2000 to 2008 and found that the median amount of compensation awarded was around 2,270,000 NTD (75,000 USD), while the average amount was around 3,720,000 NTD (125,000 USD). Plaintiffs rarely received compensation exceeding 10,000,000 NTD (333,000 USD).⁶² Of the 372 cases Chang analyzed, only sixty-nine led to a compensation award. Just five exceeded 10,000,000 NTD; the highest award was 27,462,579 NTD

medical injuries, for example, disputes regarding payment. Since the number of such cases is very low, we have removed them from the sample. Two caveats: (1) summary cases are assigned different docket titles and thus not included in the sample; and (2) the number of *yizi* judgments may have underestimated the total number of civil cases in the first decade of the century when some district courts had not yet adopted the practice of assigning *yizi* to medical malpractice cases, an issue that has now been resolved.

⁶⁰ See CHUN-YING WU (吳俊穎) ET AL., SHIZHENG FAXUE: YILIAO JIUFEN DE QUANGUO XING SHIZHENG YANJIU (實證法學：醫療糾紛的全國性實證研究) [EMPIRICAL LAW: NATIONAL EMPIRICAL STUDIES OF MEDICAL MALPRACTICE DISPUTES] 33–34 (2014) (encompassing data from 2002 to 2010). Direct comparisons of civil and criminal cases in the recent decade are lacking. However, existing evidence, though limited, indicates that civil cases remain dominant numerically. For the criminal side, Chart B above shows a gradual decline in the number of criminal case filings at the district court level since 2012, in recent years even reaching single digits. As for the civil side, Chien-Yu Liao's unpublished research (on file with the authors) identified 389 district court civil decisions from May 2015 to October 2020, a yearly average of seventy-one decisions.

⁶¹ See Shen & Chuang, *supra* note 20, at 181–82. The 2008 and 2009 figures are low due to the fact that many cases were still in process at the time of the study.

⁶² See Yun-Tzu Chang (張耘慈), Taiwan Difang Fayuan Minshi Yiliao Jiufen Panjue Zhi Shizheng Yanjiu (台灣地方法院民事醫療糾紛判決之實證研究) [An Empirical Study of Civil Cases of Medical Malpractice in Taiwan: 2000–2008], at 60 (2010) (unpublished Master's dissertation, National Yang-Ming U.) (on file with the authors). See Chart J for the distribution of award amounts among these sixty-nine cases.

(915,000 USD).⁶³ Damage awards are constrained both by the national health insurance system's extensive coverage of medical expenses and by judges' conservative evaluations of pain and suffering damages. The relatively manageable financial pressure partially explains physicians' and hospitals' lack of urgency to purchase commercial liability insurance, as shown by statistics in Part IV.C *infra*.

Although malpractice case filings increased in the first decade of this century, they later declined.⁶⁴ Moreover, historical data indicate that plaintiffs received compensation in fewer than thirty percent of cases filed,⁶⁵ suggesting that physicians' angst over *civil* litigation, at least, may be somewhat mollified.

Official statistics are unavailable regarding the proportion of criminal and civil cases brought against practitioners of each medical specialty and against larger hospitals as opposed to smaller clinics. However, two scholars' studies present a presumptively accurate picture of Taiwanese medical injury litigation during the early years of this century. One is Pang-Yang Liu's empirical examination of *criminal* medical cases in district courts from 2000 to 2010.⁶⁶ Liu found that among the 380 cases involving specialties, surgery accounted for 123 (32%), internal medicine for 75 (25%), obstetrics & gynecology for 61 (16%), and emergency medicine for 53 (14%). A higher proportion of defendants were affiliated with medical centers (35%) than with regional hospitals, district hospitals, and clinics (22%, 19%, and 19%, respectively).⁶⁷ Yun-Tzu Chang's study analyzing *civil* district court decisions from 2000 to 2008 reported that among the 469 defendants' specialties, surgery (including orthopedics) accounted for 126 cases (27%), internal medicine for 89 (19%), obstetrics & gynecology for 90 (19%), and emergency medicine for 42 (9%). Defendants affiliated with medical centers (188) likewise outnumbered those affiliated with regional hospitals (124), district hospitals (72), and clinics (59).

⁶³ *Id.*

⁶⁴ LawBank Database, *supra* note 59 (see Chart G).

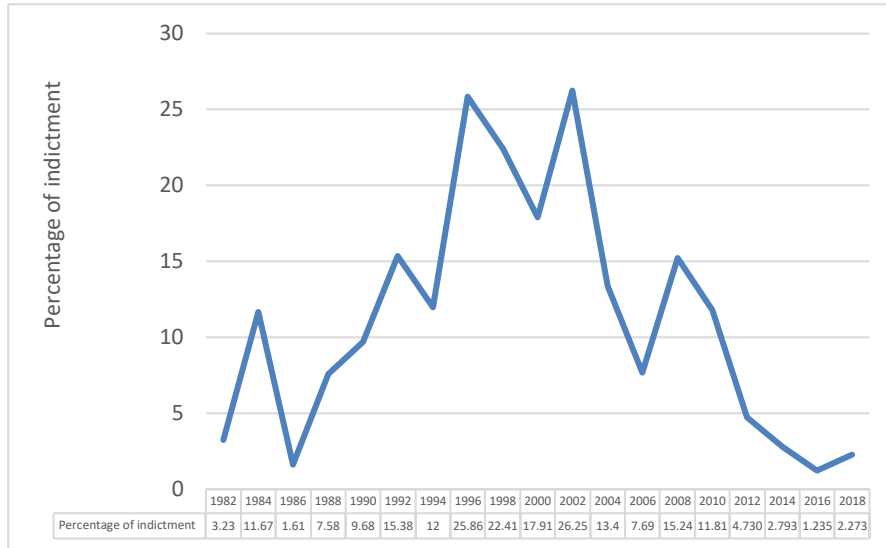
⁶⁵ See, e.g., Shen & Chuang, *supra* note 20, at 181–82, 189–90; WU ET AL., *supra* note 60, at 33–34, 91–92; Chang, *supra* note 62 (all analyzing early twenty-first century cases).

⁶⁶ See generally Pang-Yang Liu (劉邦揚), Woguo Difang Fayuan Xingshi Yiliao Jiufen Panjue de Shizheng Fenxi (我國地方法院刑事醫療糾紛判決的實證分析) [*Empirical Study of Medical Malpractice Judgments from District Criminal Courts in Taiwan: 2000–2010*], 8 TECH. L. REV. 257 (2011).

⁶⁷ *Id.* at 279. The percentages of guilty verdicts for different levels of hospitals were seventeen to eighteen percent for medical centers and regional hospitals and double that (thirty-four to thirty-five percent) for district hospitals and clinics. A possible explanation for this difference between larger healthcare institutions (medical centers and regional hospitals) and smaller ones (district hospitals and clinics) may be that larger hospitals, with their deeper pockets, tend to have better legal access.

Medical center defendants' winning percentage (90%) was higher than that of clinics (70%).⁶⁸

Chart A: *Biennial indictment rate for death due to negligence in medical malpractice cases (including delayed indictments)*



⁶⁸ See Chang, *supra* note 62, at 72. The winning percentages of defendants affiliated with medical centers, regional hospitals, district hospitals, and clinics were ninety percent, eighty-eight percent, eighty-six percent, and seventy-one percent, respectively. Compared with Liu's data on criminal cases, Chang's data showed that in civil cases, only defendants affiliated with clinics saw a significant drop in their winning percentage. *Id.* The majority of both civil and criminal cases involve larger hospitals (medical centers and regional hospitals). One possible explanation is that, under the National Health Insurance system, healthcare delivery has been increasingly concentrated in larger hospitals, naturally resulting in more disputes. Another possibility is that smaller healthcare institutions, due to limited resources and access to legal services, are more inclined to accept settlement offers early to avoid litigation. Further empirical study is needed to assess these hypotheses.

Table A: Yearly number of prosecutorial investigations and indictments for death due to professional negligence in criminal medical malpractice cases, 1981 to 2018

Year	Total Investigations	# of Indictments (including delayed indictments)	Indictment Rate
1981	75	10	13.3%
1982	62	2	3.2%
1983	57	2	3.5%
1984	60	7	11.7%
1985	84	3	3.6%
1986	62	1	1.6%
1987	60	3	5.0%
1988	66	5	7.6%
1989	68	4	5.9%
1990	62	6	9.7%
1991	53	4	7.5%
1992	52	8	15.4%
1993	56	8	14.3%
1994	50	6	12.0%
1995	59	9	15.2%
1996	58	15	25.9%
1997	71	15	21.1%
1998	58	13	22.4%
1999	59	5	8.5%
2000	67	11	16.4%
2001	58	6	10.3%
2002	80	17	21.2%
2003	125	21	16.8%
2004	97	13	13.4%
2005	76	10	13.2%
2006	91	7	7.7%
2007	116	26	22.4%

2008	105	16	15.2%
2009	109	9	8.3%
2010	127	14	11.0%
2011	119	16	13.4%
2012	148	7	4.7%
2013	160	3	1.9%
2014	179	5	2.8%
2015	204	8	3.9%
2016	162	2	1.2%
2017	121	2	1.6%
2018	132	3	2.3%

Chart B: Yearly criminal medical malpractice cases and defendants in district courts, 2002 to 2019

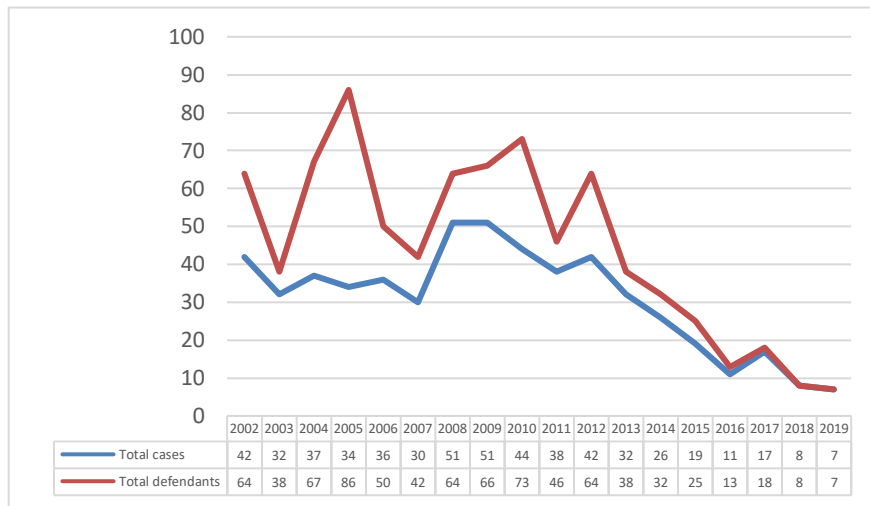


Chart C: Yearly and three-year average percentage of guilty verdicts for medical malpractice cases in district courts and High Court

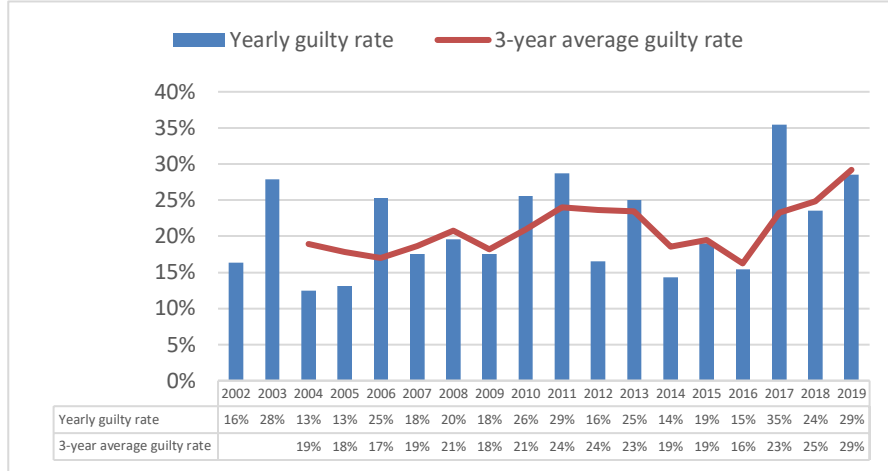


Chart D: Number of MRC assessments, 1987 to 2020

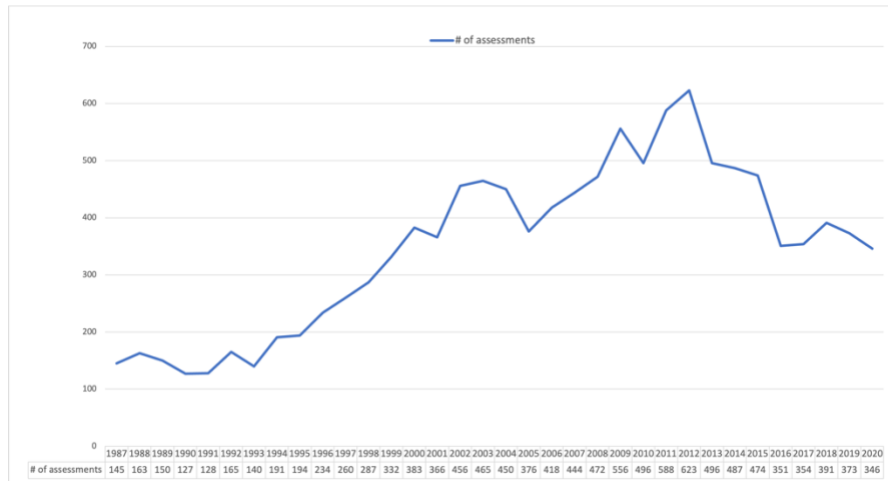


Chart E: MRC assessments confirming medical errors, 1987 to 2020

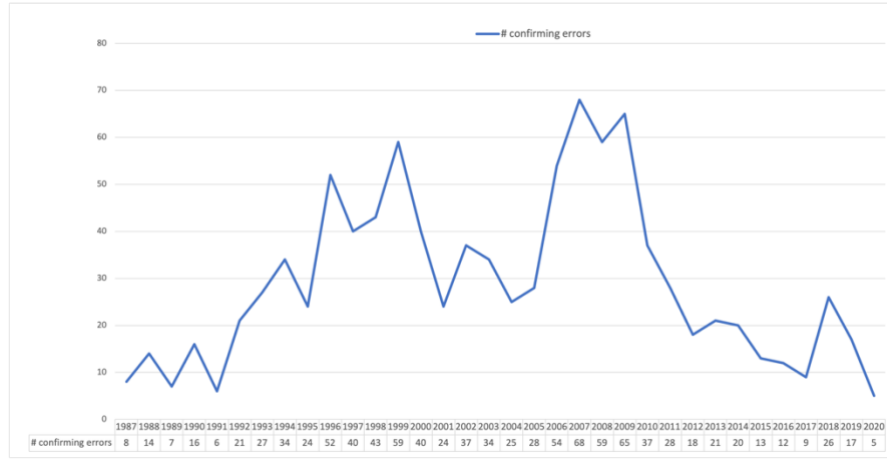


Chart F: Sentencing distribution of death due to negligence in medical malpractice cases, 1987 to 2020

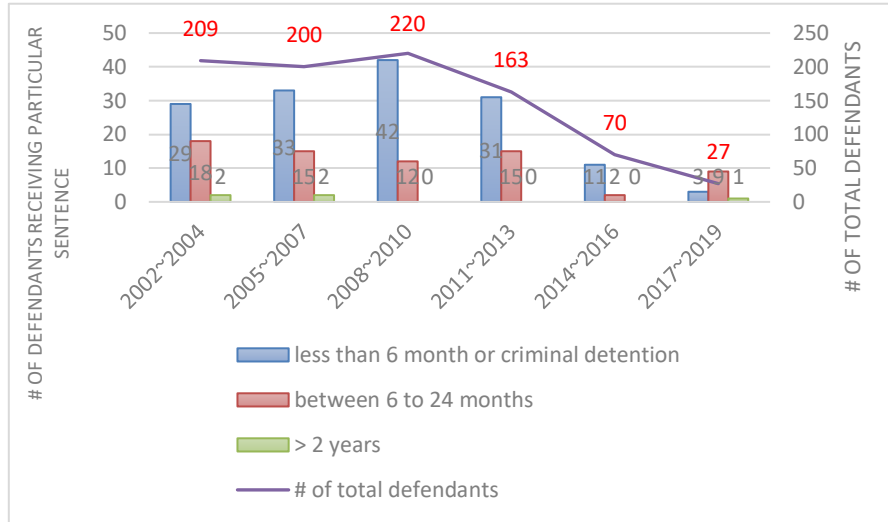


Chart G: Medical malpractice filings in civil courts, 2006 to 2021

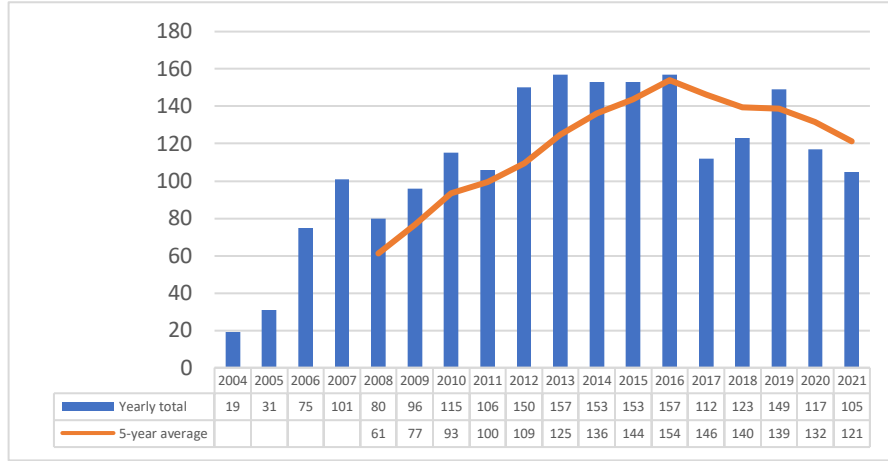


Chart H: Discrepancy between civil and criminal medical malpractice cases from 2002 to 2010 based on the study of Wu and colleagues

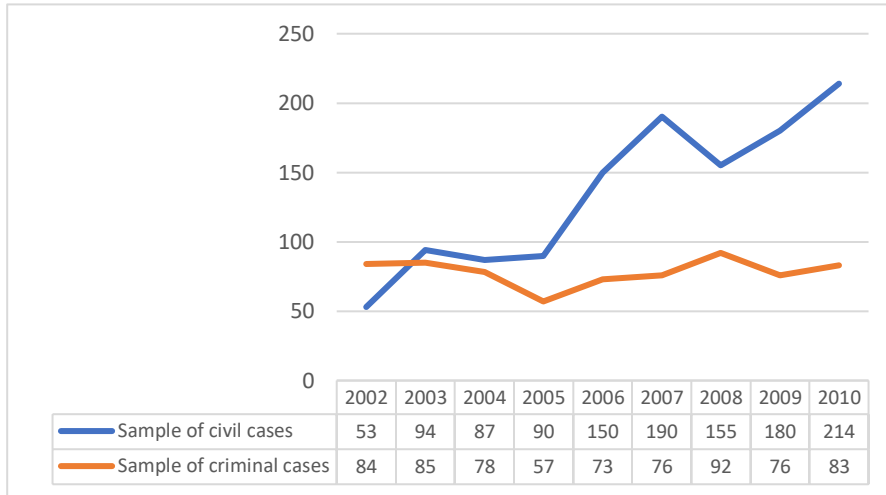


Chart I: Civil medical malpractice cases in comparison to overall civil cases, 2000-2009

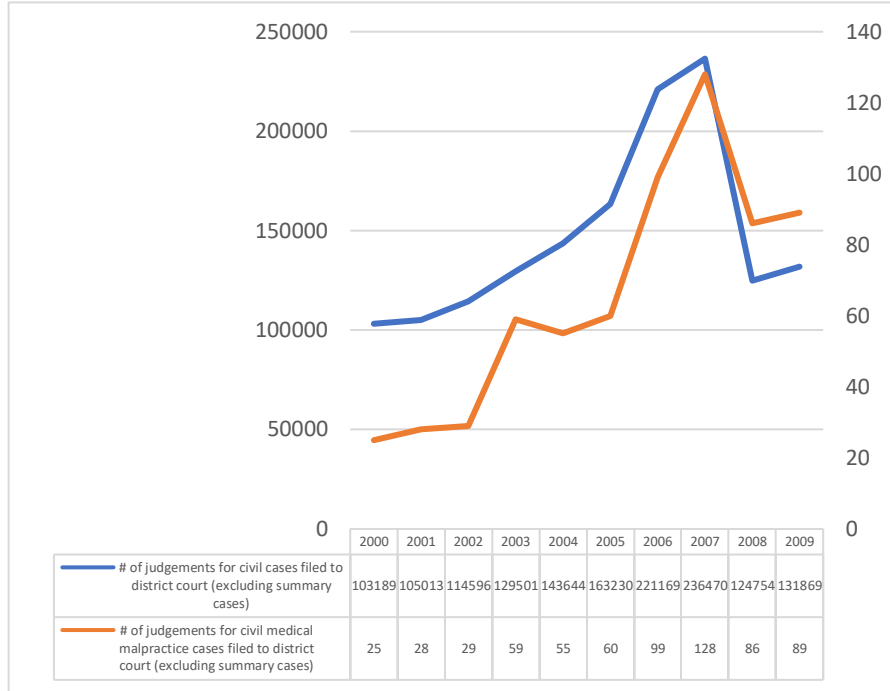
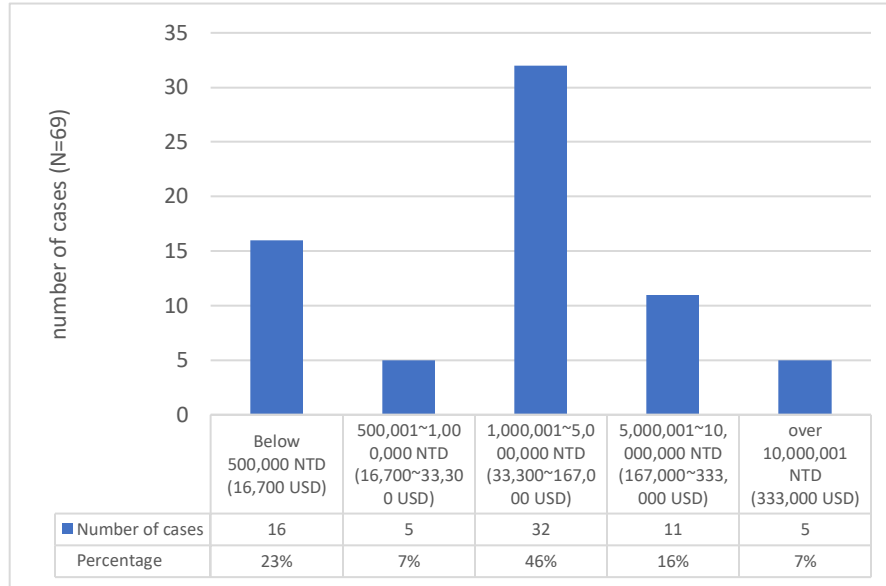


Chart J: Awards in district court medical malpractice cases, 2000 to 2008

III. MEDICAL COMPENSATION SYSTEMS IN ACTION: FIVE KEY ASPECTS

Part III examines five aspects of Taiwan's medical injury compensation law in action: the connections between criminal and civil complaints, the evolving role of informed consent claims, the dominance of third-party expert assessment of medical evidence and the criticisms of that assessment system, the burgeoning use of alternative dispute resolution mechanisms, and the role of administrative compensation systems.

A. Leveraging the Criminal Justice System Against Medical Providers

The widespread use of criminal law by aggrieved persons in Taiwan is often referred to as the practice of "*forcing civil compensation through criminal charges*" (以刑逼民, *yi xing bi min*). When complainants file criminal complaints (whether in medical or other types of cases), prosecutors must

investigate the basis of the complaints⁶⁹ unless, for certain crimes such as injury due to negligence, parties reach settlement or mediation agreements, and the complaints are withdrawn before prosecutors make final decisions on whether to indict.⁷⁰

Complainants and their attorneys thus obtain three advantages: fact-finding at public expense rather than at their own expense;⁷¹ avoidance of court fees based on the amount claimed in a civil action;⁷² and negotiating leverage from the *in terrorem* effect of threatening potential defendants with criminal prosecution.⁷³ They might be viewed, in the language of law and economics scholars, as free-riders on the operation of the criminal justice system.

Concern about “forcing civil compensation through criminal charges” has been *the* central reason behind the medical community’s dissatisfaction with current medical injury compensation law. Medical professionals hate to be treated as suspected criminals, and they view investigations by prosecutors as interfering with the daily functioning of the healthcare system and trampling on their professional pride.

Their dissatisfaction is shared by some legal scholars and even some patient advocacy groups. Hsiu-I Yang, a leading scholar of medical malpractice law, and Yu-Ying Huang criticize reliance on criminal law as an unwise and

⁶⁹ Interview with Prosecutor Fang-Yu Lin, *supra* note 16.

⁷⁰ The legal effects of alternative dispute resolution agreements in criminal cases are discussed *infra* in Part III.D.1.

⁷¹ According to Article 2 of the Operational Guideline for Medical Dispute Assessment (醫療糾紛鑑定作業要點, *yi liao jiu fen jian ding zuo ye yao dian*) issued by the Ministry of Health and Welfare, currently only judges and prosecutors can file requests for such assessments. This limitation means patients and families must first initiate the litigation process to obtain access to such expert opinion, and economically it makes more sense for them to seek prosecutors for such assistance. For the text of the Operational Guidelines, see <https://dep.mohw.gov.tw/DOMA/cp-2712-7681-106.html>.

In 2018, the Ministry of Health and Welfare commissioned the Taiwan Drug Relief Foundation (藥害救濟基金會, *yao hai jiu ji ji jin hui*) to pilot-test a system of medical expert consultation and dispute evaluation to provide patients and families access to expert opinions before filing litigation. The experience with the pilot system laid the foundation for the 2022 passage of the Medical Accident Prevention and Dispute Resolution Act (醫療事故預防及爭議處理法, *yi liao shi gu yu fang ji zheng yi chu li fa*), which will revise the system of medical expert consultation and medical dispute evaluation. See *infra* Part V.D.

⁷² Compare Code of Criminal Procedure art. 504-05 (FAWUBO FAGUI ZILIAOKU) (Taiwan) with Code of Civil Procedure art. 77-113 (FAWUBO FAGUI ZILIAOKU) (Taiwan) (providing for court fees based on the amount of claim).

⁷³ Similar leverage is available to people complaining of medical malpractice in Germany. See STGB [PENAL CODE] §§ 222, 229 (Ger.). However, a slight possibility exists that sanctions against unlawful coercive actions under German Penal Code (StGB) § 240 may place restraints on the practice. *Id.* § 240. (We thank Hannes Beck for information about this and other aspects of German law.)

ineffective use of judicial resources.⁷⁴ Yang and Huang argue that the practice has resulted in what they call the phenomenon of “three-lows-one-high” (三低一高, *san di yi gao*). The “three lows” refer to the low percentages of defendants criminally charged, criminally convicted, and actually serving sentences. “One high” denotes the percentage of complaints that prosecutors still must investigate, a source of tremendous pressure on medical professionals.⁷⁵

In practice, filing criminal charges may have drawbacks as well as benefits to aggrieved patients and families. Rates of indictment and guilty verdicts remain quite low in medical cases compared to other types of negligence cases.⁷⁶ Technically, if the criminal filing goes nowhere, plaintiffs can still file subsequent civil litigation, and judges in civil cases are not bound by prior criminal decisions. However, the Code of Civil Procedure (民事訴訟法, *min shi su song fa*) Article 222 requires civil judges to “determine the facts by free evaluation” (依自由心證判斷事實之真偽, *yi zi you xin zheng pan duan shi shi zhi zhen wei*). This is often referred to as the “principle of free evaluation of evidence through inner conviction” (自由心證, *zi you xin zheng*), and a defendant’s receiving a not-guilty verdict in advance may often nudge civil judges’ “free evaluation” against the plaintiff.⁷⁷

⁷⁴ See Hsiu-I Yang (楊秀儀) & Yu-Ying Huang (黃鈺嫻), *Dang Falu Yujian Yiliao: Yiliao Jiufen Lifalun Shang de Liang Ge Zhuzhang* (當法律遇見醫療：醫療糾紛立法論上的兩個主張) [*When Law Meets Medicine: Two Legislative Approaches to Medical Dispute Resolution*], 115 JUDICIAL ASPIRATIONS (司法新聲) 7, 18–24 (2015) (arguing that medical injuries should lead to criminal liability only when criminal intent is proven).

⁷⁵ *Id.* at 22.

Yang is also a long-time board member of one of the major patient advocacy groups in Taiwan, the Taiwan Healthcare Reform Foundation (醫改會, Yibing Shuangshu). Perhaps in part due to this connection, the Foundation shares Yang’s position that employment of criminal law is not an effective use of scarce judicial resources. See Chia-Fang Chang (張嘉芳), Yigai Hui: Yiliao Susong Yibing Shuangshu (醫改會：醫療訴訟醫病雙輸) [*Taiwan Healthcare Reform Foundation: Both Patients and Physicians Lost in Medical Malpractice Litigation*], UNITED NEWS (Sept. 23, 2014), <https://health.udn.com/health/story/5999/359570>.

⁷⁶ See Hong, *supra* note 50, at 108–09.

⁷⁷ This observation is supported by the observation of Chun-Ying Wu and colleagues that the winning percentage of plaintiffs in civil cases is strongly correlated with the result of the criminal procedure. See WU ET AL., *supra* note 60, at 217. Wu and colleagues studied civil decisions by the district courts and High Court from 2002 to 2007. *Id.* Of 580 cases, 245 involved simultaneous or previous criminal proceedings. *Id.* Among the 245 cases, the plaintiffs’ winning percentage in cases where the defendants were not indicted was merely eight percent, while the percentage in cases where defendants were indicted but not yet entering trial jumped to forty-two percent. *Id.* In cases where defendants were found criminally liable, plaintiffs’ civil winning percentage increased further to sixty-three percent. *Id.* If defendants were acquitted by the court, however, the percentage fell sharply to twenty-seven percent. *Id.*

B. *The Evolving Role of Informed Consent Claims*

Medical injury claims, especially civil claims, are often based on both the delivery of substandard healthcare and the failure to obtain legally sufficient informed consent. In countries like the United States, substandard care and informed consent claims are assessed separately, with the former typically being the main battlefield and the latter typically playing a secondary or supplementary role – “background music,” to borrow Professor Twerski’s metaphor.⁷⁸

In Taiwan, particularly in criminal law, courts often have difficulty separating these two claims. They have long struggled with the role of claimed informed consent violations in determining criminal negligence.⁷⁹ The general view nowadays is that the failure to obtain informed consent does not of itself establish criminal negligence.⁸⁰ This view can be traced back at least to a 2003 district court decision stating that “[t]he failure to fulfill the duty to inform does not directly reflect or cause the blameworthiness of the medical practice itself. Rather, the medical practice constitutes a criminal offense only when it violates a medical norm and causes harm.”⁸¹ In practice, legal causality exists almost only in cases where physicians violated a medical norm or standard.⁸² This judicial practice results in tautological reasoning that the failure to obtain informed consent helps prove criminal negligence only in cases where the healthcare has been negligently delivered and has caused harm.

⁷⁸ Professor Aaron Twerski used this phrase as a guest lecturer in law classes in both Arkansas and Taiwan. Twerski’s seminal work, with Neil Cohen, on issues discussed here is Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 20 U. ILL. L. REV. 607 (1988).

⁷⁹ See generally Li-Ching Chang (張麗卿), Xingshi Yiliao Panjue Guanyu Gaozhiiwu Bianqian Zhi Yanjiu (刑事醫療判決關於告知義務變遷之研究) [*The Change of the Informed Consent Obligation in Criminal Medical Judgments*], 39 TUNGHAI U. L. REV. 99 (2013) (analyzing the evolution of the court’s view on how violating informed consent would affect criminal liability over time).

⁸⁰ *Id.* at 136–39 (arguing that since around the millennium, Taiwanese courts have gradually adopted the view that the violation of informed consent alone does not constitute negligence).

⁸¹ *Id.* at 137; Jiayi Difang Fayuan 92 Niandu Zi Zi Di 20 Hao Xingshi Panjue (嘉義地方法院 92 年度自字第 20 號刑事判決) [Chiayi District Court Zi Zi No. 20 Criminal Judgment of 2003] (Chiayi District Ct. Apr. 13, 2003) (Taiwan).

⁸² In a 2011 Taiwan High Court Criminal Decision, for example, the court ruled that “[i]n this case, victim’s family had signed consent forms for various tests, meeting the formal requirement of the informed consent obligation. . . . The physician’s treatment met the medical standard and he committed no error. Therefore, whether the defendant had met his duty to properly inform . . . has no bearing on the subsequent medical intervention, and clearly has no causal connection with the victim’s death.” Taiwan Gaodeng Fayuan 100 Niandu Yi Shangsuzi Di 3 Hao Xingshi Panjue (臺灣高等法院 100 年度醫上訴字第 3 號刑事判決) [Taiwan High Court Yi Shang Su Zi No. 3 Criminal Decision of 2011] (Taiwan High Ct. Aug. 3, 2011) (translation by the authors).

Legal causality plays a key role in civil informed consent cases as well. Traditionally, civil courts have taken the view that informed consent violations justify compensation only when the medical behaviors lacking patient consent are causally related to physical injury. Only in rare cases do civil courts sometimes award compensation for medical behaviors that do not involve medical error.⁸³

In the past decade, a growing number of civil cases have deviated from the traditional view that tied compensation to physical damage.⁸⁴ The Taichung district court, in a 2018 decision, for example, viewed informed consent claims as based on patients' right to autonomy and emphasized that plaintiffs do not need to prove physical damages to receive compensation.⁸⁵ Instead, the court stated that "[a]lthough whether the infringement on patients' right to autonomy . . . leads to economic damages should be prudently assessed in trial of fact, . . . patients should still be able to request non-economic damages based on Article 195 Section 1 of the Civil Code."⁸⁶ On appeal, the High Court agreed, stating: "[i]t is necessary to elevate patient autonomy to a legally protected interest in making patients' own medical decisions. *Such interest should be distinguished*

⁸³ A rare example is Taipei Difang Fayuan 99 Niandu Yi Zi Di 27 Hao Minshi Panjue (台北地方法院99年度醫字第27號民事判決 [Taipei District Court Yi Zi No. 27 Civil Decision of 2010] (Taipei District Ct. Dec. 31, 2010) (Taiwan). In this case, the patient suffered from thyroid eye disease and underwent surgery on both eyes, but lost vision afterward. *Id.* The patient argued that the physician did not properly convey the risk of vision loss and the possibility of operating on one eye first. *Id.* The district court agreed and held that, even though the operation was successful, the hospital should be held liable for failing to properly instruct its employees to fulfill the duty of informed consent. *Id.* On appeal, however, the High Court set aside the consent issue and based its decision primarily on whether the provider had delivered substandard care.

⁸⁴ Examples include Taipei Difang Fayuan 106 Niandu Yi Zi Di 30 Hao Minshi Pan (臺北地方法院106年度醫字第30號民事判 [Taipei District Court Yi Zi No. 30 Civil Judgment of 2017] (Taipei District Ct. Mar. 23, 2017) (Taiwan); Taipei Difang Fayuan 106 Niandu Yi Zi Di 45 Hao Minshi Panjue (臺北地方法院106年度醫字第45號民事判決) [Taipei District Court Yi Zi No. 45 Civil Judgment of 2017] (Taipei District Ct. Nov. 11, 2017) (Taiwan); Taizhong Difang Fayuan 107 Niandu Yi Zi Di 5 Hao Minshi Panjue (臺中地方法院107年度醫字第5號民事判決) [Taichung District Court Yi Zi No. 5 Civil Judgment of 2018] (Taichung District Ct. July 16, 2018) (Taiwan). For a review of civil judgments that took both the traditional view and the new perspective, see Wu Chih Cheng (吳志正), Weifan Yiliao Gaozhi Yiwu Zhi Fayi Qin Hai Leixing Yu Minshi Zeren—Cong Shiwu Caipan Zhi Youyi Tanqi (違反醫療告知義務之法益侵害類型與民事責任——從實務裁判之猶疑談起) [*The Injury Pattern and Liability of Violating Informed Consent Doctrine: With Special Reference to Judicial Decisions*], 110 TAIPEI U. L. REV. 94, 111–29 (2019).

⁸⁵ Taizhong Difang Fayuan 105 Niandu Yi Zi Di 16 Hao Minshi Panjue (臺中地方法院105年度醫字第16號民事判決) [Taichung District Court Yi Zi No. 16 Civil Judgment of 2016] (Taichung District Ct. May 30, 2016) (Taiwan), <https://judgment.judicial.gov.tw/FJUD/data.aspx?ty=JD&id=TCDV,105%2c%e9%86%ab%2c16%2c20180530%2c1> (translation by the authors).

⁸⁶ *Id.*

from the blameworthiness of the medical treatment itself, and serves the function of compensating for non-economic damages, which include patients losing opportunities to make medical choices and prevent the risk of harm.”⁸⁷

Another noteworthy aspect of Taiwan’s informed consent law is its apparent adoption of the reasonable patient standard. In addition to the Civil Code, the statutory bases for the legal duty of informed consent are the Physician Act (醫師法, *yi shi fa*) § 12-1 and the Medical Care Act (醫療法, *yi liao fa*) §§ 63, 64, and 81.⁸⁸ A doctrinal issue is whether the scope of the legal duty is limited to information listed in these provisions. In a 2005 criminal case, the Supreme Court attempted to answer this question.⁸⁹ The plaintiff, whose wife had died from complications of cardiac catheterization, claimed that the defendant physician had violated the legal duty of informed consent by failing to provide information on the procedure’s potential risk. The Court ruled that the range of information required to be disclosed may exceed what is prescribed in the statutory provisions. If it is unclear whether particular information must be disclosed, the Court announced a general principle that physicians must disclose such information if, upon receiving the information, patients in normal circumstances might have rejected the treatment.⁹⁰

Some legal scholars view this decision as the judicial adoption of the “reasonable patient standard” from the United States and other Western nations.⁹¹ The “might have rejected the treatment” principle incorporates how

⁸⁷ Taiwan Gaodeng Fayuan Taizhong Fenyuan 107 Niandu Yi Shang Zi Di 6 Hao Minshi Panjue (臺灣高等法院台中分院107年度醫上字第6號民事判決) [Taiwan High Court Taichung Branch Yi Shang Zi No. 6 Civil Judgment of 2018] (Taiwan High Ct. May 5, 2018), <https://judgment.judicial.gov.tw/FJUD/data.aspx?ty=JD&id=TCHV,107%2c%e9%86%ab%e4%b8%8a%2c%2c20200526%2c1> (emphasis added). A similar approach is evident in other jurisdictions. *E.g.*, Saikō Saibansho [Sup. Ct.] Feb. 29, 2000, 54 SAIBANSHO MINJI HANREISHŪ [MINSHŪ] 582 (Japan) (damages awarded to a Jehovah’s Witness for violating her blood transfusion refusal, despite transfusion’s life-saving effects) (English translation by Leflar available in CURTIS J. MILHAUPT ET AL., THE JAPANESE LEGAL SYSTEM: CASES, CODES AND COMMENTARY 347–56 (2006)); *Lugenbuhl v. Dowling*, 701 So. 2d 447 (La. 1997).

⁸⁸ See Part VII, the Statutory Appendix for English translations.

⁸⁹ See *Zuigao Fayuan 94 Niandu Tai Shang Zi Di 2676 Hao Xingshi Panjue* (最高法院94年度台上字第2676號刑事判決) [Supreme Court No. 2676 Criminal Decision of 2005] (Taiwan S. Ct. May 20, 2005).

⁹⁰ *Id.*

⁹¹ See Chen-Chi Wu (吳振吉), *Yiliao Xingwei Zhi Guoshi Rending- Jianping Zuigao Fayuan 106 Niandu Taishangzi Di 227 Hao Minshi Panjue Zhi “Yiliao Changgui” Yu “Yiliao Shuizhun”* (醫療行為之過失認定—簡評最高法院 106 年度台上字第 227 號民事判決之「醫療常規」與「醫療水準」) [*The Determination of Medical Negligence: A Brief Comment on “Medical Customs” and “Medical Standards” in a Supreme Court Judgment*], 10 ANGLE HEALTH L. REV. 69, 80–84 (2017) (stating that “in recent years, the Taiwanese court in a small number of cases has . . . adopted the medical standard, conceptualized in a way similar to the reasonable physician standard in the [U.S.], as the benchmark for determining medical negligence”).

causation is interpreted in informed consent cases in many Western nations.⁹² However, as explained above,⁹³ judgments of the Supreme Court in Taiwan do not enjoy the same precedential effect as their counterparts in U.S. jurisdictions. The impact of this Supreme Court case is therefore limited. Some recent cases, however, have attempted to make the adoption of the reasonable patient standard more conspicuous.⁹⁴ A branch of the High Court, for example, stated that “[t]he scope of informed consent by healthcare institutions and physicians should be delineated against the purpose of the disputed healthcare intervention and information deemed valuable by the reasonable patient standard.”⁹⁵

The 2005 Supreme Court criminal case also adopted the principle that informed consent explanations should be not just written but also verbal. A common practice among healthcare providers has been to have patients sign written informed consent forms without giving them substantive oral explanations. The practice results both from time constraints from physicians’ heavy workload and from their misunderstanding that a written form alone can absolve them from medical liability for failing to explain properly. The 2005 case, however, specifically requires healthcare professionals to offer substantive oral explanations. If providers merely “have patients or their families sign written forms containing information that needed to be explained, the duty to obtain informed consent has not been met.”⁹⁶

⁹² See, e.g., *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972); *Reibl v. Hughes*, [1980] 2 S.C.R. 880 (Can.); *Rogers v. Whitaker* (1992) 175 CLR 479, 490 (Austl.); Robin F. Wilson, *The Promise of Informed Consent*, in *THE OXFORD HANDBOOK OF U.S. HEALTHCARE LAW* 221 (Glenn Cohen et al. eds., 2016).

⁹³ *Supra* note 5 and accompanying text.

⁹⁴ See, e.g., Taiwan High Court Taichung Branch Yi Shang Zi No. 6 Civil Judgment of 2018, *supra* note 87 (authors’ translation). The case was later appealed to the Supreme Court. While the Supreme Court did not touch upon the issue of the reasonable patient standard, it eventually upheld the High Court decision. *Zuigao Fayuan 109 Niandu Tai Shang Zi Di 2017 Hao Minshi Caiding* (最高法院109年度台上字第2017號民事裁定) [Supreme Court No. 2017 Civil Procedural Decision of 2020] (Taiwan S. Ct. May 26, 2020), <https://judgment.judicial.gov.tw/FJUD/data.aspx?ty=JD&id=TPSV,109%2c%e5%8f%b0%e4%b8%8a%2c2017%2c20200826%2c1> (last visited Dec. 15, 2023).

⁹⁵ *Id.*

⁹⁶ Supreme Court No. 2676 Criminal Decision of 2005, *supra* note 89. In practice, physicians often decide the scope of disclosure by the risk associated with the treatment. For riskier treatments such as surgery, hospitals and physicians are more willing to spend time and effort to communicate with patients. If the risk is low, communication is often sketchy and formal to save time. Interview with Dr. Chen-chi Wu (吳振吉), National Taiwan University Hospital, Taipei (Nov. 5, 2022).

C. *The Expert Assessment System and Its Critics*

When medical malpractice complaints are filed, both judges and prosecutors obtain the assistance of a Medical Review Committee (MRC, 醫事審議委員會) to review the available documentary evidence, starting with the patient's medical records.⁹⁷ Expert assessments of these documents are the dominant forms of evidence in both criminal and civil courts.⁹⁸

The heavy reliance on third-party expert assessment is an unusual feature of Taiwan's medical malpractice litigation. In the United States, a similar role is played by the mechanism of expert testimony, but the burden is on the parties to present their own expert witnesses. It is commonplace for U.S. plaintiffs' lawyers to seek private assessments from physicians before filing a lawsuit, and it is relatively rare that a court finds it necessary to request third-party expert assessment itself.⁹⁹ In Taiwan, however, at present it is the judges and prosecutors who exercise exclusive legal authority to request third-party expert assessment on parties' behalf.¹⁰⁰

The main basis for MRC assessments is the dossier compiled and submitted by judges or prosecutors, with the patient's medical records as the dossier's central component. The concepts of "medical norm" and "medical standard"

⁹⁷ Major hospitals also conduct expert assessments at the request of the parties. Unlike MRC expert assessments, the parties must cover the expenses of hospital-conducted assessments. Consequently, they are less frequently used, although they are often speedier. Interview with Prosecutor Fang-Yu Lin, *supra* note 16. The Taiwan Society of Emergency Medicine also offers expert assessments at no cost to the parties. Chao-Hsin Wu (吳肇鑫), *Bang Bang Zaoyu Yiliao Jiufen De Jizhen Yisheng He Bing Jia* (幫幫遭遇醫療糾紛的急診醫生和病家) [*Help Emergency Doctors and Patients and Their Families Experiencing Medical Malpractice Disputes*], DR. 131, <https://dr131.com> (last visited Dec. 15, 2023).

⁹⁸ According to Shen and Chuang, *supra* note 20, among 657 district court civil cases from 2000 to 2009, 569 of them admitted written documents (書證, *shu zheng*), predominantly plaintiffs' medical records, while 523 of them (eighty percent of all cases) admitted expert assessment (鑑定, *jian ding*) of these records as evidence. Similarly, Pang-Yang Liu (劉邦揚) found that among 277 criminal cases decided from 2000 to 2010, ninety-six percent involved at least one round of expert assessment as evidence. Liu, *supra* note 66.

⁹⁹ The practice in Japan is similar. See Saikōsaibansho Jimu Sōkyoku (最高裁判所事務総局) [SUPREME COURT GENERAL SECRETARIAT], 令和3年司法統計年報1民事・行政編 [ANNUAL REPORT OF JUDICIAL STATISTICS FOR 2021, VOL. 1 (CIVIL CASES)] 39 Table 25, <https://www.courts.go.jp/app/files/toukei/592/012592.pdf> (only 47 cases with court-appointed expert witnesses out of 820 medical cases); see also Chiu Chi (邱琦), *Tairi Minshi Yiliao Susong—Shiwu Bijiao Yanjiu* (Shang) (臺日民事醫療訴訟—實務比較研究(上)) [*Medical Lawsuits in Taiwan and Japan: A Compare [sic] Study of Legal Practices I*], 2 ANGLE HEALTH L. REV. 185, 193–97 (2016) (observing that Japanese physicians, particularly in the Tokyo area, are more willing than Taiwanese physicians to provide opinions for parties in medical malpractice litigation and to testify in court).

¹⁰⁰ When a 2022 statutory reform of the alternative dispute resolution process is implemented, however, parties will have broader rights to request MRC reviews. See *infra* Part V.C.4.

serve as key criteria for experts conducting the assessment.¹⁰¹ Expert assessment reports often contain statements indicating whether the medical intervention at issue deviated from the “medical norm” or the “medical standard” and therefore constituted a medical error.¹⁰²

Whether medical errors are identified in MRC assessments, in turn, has a strong influence on criminal courts’ eventual judgments. In Liu’s study, for example, which analyzed 277 criminal cases with 380 defendants, 226 of the defendants received expert opinions indicating no medical errors. Among them, 216 (96%) were eventually acquitted. Another 110 defendants received expert opinions recognizing the existence of medical errors. Among this group, 68 (62%) received a guilty verdict, while the court still acquitted 42 (38%).¹⁰³ In short, courts are reluctant to overturn expert opinions favoring physicians in the criminal context. In cases where medical errors are found by the MRC, district courts nevertheless acquit a substantial proportion of criminal defendants. The situation is similar in the High Court. According to Wu et al., in 293 High Court cases receiving assessment reports favorable to the defendants, defendants were acquitted in 277 cases (95%). Even in 176 cases receiving assessment reports unfavorable to the defendants, defendants were still acquitted in 77 (44%).¹⁰⁴

The court’s deference to outside expert assessment is even more pronounced in civil cases. According to Shen & Chuang’s study, more than ninety percent of district court judgments are consistent with expert assessment on both breach of duty of care and causation. The percentage is similar in High Court cases.¹⁰⁵

In rare cases, courts convict medical defendants despite expert assessments finding no medical error. A prominent example involved a patient who suffered a serious allergic reaction to Vitamin B1 supplements added to an intravenous

¹⁰¹ TAIWAN JOINT COMMISSION ON HOSPITAL ACCREDITATION, *supra* note 31, at 11.

¹⁰² Reports of MRC assessments are unavailable to the public, although excerpts of these reports are often quoted in court decisions. In Taiwan Gaodeng Fayuan 101 Niandu Yi Shangsu Zi Di 2 Hao Xingshi Panjue (臺灣高等法院101年度醫上訴字第2號刑事判決) [Taiwan High Court Yi Shang Su Zi No. 2 Criminal Decision of 2012] (Taiwan High Ct. Dec. 26, 2012), for example, the court quoted the MRC report stating that the defendant’s performance of posterior spinal fusion surgery and response to subsequent ischemic stroke did not violate medical norms. This assessment played a key role in the court’s finding the defendant not guilty.

¹⁰³ Liu, *supra* note 66, at 283. The remaining forty-four defendants either received inconclusive reports or were not subject to expert assessment at all.

¹⁰⁴ See Chun-Ying Wu (吳俊穎), Tseng-Wei Yang (楊增暉) & Rong-Chi Chen (陳榮基), Yiliao Jiufen Jianding Yijian Dui Faguan Xinzheng Zhi Yingxiang (醫療糾紛鑑定意見對法官心證之影響) [How Medical Assessments Impact Trials’ Outcomes: A Nationwide Study], 12 TECH. L. REV. 97, 117 (2015).

¹⁰⁵ See Shen & Chuang, *supra* note 20, at 223–25.

injection.¹⁰⁶ The key issue was whether the prevailing medical norm required the providers to conduct an intradermal injection test for allergy before adding vitamin supplements to the injection.¹⁰⁷ Despite several expert assessment opinions finding no such requirement, the trial court found the defendants guilty.¹⁰⁸ The court reasoned that the providers should have paid attention to the potential for allergic reactions, had the capacity to conduct an intradermal injection test for such reactions, and yet failed to do so.¹⁰⁹ The Supreme Court affirmed the conviction.¹¹⁰ Cases like this often trigger fierce pushback from the medical community and fuel physician rhetoric that the legal system is intentionally hostile toward them.

Despite the critical role of medical records, obtaining them was once a key legal hurdle for patients and families. Before 2004, patients and families had no legal right to obtain their medical records from hospitals and clinics, which often were reluctant to share such information. A 2004 amendment to the Medical Care Act granted a right of access, and violating this right now may lead to administrative penalties for healthcare institutions.¹¹¹ In addition, since 2003 a mechanism of evidence preservation (證據保全, *zheng ju bao quan*) has been instituted in both criminal and civil procedure, allowing parties to request prosecutors or judges to secure necessary records directly from hospitals and clinics, which have the legal obligation to provide them promptly.¹¹²

Even with this reform, however, many plaintiffs remain suspicious that their medical records have been hidden or altered. One reason is that hospitals and clinics are legally allowed up to fourteen days to prepare the full medical records,¹¹³ which may be a reasonable administrative timeline but leaves room for plaintiffs' suspicions. Moreover, even with the mechanism of evidence

¹⁰⁶ See *Zuigao Fayuan 98 Niandu Tai Shang Zi Di 656 Hao Minshi Panjue* (最高法院98年度台上字第656號民事判決) [Supreme Court No. 656 Civil Decision of 2009] (Taiwan S. Ct. April 16, 2009). The Court applied the “should have cared, could have cared, but did not care” concept of negligence. See *supra* Part I.B.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ Medical Care Act § 71 (Taiwan). A 2022 law specified the time limit for applying for medical records and the entities (family members) who are qualified to apply.

¹¹² This procedure resembles the Japanese law procedure of *shōko hozen* (証拠保全). MINJI SOSHŌHŌ [MINSOHŌ] [C. C. PRO.] art. 234-42 (Japan) (authorizing and governing evidence preservation actions). See generally Shozo Ota, *Reform of Civil Procedure in Japan*, 49 AM. J. COMP. L. 561 (2001) (definitive overview).

¹¹³ The fourteen-day timeline was set by an administrative interpretation of the law by the Ministry of Health and Welfare in 2004. Weishu Yizi Di 0930217501 Hao Hanshi (衛福部衛署醫字第0930217501號函示) [Department of Health Yi Zi No. 0930217501 Administrative Interpretation Weifubu] (Taiwan).

preservation, judges and prosecutors often do not know what to look for or where to find it, so they cannot assess a penalty for hospitals' failing to provide it. This dynamic has often led to conflicts between hospitals and prosecutors, and many hospitals nowadays set up official liaisons to handle prosecutorial requests.¹¹⁴

Procedurally, requests for MRC assessments may be granted only in disputes that have either triggered investigations by prosecutors or have entered the trial stage.¹¹⁵ The MRC, upon receiving requests from judges or prosecutors, assigns the request to a preliminary assessment physician (初鑑醫師, *chu jian yi shi*). These physicians are mostly senior doctors in medical centers, but they occasionally “contract out” the task of preliminary assessment to less experienced physicians. The preliminary assessment opinion is then submitted to the MRC, and a full committee meeting takes place to finalize the report.¹¹⁶

Critics of the expert assessment process have raised three objections. First, plaintiffs have not been allowed to request an expert assessment in disputes that have not yet reached prosecutorial investigation or the trial stage. For plaintiffs whose main motivation is to know what happened, this design strongly motivates them to pursue litigation rather than adopting less confrontational and expensive solutions. Recognizing this incentive, patient advocacy groups pushed for legislation to implement an expert assessment system designed for ADR processes. A legislative package for medical ADR reform included this idea, but the first two attempts to enact the package failed in 2015 and 2018.¹¹⁷

¹¹⁴ This observation is based on the experience of our co-author, Chih-Cheng Wu, a veteran mediator and researcher of medical malpractice law.

¹¹⁵ According to Article 2 of the Operational Guideline for Medical Malpractice Disputes Assessment, *supra* note 71, “[t]he assessment of medical malpractice disputes . . . is limited to cases commissioned by the judicial or prosecutorial authorities. Cases under the following circumstances will not be accepted: 1. Commissions from the litigating parties and non-judicial or prosecutorial authorities; 2. Requests for pathological examinations of organs, tissues, or specimens.” *Id.*

¹¹⁶ Article 15 of the Operational Guideline states that “[t]he assessment opinion of the Medical Assessment Team shall be reached by unanimous decision among members. No minutes of the meeting will be produced.” *Id.*

¹¹⁷ The 2015 bill was titled the Yiliao Jiufen Chuli Ji Yiliao Shigu Buchang Fa (醫療糾紛處理及醫療事故補償法) [Medical Dispute Resolution and Medical Incident Compensation Act]. The Executive Yuan first submitted the bill in 2012, and it passed out of the legislative committee in 2014. Article 7 § 1 of the 2014 version required local governments to offer “preliminary assessment” (初步鑑定, *chu bu jian ding*) services for medical disputes not yet entering litigation. The bill eventually lost legislative momentum mainly due to the medical community’s opposition to another component of the bill: the public compensation fund. In the 2018 bill, the term “preliminary assessment” was replaced by “identification of legal issues or evaluative comment” (爭點整理或評析意見, *zheng dian zheng li huo ping xi yi jian*) to avoid the implication that it could be used by the court as evidence. After the failed 2018 attempt, the government commissioned the Taiwan Drug Relief Foundation (藥害救濟基金會, *yao hai jiu ji jin hui*) to pilot-test a system of medical expert consultation

In May 2022, however, the patient advocacy groups' efforts finally bore fruit. The Legislative Yuan passed the Medical Accident Prevention and Dispute Resolution Act (醫療事故預防及爭議處理法, *yi liao shi gu yu fang ji zheng yi chu li fa*), which institutionalizes a system both for medical expert consultation (醫事專業諮詢, *yi shi zhuan ye zi xun*) for requests filed directly by patients and families, and for medical dispute evaluation (醫療爭議評析, *yi liao zheng yi ping xi*) for requests forwarded by local health bureaus.¹¹⁸

A second common criticism of the expert assessment system is its lack of opportunity for cross-examination of the experts performing the assessments. Expert assessment as evidence is considered “institutional assessment” (機關鑑定, *ji guan jian ding*), which legally means that the final report reflects the opinion of the entity as a whole, rather than the opinions of individuals assigned to conduct the assessments. Technically, the court can request the institutional entity to send representatives to the court to answer questions concerning its report. In reality, however, the court almost never calls, or simply cannot find, individual physicians to come to the court as witnesses.¹¹⁹ The main reason is physicians' unwillingness to testify in court in fear of potential peer retribution—a genuine concern as the Taiwanese medical community is relatively small.¹²⁰

A third criticism is the assessment system's effect of delaying justice. Medical malpractice litigation practice in Taiwan—both civil and criminal—is notoriously time-consuming. For example, according to Shen and Chuang's study of civil cases from 2000 to 2009, the average time between the occurrence

and medical dispute evaluation. The pilot system provided a basis for part of the 2022 legislation. See *infra* Part III.C.

¹¹⁸ Ministry of Health and Welfare, Lifayuan Sandu Tongguo “Yiliao Shigu Yufang Ji Zhengyi Chulifa” Yingzao Yibing Hexie Guanxi (立法院三讀通過「醫療事故預防及爭議處理法」營造醫病和諧關係) [*The Legislative Yuan Passed the Medical Accident Prevention and Dispute Resolution Act for Building a More Harmonious Patient-Physician Relationship*] [hereinafter *The Legislative Yuan Passed the Medical Accident Prevention and Dispute Resolution Act*], <https://www.mohw.gov.tw/cp-5268-69786-1.html> (last visited Dec. 15, 2023).

¹¹⁹ By contrast, other individuals whose evidence is relevant to health care cases, such as coroners and social workers, are identifiable by name. Interview with Prosecutor Fang-Yu Lin, *supra* note 16.

¹²⁰ This fear may also contribute to the lack of U.S.-style expert witnesses or Japanese-style private assessments in Taiwan. All that most physicians are willing to do is to provide private consultations that do not show up in the court record. In fact, there is apparently only one U.S.-style expert witness recorded in Taiwan's litigation history. The case involved inflammatory cardiomyopathy, which is notoriously difficult to diagnose. To assist its decisionmaking, the court called a renowned emergency physician, who did not participate in the expert assessment process, as witness. Taiwan Gaodeng Fayuan Tainan Fenyuan 102 Niandu Yi Shang Geng Yi Zi Di 1 Hao Minshi Panjue (臺灣高等法院臺南分院102年度醫上更一字第1號民事判決) [Taiwan High Court Tainan Branch Yi Shang Geng Zi No. 1 Civil Judgment of 2013] (Taiwan High Ct. July 14, 2013).

of the injury and the district court judgment was forty-eight months.¹²¹ It took another nineteen months on average to reach the High Court judgment, and another eleven months until the Supreme Court judgment.¹²²

Delays in resolving criminal cases, while not as extreme, are likewise of concern.¹²³ A key contributor to the delay is the time spent on expert assessment. For the MRC, one round of expert assessment typically takes eight to ten months to complete,¹²⁴ and the empirical study by Yun-Tzu Chang calculated that, out of 372 district court civil judgments analyzed from 2000 to 2008, 364 (98%) underwent at least one round of expert assessment, with 154 (41%) requesting two or even more.¹²⁵ Moreover, lacking the opportunity to directly question the physicians writing the assessment report, what courts sometimes do instead is to request re-assessment, perhaps by different entities, further prolonging the litigation process.¹²⁶

¹²¹ Shen & Chuang, *supra* note 20, at 198–99. Their study encompassed 657 district court judgments, 299 High Court cases, and 109 Supreme Court decisions.

¹²² *Id.*

¹²³ See Pang-Yang Liu (劉邦揚), Xingshi Yiliao Jiufen Panjue Yu Shangsu Shen De Shizheng Kaocha (刑事醫療糾紛判決於上訴審的實證考察) [*An Empirical Study of Medical Malpractice Judgments in Taiwan's Criminal Appellate Courts*], 18 ACAD. SINICA L.J. 267, 291–293 (2016) (calculating the time needed to reach judgment at different levels of the court). Criminal cases on average take less time to finalize, likely due to the fact that in general, only cases of *death* (not injury) due to negligence can be appealed to the Supreme Court. *Id.* Liu's studies found that the mean time from occurrence of the injury to final judgment is 4.8 years (1739 days). Appeals to the High Court on average took 1.1 years to complete, while appeals to the Supreme Court, involving almost all death due to negligence cases, took 1.7 years (630 days). *Id.*

¹²⁴ See Hsiu-I Yang (楊秀儀), Lun Chubu Jianding Dui Yiliao Jiufen Chuli Zhi Yiyi—Dui Lifayuan 'Yiliao Jiufen Chuli Ji Yiliao Shigu Buchang Fa'caoan Di qi Tiao Zhi Qidai Yu Zhanwang (論初步鑑定對醫療糾紛處理之意義—對立法院「醫療糾紛處理及醫療事故補償法」草案第七條之期待與展望) [*On the Role of Preliminary Assessment for Medical Dispute Resolution: Expectation for the Article 7 of the "Medical Dispute Resolution and Medical Incidents Compensation Act" by the Legislative Yuan*], 216 TAIWAN L. REV. 48, 60 (2013).

¹²⁵ Chang, *supra* note 62, at 65. Our co-author Chih-Cheng Wu observes from personal experience that an important reason for the need for reassessment is the fact that prosecutors and judges often do not know, or lack expert support to figure out, what questions to ask for assessment. Formerly, judges and prosecutors often asked questions like “is there negligence in the case,” which the MRC and other assessment entities were trained to avoid answering. Nowadays, judges and prosecutors, other than those who are well-connected and can seek private consultation with physician friends, would often simply ask plaintiffs to specify questions and have defendants comment on them. This *laissez-faire* approach often fails to capture issues essential to deciding the case, increasing the possibility for follow-up assessments. In Taichung City, the court works with regional medical centers to speed up the process and enlists local physicians to help the court better form questions submitted for assessment. Interview with attorney Mu-Min Cheng, Taipei (Nov. 20, 2019). Overall, however, expert assessment remains a troublesome and widely criticized aspect of Taiwan's medical malpractice litigation.

¹²⁶ See Zuigao Fayuan 100 Niandu Tai Shang Zi Di 32 Hao Xingshi Panjue (最高法院100年度台上字第32號刑事判決) [Supreme Court No. 32 Criminal Judgment of 2011] (Taiwan S. Ct. 2011). This was one of the

A fourth critique of the current system is its lack of transparency. In practice, only the MRC knows who conducted the preliminary assessment. Which MRC members voted to approve the assessment report is also publicly unknown.¹²⁷ The situation is essentially the same when other entities conduct the assessment. This lack of transparency makes both parties suspicious of reports unfavorable to them. Plaintiffs often view the MRC as a place where “doctors protect doctors” (醫醫相護, *yi yi xiang hu*), while medical circles often ridicule the MRC as a place where “doctors hurt doctors” (醫醫相害, *yi yi xiang hai*).¹²⁸ The suspicions are aggravated by the procedural requirement that the MRC assessment report be approved by unanimous decision, which creates an underlying dynamic to reach compromises that may mix in non-medical considerations.¹²⁹ For example, it is rumored that the assessment process often considers the reputation of defendant physicians, with higher-ranking ones receiving more favorable opinions.¹³⁰

D. Alternative Dispute Resolution Mechanisms in Practice

The time-consuming nature of the process, the low success rate for civil plaintiffs, and the low conviction rate in criminal cases to which civil claims are appended all make medical malpractice litigation a problematic means of seeking compensation, and one that also inflicts significant emotional burdens on all sides. To alleviate these burdens and improve the overall efficiency of dispute resolution processes, many stakeholders have been promoting alternative dispute resolution (ADR) mechanisms, in particular third-party mediation, as a promising substitute. Effective settlement practices have been identified as one key reason for the recent decline in prosecutions of health care personnel.¹³¹

Currently, the structure of medical ADR features a complex mosaic of procedural options (Diagram 3). To simplify the ADR system and improve its

longest disputes to be finalized, taking 15 years to resolve. The incident occurred in 1996, while the Supreme Court decision came in 2011.

¹²⁷ Operational Guideline for Medical Malpractice Disputes Assessment, *supra* note 71, at 15.

¹²⁸ Chun-Ying Wu (吳俊穎) et al., Yiliao Jiufen Jianding De Weilai—You Zhuanye Jianding Tantaoy Yiliao Jiufen Jianding Zhi Xingge (醫療糾紛鑑定的未來—由專業鑑定探討醫療糾紛鑑定之興革) [*The Future of Medical Dispute Assessment—Compare Medical Dispute Assessment with Other Types of Professional Assessment*], 183 TAIWAN L. REV. 36, 36–37 (2010).

¹²⁹ Operational Guideline for Medical Malpractice Disputes Assessment, *supra* note 71, art. 15.

¹³⁰ This report comes from our co-author Chih-Cheng Wu, a physician, law teacher, and experienced mediator.

¹³¹ Interview with Prosecutor Fang-Yu Lin, *supra* note 16.

effectiveness, the Legislative Yuan in 2022 passed the Medical Accident Prevention and Dispute Resolution Act (醫療事故預防及爭議處理法, *yi liao shi gu yu fang ji zheng yi chu li fa*) to consolidate existing third-party mediation processes into one-stop forums at the local jurisdiction level.¹³² The new forums are styled “medical dispute mediation committees” (醫療爭議調解會, *yi liao zheng yi diao jie hui*).¹³³ When the new system is implemented, all medical disputes will go through mandatory mediation before entering trial, and the mediation must conclude in three months.¹³⁴ The new system will also allow mediators to invite experts with medical, legal, psychological, and social work backgrounds to offer their opinions.¹³⁵

The effective date of the Act is not yet determined as of this writing, and restructuring the system will take a few years before the new structure becomes operational.¹³⁶ Diagram 3 depicts the current ADR system. Diagram 4 summarizes the future ADR structure once the Act becomes effective.

¹³² *The Legislative Yuan Passed the Medical Accident Prevention and Dispute Resolution Act*, *supra* note 118.

¹³³ *Id.* The establishment of medical dispute mediation committees is provided in Article 12 of the law (official English translation not yet available; our unofficial translation is in the Statutory Appendix).

¹³⁴ The three-month time limit is provided in Article 14 § 1. The requirement of mandatory mediation for both civil and criminal medical disputes is in Articles 15 and 16.

¹³⁵ The option to invite outside experts to express opinions is provided in Article 21 § 2.

¹³⁶ Interview with Jui-Yuan Hsueh (薛瑞元), Minister of Health and Welfare, Taipei (May 6, 2023). Minister Hsueh said he hoped the new law would be implemented within 2023, but that “[i]t depends on my boss [President Tsai].”

Diagram 3: The Current ADR Process

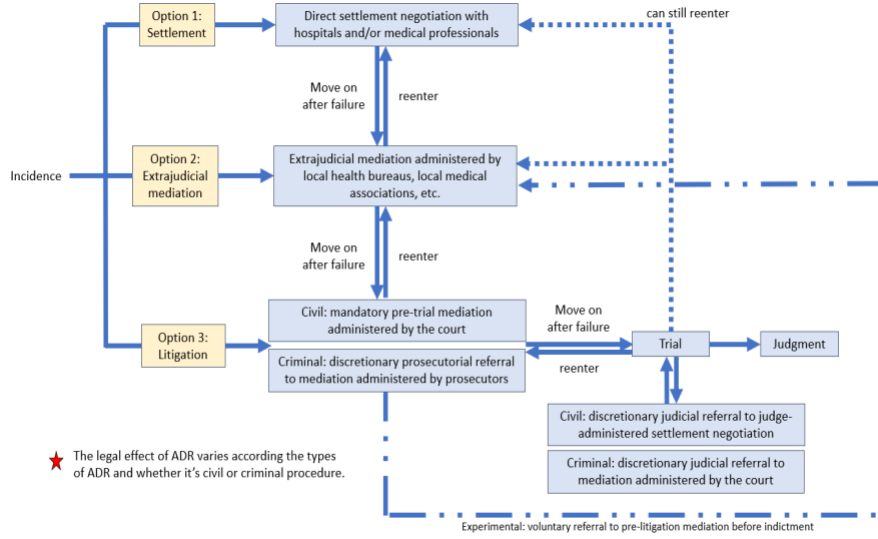
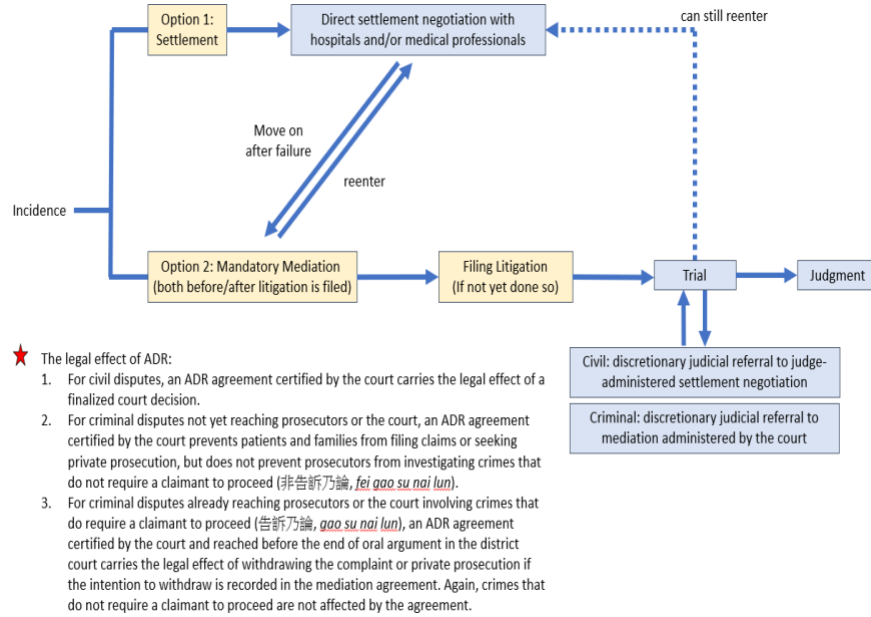


Diagram 4: *The Future ADR Structure under the Medical Accident Prevention and Dispute Resolution Act (enacted 2022; effective 2024)*



1. Options for the ADR Process

In choosing among mediation options, unlike in the United States and many other countries, in Taiwan usually the potential plaintiffs themselves make the decisions, rather than their lawyers. Even after the initiation of litigation, there is no legal requirement in civil cases that plaintiffs be represented by a lawyer, and some plaintiffs cannot afford one.¹³⁷ The typical role played by lawyers in the ADR process, especially before litigation, is as consultants. Potential plaintiffs commonly approach lawyers for advice at different stages of the ADR

¹³⁷ Interview with attorney Mu-Min Cheng (鄭牧民), *supra* note 125. Chapter seven of the Bylaws of the Taipei Bar Association (臺北律師公會, *tai bei lu shi gong hui*) limits the hourly consultation fee in ordinary cases to 8,000 NTD (270 USD). See *Taipei Bar Assoc. Charter*, TAIPEI BAR ASSOC., <https://www.tba.org.tw/關於我們/公會規章/會務相關法規/公會章程/> (last visited Nov. 4, 2023). In rare exceptions where the case is complicated or unusual, the hourly fee limit can be raised to 12,000 NTD (400 USD). *Id.* Although some big-name lawyers may charge more, the market price for an hour of consultation typically falls around 4,000–6,000 NTD (130–200 USD). Interview with attorneys Hsien-Hsun Wang (王憲勳) and Meng-Syuan Lee (李孟軒), Taipei (Oct. 10, 2022).

process. In part due to their consulting role, lawyers usually respect clients' choices among different procedural options.

Prosecutors and judges are also important players in ADR processes. Their view of ADR is nuanced and technical. In civil cases, judges typically welcome settlement, relieving them of the burden of writing opinions and helping them clear their dockets. In criminal cases, however, a factor that may negatively affect prosecutors and judges' view toward ADR is the administrative time limit imposed on them to finish a case.¹³⁸ If prosecutors or judges fail to meet the time limit too often, such violations may leave a negative mark on their annual performance evaluations, adversely affecting their chance of receiving bonuses or promotions. Thus prosecutors and judges in criminal cases may focus their energy on investigating the cases rather than encouraging ADR, which is quite time-consuming itself.¹³⁹ In addition, in the current system most ADR agreements involving criminal disputes do not carry the legal effect of terminating the litigation, further diminishing prosecutors' and judges' incentive to encourage ADR agreements.

Three action options are currently available for patients and families seeking legal remedies: direct settlement negotiation (Option One), extrajudicial third-party mediation (Option Two), and litigation (Option Three).¹⁴⁰ Although most complainants pursue Options One to Three in sequential fashion, moving onto the next when the previous one fails, legally there is no required order. Patients and families may go directly to Options Two or Three.¹⁴¹ Parties deeper in the process may also revert back to previous options.

¹³⁸ Interview with Judge Ning-Li Lu (呂寧莉), Taipei (Dec. 3, 2019). The limit typically is one year for prosecutors. For judges, the limits are sixteen months, twenty-four months, and twelve months for District Court, High Court, and Supreme Court judges respectively. *Id.*

¹³⁹ *Id.*

¹⁴⁰ See Diagram 3. Missing in the picture is arbitration, a popular ADR option for medical disputes in countries like the U.S. but seldom used in Taiwan. Proponents of arbitration, however, now call for broader application of arbitration of medical disputes. See, e.g., En-Wei Lin (林恩璋), Lun Yiliao Zhongcai Yu Yiliao Fenzheng Zhi Youyue Xing: Yi Falu Fengxian Guanli Guandian wei Zhongxin (論醫療仲裁於醫療紛爭之優越性：以法律風險管理觀點為中心) [*The Advantages of Medical Arbitration in Medical Disputes: By the View of Legal Risk Management*], 7 KAINAN L. J. 94 (2015); Ting Chang, Taiwan Yiliao Jiufen Shiyong Zhongcai Zhidu Zhi Yanjiu-Yi Meiguo ADR Jingyan wei Zhongxin (臺灣醫療糾紛適用仲裁制度之研究—以美國ADR經驗為中心) [*On the Use of Arbitration for Medical Disputes in Taiwan: Lessons from the U.S. Experience*], 51 TUNGSHAI U. L. J. (東海大學法學研究) 217 (2017). The Chinese Arbitration Association (中華民國仲裁協會) now provides arbitrators with a medical background. See CHINESE ARBITRATION ASSOCIATION, <http://www.arbitration.org.tw/ArbitratorResults.php> (last visited Nov. 4, 2023). In 2022, for instance, eighteen out of 853 Taiwanese arbitrators listed by the association were medical doctors. *Id.*

¹⁴¹ Interview with attorney Meng-Syuan Lee, *supra* note 137.

Third-party mediation is the centerpiece of the current ADR system. It can take place either before or after a lawsuit is filed. Extrajudicial (訴訟外, *su song wai*) mediation (Option Two) is administered mainly by local health bureaus or medical associations, and occasionally by townships and county-administered cities (鄉鎮市, *xiang zhen shi*).¹⁴² Mediation after the complainant has resorted to Option Three and initiated a lawsuit is administered by the court or (in criminal cases) by prosecutors.¹⁴³

In civil malpractice cases, parties are legally required to go through one round of court-administered mediation before entering trial.¹⁴⁴ This is termed “mediation during litigation” (訴訟上調解, *su song shang diao jie*).¹⁴⁵ When the dispute enters trial, the court still has discretionary power to refer the case back to settlement negotiation overseen by the court, commonly called “settlement during litigation” (訴訟上和解, *su song shang diao jie*).¹⁴⁶

In criminal proceedings, during investigation and before indictment, prosecutors have discretionary power to refer the case to third-party mediation, termed “mediation by referral” (移付調解, *yi fu diao jie*).¹⁴⁷ Once the criminal complaint enters trial, the court itself also has discretion to conduct mediation by referral.¹⁴⁸ Even during trial, parties still may reenter negotiations under Options One and Two.

The various procedural options in the current system are complicated even for lawyers to navigate. Moreover, ADR agreements reached via different options carry different legal effects, causing confusion among both parties and their representatives.

¹⁴² The legal basis for the latter platform is the Township and County-Administered City Mediation Act. See Xiangzhen Shi Tiaojie Tiaoli (鄉鎮市調解條例) [Township and County-Administered City Mediation Act] (Jan. 13, 2023), <https://law.moj.gov.tw/ENG/LawClass/LawAll.aspx?pcode=10020003> (Taiwan) [hereinafter Township and County-Administered City Mediation Act]. However, the role of this platform in the context of medical malpractice dispute resolution has been decreasing, particularly in civil disputes, and therefore it is not listed in Diagram 3.

¹⁴³ Kevin Chien-Chang Wu and Ching-Ting Liu observed that “[i]f the dispute was not successfully mediated outside of the litigation procedure, it is also difficult for the disputing parties to reach an agreement via the mediation by the court or referred by the prosecutor.” Wu & Liu, *supra* note 2, at 292.

¹⁴⁴ Civil Code art. 403 (FAWUBO FAGUI ZILIAOKU) (Taiwan).

¹⁴⁵ Sometimes the court dismisses the mediation outright. *Id.* art. 406. In other cases, the mediation process goes nowhere. This occurs, for example, if the process breaks down quickly as parties have no intention to talk, or even skip the meeting altogether.

¹⁴⁶ *Id.* art. 377.

¹⁴⁷ *Id.* art. 248-2.

¹⁴⁸ *Id.* art. 271-4.

In civil disputes, ADR agreements achieved via Options One (direct settlement negotiation) and Two (extrajudicial mediation) processes are treated merely as civil contracts, which legally do not bar parties from bringing subsequent litigation.¹⁴⁹ Once a dispute has entered civil trial, ADR agreements from settlement and mediation processes administered or overseen by the court have the legal effect of enforceable finalized civil judgments.¹⁵⁰

The legal effect of ADR agreements in criminal procedure is more complex. The general rule is that in most situations, ADR agreements have no binding effect on judges or prosecutors. Rather, they serve only as a discretionary factor in prosecutors' consideration of whether to indict and whether the defendant qualifies for delayed prosecution (緩起訴, *huan qi su*), and in judges' consideration of probation (緩刑, *huan xing*) or reduced sentence (減刑, *jian xing*).¹⁵¹

¹⁴⁹ Civil Code art. 736 (FAWUBU FAGUI ZILIAOKU) (Taiwan). For example, parties may dispute the validity, scope, or meaning of terms of the contract, in which case the court must respond. In practice, however, the settlement or mediation agreement often has an anchoring effect: the court may hesitate to exceed the scope and amount of compensation laid out in the agreement. Such judicial constraint, in turn, may discourage most plaintiffs from suing afterward as there is little to gain. Interview with Chih-Chia Wang, Taipei (Oct. 10, 2022). Mediation agreements reached through the Township and County-Administered City Mediation Act process, however, do have the legal effect of enforceable civil judgments. Township and County-Administered City Mediation Act, *supra* note 142.

¹⁵⁰ Civil Code art. 380, 416 (FAWUBU FAGUI ZILIAOKU) (Taiwan); Qiangzhi Zhixing Fa (強制執行法) [Compulsory Enforcement Act] art. 4 (Taiwan), *translated in* FAWUBU FAGUI ZILIAOKU (Laws and Regulations Database of the Republic of China (Taiwan)), *supra* note 5. Technically, mediation agreements reached outside the courtroom through Option One and Two processes remain merely civil contracts. Most parties, however, would report the agreements to the court and turn them into mediation or settlement during litigation, making them final and enforceable.

¹⁵¹ In practice, the court would view the existence of an ADR agreement as a proxy for determining the defendant's degree of repentance or "post-offense attitude" (犯後態度, *fan hou tai du*), a key factor in deciding whether the defendant qualifies for probation or reduced sentence. The conditions for probation are laid out in Criminal Code Article 74 (FAWUBU FAGUI ZILIAOKU) (Taiwan). That provision does not directly mention ADR agreements. Rather, it is judicial practice to equate reaching an agreement with repentance (a condition for probation).

For cases illustrating the judicial approach on this point, *see* Supreme Court No. 4259 Criminal Judgment of 2018, *supra* note 57. Another illustrative case is one in which the defendant physician signed an extrajudicial mediation agreement and made a compensation payment. *See* Taipei Difang Fayuan 104 Niandu yi Su Zi Di 2 Hao Xingshi Panjue (臺北地方法院104年度醫訴字第2號刑事判決) [Taipei District Court 104 Medical Litigation No. 2 Criminal Judgment of 2015], 2015 1 (Taipei District Ct. Dec. 27, 2015) (Taiwan). The agreement contained a statement that the complainants would withdraw their criminal complaint. *Id.* However, in subsequent court sessions, the deceased patient's son claimed that his understanding was that the agreement was civil in nature, unrelated to the criminal case. *Id.* The district court viewed the misunderstanding as revealing that the defendant physician was dishonest and unwilling to disclose the truth during the negotiation process and ruled that the defendant was not eligible for probation because the defendant had not shown repentance and might repeat the offense. *Id.* The decision, however, was reversed in the High Court on the ground that the healthcare delivery was not negligent. *See* Taiwan Gaodeng Fayuan 107 Niandu yi Shangsuo Zi Di 4 Hao Xingshi

For crimes regarding which prosecutors can act upon their own initiative (非告訴乃論, *fei gao su nai lun*), this general rule applies to all situations.¹⁵² Once such cases have entered trial, a judgment must be made regardless of whether an ADR agreement has been reached.

For crimes requiring a complainant for prosecutors to proceed (告訴乃論, *gao su nai lun*), however, the general rule has an exception: ADR agreements containing complainants' explicit statement to withdraw or forego any criminal complaint may end litigation sooner.¹⁵³ Agreements reached via Options One and Two processes or through mediation by prosecutorial or judicial referral carry the legal effect of withdrawing the complaint and precluding relitigation in the time window between the filing of criminal complaints and the end of oral argument at the district court.¹⁵⁴ Outside the time window, the general rule comes back in full force.¹⁵⁵

Another exception involves an alternative mediation platform administered by township and county-administered cities (鄉鎮市調解, *xiang zhen shi diao jie*), the lowest level of Taiwan's government structure.¹⁵⁶ The essential function of these local mediation forums is to resolve daily disputes among citizens.¹⁵⁷ The scope of these forums also extends to disputes involving crimes requiring a complainant to proceed.¹⁵⁸ Mediators for these forums lack medical expertise, rendering these platforms mostly useless for resolving medical disputes. Despite this ineffectiveness, some prosecutors do refer mediations to these forums, and the Township and County-Administered City Mediation Act (鄉鎮市調解條例, *xiang zhen shi diao jie tiao li*) Article 28 gives agreements reached in these forums the legal effect of withdrawing the complaint or private prosecution for crimes requiring a complainant to proceed.¹⁵⁹ To carry that legal effect, the

Panjue (臺灣高等法院107年度醫上訴字第4號刑事判決) [Taiwan High Court Annual Appeals Medical Journal No. 4 Criminal Judgment of 2018], 2018 1 (Taiwan High Ct. May 26, 2020).

¹⁵² The most that ADR agreements can do in these situations is to include clauses expressing complainants' willingness not to hold the defendant criminally liable. As shown in the 2015 case discussed in the previous footnote, that only serves as one factor that the court or prosecutors may consider in making indictment or sentencing decisions.

¹⁵³ Code of Criminal Procedure art. 238 (FAWUBU FAGUI ZILIAOKU) (Taiwan).

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

¹⁵⁶ See *supra* note 142, Township and County-Administered City Mediation Act. Article 1 of that law states that "[t]ownships and county-administered cities shall establish mediation committees in charge of the following matters: 1. Civil cases; and 2. Criminal cases instituted only upon complaint." *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

agreements must be reached before the conclusion of oral argument in district court, and the intention to withdraw must be recorded in the mediation agreement and certified by the court.¹⁶⁰

In the authors' view, the excessive complexity of Taiwan's current medical ADR system as detailed above requires reform, and the Medical Accident Prevention and Dispute Resolution Act of 2022, when it is implemented, will represent an important step forward in improving the efficiency and fairness of ADR proceedings.

2. *The Role of Third-Party Mediators*

The key players in the various mediation processes shown in Diagram 3 are the third-party mediators (調解委員, *diao jie wei yuan*). How these mediators are recruited and assigned varies greatly across jurisdictions. Some rely heavily on the assistance of medical associations. For example, in an Option Two mediation, the health bureaus in both Taipei and Taichung refer the case to the local medical association, which recommends medical experts to assist in the case.¹⁶¹ In Taipei, medical experts do not serve as mediators themselves but work alongside the official mediator assigned by the health bureau, who typically has a legal background.¹⁶²

By contrast, in New Taipei City (which boasts the highest success rate for extrajudicial mediation),¹⁶³ the health bureau and the medical association work parallel to each other. They both provide mediation services and have their respective pools of mediators (with some personnel overlaps). A key feature of mediations administered by the New Taipei City health bureau is its co-mediator

¹⁶⁰ Due to the low quality of these alternative forums, and to avoid unnecessary prosecutorial investigation that sometimes causes traumatic experiences to medical professionals, in 2017 the Health Ministry in collaboration with the Ministry of Justice initiated a Pilot Plan for Diverse and Two-Way Medical Dispute Resolution (多元雙向醫療爭議處理機制試辦計畫, *duo yuan shuang xiang yi liao zheng yi chu li ji zhi shi ban ji hua*). The plan encouraged prosecutors to forward mediation by referral to Option Two mediation forums administered by local health bureaus, with access to some medical expert advice that previously was unavailable. The first mediation had to take place within forty-five days of the criminal claim, and the whole mediation process had to conclude within ninety days. The Pilot Plan's intent was to encourage more ADR agreements before indictment, allowing prosecutors to skip the investigation process altogether. See Taiwan Yiliao Gaige Jijin Hui (台灣醫療改革基金會) [Taiwan Healthcare Reform Foundation], <https://www.thrf.org.tw/medicaldisputes/1758>; *Pilot Plan for Diverse and Two-Way Medical Dispute Resolution*, Ministry of Health and Welfare, <https://dep.mohw.gov.tw/doma/cp-2712-42946-106.html>.

¹⁶¹ Interview with attorney Mu-Min Cheng, *supra* note 125.

¹⁶² *Id.*

¹⁶³ *Matters Related to Medical Dispute Resolution and Assessment*, *supra* note 55.

system. Upon receiving a request, the bureau assigns two experts, one with a legal and the other with a medical background, to serve as co-mediators.¹⁶⁴ Among the various arrangements in other jurisdictions, in many the traditional single law-trained mediator system is still in place.

The overarching goal of most mediators is to prevent disputes from entering the courts.¹⁶⁵ The participation of medical experts in mediation allows some skillful mediators to engage in a *two-faced strategy* during private discussions with the parties, aiming to avoid costly litigation. On one hand, the medical experts, either as advisors or mediators, suggest to the medical side that their errors are evident, to make them more receptive to settlement. On the other hand, mediators with a legal background, with the same aim, tell the patient's side that the case may be too difficult to win in court.¹⁶⁶

Eventually, the effectiveness of such a strategy comes down to individual mediators. Mediation is an art. Practitioners can identify star mediators with success rates exceeding 80% to 90%, doubling or even tripling the mean success rate of 31% to 41% calculated for all extrajudicial mediations administered by local health bureaus from 2014 to 2020.¹⁶⁷ These star mediators tend to be experienced veterans, some of whom are physicians who acquired legal degrees later in their careers.

¹⁶⁴ See *Pilot Plan for Diverse and Two-Way Medical Dispute Resolution*, *supra* note 160.

¹⁶⁵ The mediators' priority may not be in line with patients' expectation. For example, Kevin Chien-Chang Wu & Ching-Ting Liu observed that "Due to its [sic] lack of medical expertise, local health authorities have to rely on representatives from medical associations in conducting mediation. This may raise the patient party's stereotyped suspicion of doctors shielding one another and indirectly reduce the motivation for negotiation . . . Some patient parties might look forward to disciplining healthcare professionals or facilities who were responsible for medical injuries. To the disappointment of these patient parties, discipline is not part of the goal of the mediation . . ." Wu & Lu, *supra* note 2, at 291–292 (citing Tsung-Fu Chen, Taiwan Yiliao Jiufen Chuli Jizhi Zhi Xiankuang Yu Jiantao (臺灣醫療糾紛處理機制之現況與檢討) [*Mechanisms for Medical Disputes Resolution in Taiwan: Facts and Criticisms*], 34 CROSS-STRAIT L. REV. 5 (2011)); Feng-Ao Li (李鳳翱), Yiliao Lunli Yu Falu—Tan Yiliao Jiufen Tiao Chu Zhi Shiwu (談醫療糾紛調處之實務) [*Addressing the Practices of Medical Dispute Mediation by Local Health Authority*], 9 J. HEALTHCARE QUALITY 48 (2015)).

¹⁶⁶ This advantage comes from the medical experts' ability to interpret the evidence at hand and help the mediation team formulate the best strategy forward. The amount of evidence available to mediators varies according to the timing of the mediation. If the patient side goes directly to extrajudicial mediation, the only evidence available typically is patients' medical records. Members of the mediation team can examine the records themselves, but they cannot submit them to outsiders for expert opinion. For mediations that occur after litigation has been initiated, the evidence available expands to include the expert assessment report, and it is common to have multiple reports if the mediation takes place during the appeal process. Our co-author, Chih-Cheng Wu, offers these observations based on his extensive experience as a mediator.

¹⁶⁷ *Matters Related to Medical Dispute Resolution and Assessment*, *supra* note 55.

Taiwanese mediators' compensation, even those of high reputation, is dwarfed by what US mediators typically receive.¹⁶⁸ Local health bureaus pay a flat fee of 2,500 NTD (USD 83) for each case. For mediations in court, the judge approves the fee for successful mediations based on the amount of claimed compensation. The common fee for medical cases is 4,000 NTD (USD 133) per case. For unsuccessful mediations, mediators receive compensation only for their time and transportation cost.¹⁶⁹

3. *The Limited Availability of Empirical Data on ADR*

The only official data on the effectiveness of ADR for medical disputes in Taiwan are the statistics collected by the Ministry of Health and Welfare (MOHW).¹⁷⁰ The health ministry's statistics, however, focus solely on extrajudicial mediations administered by local health bureaus.

MOHW tracked both the total number and the success rate of such mediations from 2014 to 2021, for each jurisdiction.¹⁷¹ Chart K shows the yearly statistics of mediations administered by local health bureaus: the number of successful mediations, the number of total mediations, and the success rates.¹⁷² Chart L shows the statistics for the six major metropolitan areas.¹⁷³

¹⁶⁸ Interview with attorney Scott Irby, Hot Springs, Ark. (June 15, 2023) (Mr. Irby is an attorney with the Wright Lindsey & Jennings firm). In medical malpractice cases, mediators in smaller jurisdictions such as Arkansas typically receive compensation, split equally between plaintiff and defendant, in the range of what expert witnesses receive – 300+ USD per hour or 2000+ USD per day. In larger states and in more complex litigation, U.S. mediators charge far more.

¹⁶⁹ Fayuan Banli Minshi Shijian Tiaojie Weiyuan Ri Fei Lufei Ji Baochou Zhigei Biaozhun (法院辦理民事事件調解委員日費旅費及報酬支給標準) [*Daily Travel Expenses and Remuneration Standards for Court Mediation Committee Members Handling Civil Matters*], LAW BANK, <http://db.lawbank.com.tw/Eng> (last visited Nov. 25, 2023).

¹⁷⁰ *Matters Related to Medical Dispute Resolution and Assessment*, *supra* note 55.

¹⁷¹ *Id.* The MOHW website also provides the total number of such mediations from 2008 to 2013, but not the success rate for those years.

¹⁷² *Id.*

¹⁷³ *Id.* Mediation success rates varied among the major population centers. The highest over the eight-year span was achieved by New Taipei City (sixty-four percent, 246 successful mediations out of 385 cases), and the lowest by Kaohsiung City (twenty-five percent, 280 successful mediations out of 1121 cases). For details, see Table G.

Chart K: Annual statistics of mediations administered by local health bureaus (all jurisdictions)

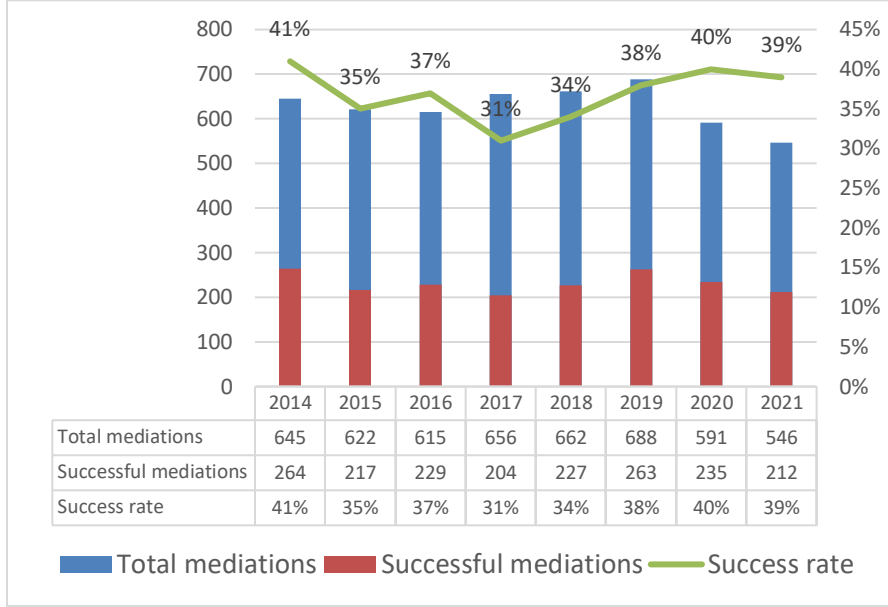
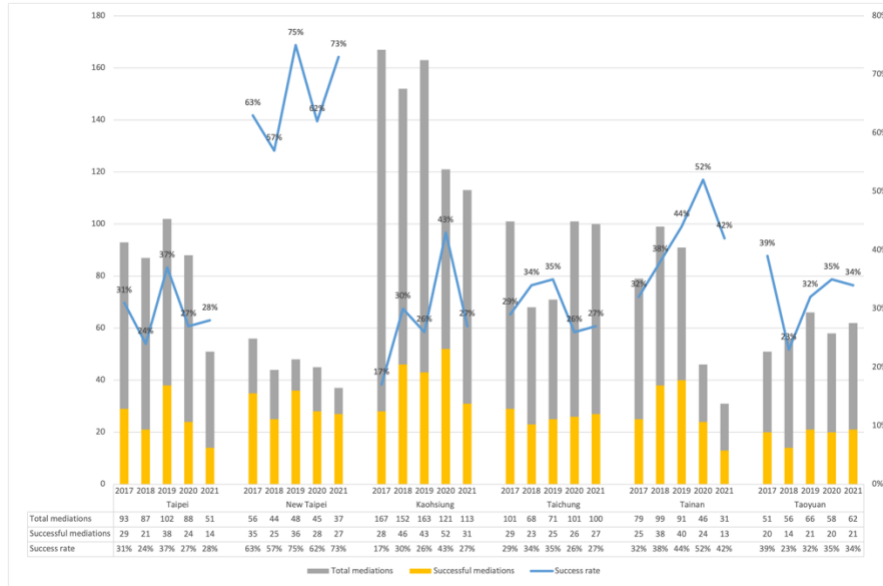


Chart L: Annual mediations administered by local health bureaus (metropolitan areas)



Health bureau-administered extrajudicial mediation is only one of several ADR possibilities currently available. Empirical data on other ADR options are difficult to obtain.

Other public and private entities are potential sources of relevant data. Individual courts may collect information on mediations occurring after litigation is initiated, i.e., mediations during litigation and mediations by referral. The success rate for these mediations is likely lower than for those administered by local health bureaus and medical associations, because easier cases tend to be resolved early and those that enter the courts are often the most intractable. However, public access to such information is lacking.

Many healthcare institutions maintain data on results of direct settlement negotiations. Likewise, local medical associations may keep records of extrajudicial mediations they administer. Such data, however, are rarely made public.

The paucity of empirical data makes it difficult to construct a comprehensive picture of how patients and their families receive compensation through ADR.

One of the few relevant empirical studies is Chun-Ying Wu and colleagues' survey comparing physicians' self-reported experience of medical malpractice disputes in 1991 and 2005. The study revealed that 42% (in 1991) and 35% (in 2005) of malpractice disputes were resolved through mediations or settlement agreements. Compensation payments were usually small: less than 100,000 NTD (3,300 USD) in 40% of disputes in 1992 and 49% in 2005, and between 100,000 and 1,000,000 NTD (3,300-33,000 USD) in 55% of disputes in 1991 and 42% in 2005. Only 5% of disputes in 1991 and 9% in 2005 involved compensation over one million NTD (33,000 USD).¹⁷⁴ These data, however, are of limited value: they are outdated and based on self-reported experience.

Despite the data's limitations, Wu and colleagues' survey supports a sentiment shared widely by observers involved in medical injury compensation: hospitals and physicians are often willing to pay a little to avoid bigger trouble. One expert suggested that hospitals often have an implicit threshold, typically around 100,000-200,000 NTD (3,300-6,600 USD), for determining whether to accept a settlement or mediation agreement. Even when providers are not clearly at fault, many are willing to accept ADR agreements with amounts below the implicit threshold to prevent the dispute from boiling over into lengthy litigation. However, if a plaintiff's demand exceeds the threshold, it becomes more likely that the hospital would prefer to resolve the case in court, unless the evidence clearly favors the patient. The implicit threshold, therefore, makes it easier for smaller cases to be settled, while more serious cases end up in court more frequently.¹⁷⁵

E. The Supplementary Role of Public Compensation Funds

Besides the court system and the ADR venues, there is also a supplementary element of Taiwan's injury compensation processes: public compensation funds. The chief examples are the Drug Injury Relief Fund (藥害救濟基金, *yao hai jiu ji ji jin*), the Vaccine Injury Compensation Fund (預防接種受害救濟基金, *yu fang jie zhong shou hai jiu ji ji jin*), and the Childbirth Accident Relief Fund (生產事故救濟基金, *sheng chan shi gu jiu ji ji jin*).¹⁷⁶

¹⁷⁴ See WU ET AL., *supra* note 60, at 46-56.

¹⁷⁵ Interview with attorney Ya-Yun Liu (劉雅雲), Taipei (Nov. 5, 2019).

¹⁷⁶ For the statutory basis and details of these funds, see Tables B and C. Table C is based on Wu & Liu, *supra* note 2, at 295, with minor revisions to reflect recent changes. A substantive difference between Wu & Liu and the authors is that we interpret the Drug Injury Relief Fund as a no-fault compensation program, while Wu & Liu view it as a fault-based scheme. The difference lies in the fact that technically the fund pays only for

Table B: *Statutory bases for major compensation funds*

Name of Fund	Statutory Basis
Drug Injury Relief Fund	Drug Injury Relief Act (藥害救濟法, <i>Yao Hai Jiou Ji Fa</i>) (since 2000)
Vaccine Injury Compensation Fund	Communicable Disease Control Act (傳染病防治法, <i>Chuan Ran Bing Fang Zhi Fa</i>) (since 1999)
Childbirth Accident Relief Fund	Childbirth Accident Emergency Relief Act (生產事故救濟條例, <i>Sheng Chan Shi Gu Jiu Ji Tiao Li</i>) (since 2015)

injuries not caused by victims, manufacturers, importing companies, etc. In practice, however, these parties are rarely found at fault and the program functions effectively as a no-fault administrative compensation regime.

Table C: Institutional features of major compensation funds

Category	Vaccine Injury Compensation Fund	Drug Injury Relief Fund	Childbirth Accident Relief Fund
Eligible claimant	Patient, legal representative, heir	Patient, legal representative, heir	Patient, heir, mother of the fetus
Time limit for filing application	Within two years after the injury is known or within five years after the injury	Within three years after the injury is known	Within two years after the incidence is known or within ten years after the incidence
Upper limits of compensation (one USD = thirty NTD)	200,000 USD	100,000 USD	133,000 USD
Duration for review	Six months; no more than nine months	Three months; no more than four months	Three months; no more than six months
Permission for concurrent litigation	Yes	Yes	No
Subrogation by competent authority	No	Yes, towards those who are liable	Yes, towards those who are liable
No-fault compensation	Yes	Yes	Yes

The history of the Childbirth Accident Relief Fund (“Childbirth Fund”) is connected to recent developments in Taiwan’s medical injury compensation regimes. The fund was established by the Childbirth Accident Emergency Relief

Act (2015), which in turn was preceded by the Birth-Related Incident Relief Pilot Plan that was in place from 2012 to 2016 (“Pilot Plan”).¹⁷⁷

The Pilot Plan was a direct policy response to the “depletion of five major medical specialties” phenomenon discussed in Part V, which hit the specialty of obstetrics and gynecology especially hard.¹⁷⁸ The Pilot Plan was funded mainly through government appropriations and a surtax on tobacco products.¹⁷⁹ Under the plan, in the case of a birth-related injury, the medical institution would apply to the government for compensation on patients’ behalf after the obstetrician and patient involved reached an agreement.¹⁸⁰ Overall, the Pilot Plan was viewed as a success. In the four-and-a-half years of its existence, it received 494 applications for compensation, of which 427 (86%) were approved, with compensation payments totaling 415,000,000 NTD (14,000,000 USD).¹⁸¹

¹⁷⁷ See MINISTRY OF HEALTH AND WELFARE, SHENGCHAN SHIGU JIUJI BAOGAO (2018 生產事故救濟報告) [2018 BIRTH ACCIDENT RELIEF REPORT] 14 [hereinafter 2018 BIRTH ACCIDENT RELIEF REPORT], <https://dep.mohw.gov.tw/DOMA/cp-5059-58136-106.html> (last visited Dec. 15, 2023).

¹⁷⁸ *Id.*

¹⁷⁹ Wu & Liu, *supra* note 2, at 298–299.

¹⁸⁰ *Id.* (observing that “[i]n the pilot plan, once the medical facility received compensation from the government, the obstetrician would be deemed not liable by a review committee that determined the compensation. There is criticism against the review committee’s taking the place of the court in determining liability.”) (citation omitted).

¹⁸¹ See 2018 BIRTH ACCIDENT RELIEF REPORT, *supra* note 177, at 17; Table D.

Table D: *Approved Applications under the Pilot Plan, 2012-June 2016*

	Deaths	Average Payout (Death)	Severe Injuries	Average Payout (Severe Injuries)	Total Cases	Total Amount of Payouts
Mothers	99	1.98 million NTD (66,000 USD)	24	1.32 million NTD (44,000 USD)	123	228 million NTD (7.6 million USD)
Newborns	123	290,000 NTD (9,700 USD)	105	1.23 million NTD (41,000 USD)	228	165 million NTD (5.5 million USD)
Fetuses	76	300,000 NTD (10,000 USD)	N/A	N/A	76	22.6 million NTD (750,000 USD)

The health ministry trumpeted the Pilot Plan's success in cutting requests for MRC expert assessment involving obstetricians and gynecologists by seventy-two percent, and credited the Pilot Plan for the rebound in the number of young physicians willing to join the specialty.¹⁸² Building on this success, the Pilot Plan was extended for two years, ending in 2016 when the law enabling the Childbirth Fund took effect.

The Childbirth Fund, as with the Pilot Plan, is funded mainly by a government appropriation, making it popular among physician groups since

¹⁸² See Ministry of Health and Welfare, 「Shengyu Shigu Jiuji Jihua」 Chengxiao Feiran, Jiangdi Chanke Yiliang Jiufen, Gaishan Zhiye Huanjing (「生育事故救濟試辦計畫」成效斐然，降低產科醫療糾紛，改善執業環境) [News Announcement: Birth-Related Incident Relief Pilot Plan a Tremendous Success: Lowering Medical Disputes and Improving Practice Environment of Ob-Gyns] (May 8, 2015) [hereinafter *Birth-Related Incident Relief Pilot Plan a Tremendous Success*], <https://www.mohw.gov.tw/cp-2644-20603-1.html> (last visited Dec. 15, 2023). Hoping to replicate and expand the success, in 2014 the Ministry further implemented a Pilot Plan on Encouraging Healthcare Institutions to Properly Address Medical Disputes related to Surgery and Anesthesia Incidents (鼓勵醫療機構妥善處理手術及麻醉事故爭議事件試辦計畫). However, that initiative captured fewer cases than hoped and was soon terminated. Interview with Dr. Chen-chi Wu, *supra* note 96.

taxpayers, rather than physicians, foot the bill. Amounts of compensation, after a 2019 increase, rose to 4,000,000 NTD (130,000 USD) for incidents involving death of the mother, and to 3,000,000 NTD (100,000 USD) for incidents causing serious injuries to either the mother or the child.¹⁸³

Childbirth Fund compensation recipients are not barred from filing subsequent lawsuits. To discourage litigation, however, the law requires recipients to return the money if they do go to court.¹⁸⁴ The Childbirth Accident Emergency Relief Act also includes a requirement for medical care institutions and midwifery agencies to conduct patient safety measures such as mandatory incident reporting and root cause analyses of severe childbirth accidents,¹⁸⁵ the first such requirements in Taiwanese medical history. These reports and analyses are excluded from evidence in civil actions.¹⁸⁶ This rule, aimed at encouraging reporting accuracy and candor among healthcare staff reviewing adverse incidents, is designed both to facilitate dispute resolution and to promote patient safety by enabling providers to learn from mistakes.¹⁸⁷

From its inception in mid-2016 through 2020, the Childbirth Fund received 1,242 applications and approved 1,167 (94%) of them, with total payments of 688,000,000 NTD (23,000,000 USD).¹⁸⁸ Roughly two-thirds of the applications (758 or 61%) were filed by healthcare institutions on behalf of victims.¹⁸⁹ By doing this procedural favor for patients and families, many healthcare institutions aim at reshaping the hostile dynamic between both sides and building a more trusting, collaborative patient-physician relationship, which in turn may contribute to the reduction of malpractice litigation.¹⁹⁰

¹⁸³ The amount is set by the Regulations Governing the Childbirth Accident Relief (生產事故救濟作業辦法), <https://law.moj.gov.tw/LawClass/LawAll.aspx?pcode=L0020191> (last visited Dec. 15, 2023).

¹⁸⁴ Childbirth Accident Emergency Relief Act, art. 12 (Taiwan).

¹⁸⁵ *Id.* art. 22.

¹⁸⁶ *Id.* art. 22 § 4.

¹⁸⁷ See Chih-Cheng Wu (吳志正), *Dui Bingren Anquan Tongbao Fazhi zhi Jiantao yu Zhanwang* (對病人安全通報法制之檢討與展望) [*Review and Prospect on Patient-Safety Reporting Legislation*], 1 *ANGLE HEALTH L. REV.* 68, 71–76 (2016). These statutory provisions and relevant policy discussions are examples of the growing influence of the U.S.-originated patient safety movement on the Taiwanese healthcare system. One key idea of the movement calls for identifying and reducing the number of preventable medical errors through information-sharing mechanisms such as error reporting systems. See generally INSTITUTE OF MEDICINE, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 2000).

¹⁸⁸ For the breakdown by victims and types of injuries, see MINISTRY OF HEALTH & WELFARE, 2021 SHENGCHAN SHIGU JIUJI BAOGAO (2021 生產事故救濟報告) [2021 ANNUAL REPORT OF CHILDBIRTH ACCIDENT RELIEF] 19; Table E.

¹⁸⁹ *Id.* at 11.

¹⁹⁰ See *Birth-Related Incident Relief Pilot Plan a Tremendous Success*, *supra* note 182. The Birth-Related Incident Relief Pilot Plan achieved a seventy-two percent reduction in the number of MRC requests, indicating

Table E: *Approved applications under the Childbirth Fund, June 2016-2020*

	Death	Severe Injuries	Total Cases	Total Payouts (million NTD)
Mothers	102	246	348	258 (8.6 million USD) for death 91.5 (3.1 million USD) for severe injuries
Newborns	189	87	276	56.7 (1.9 million USD) for death 119 (4 million USD) for severe injuries
Fetuses	543	N/A	543	162.9 (5.4 million USD)
Combined	835	333	1,167	688.1 (22.9 million USD)

IV. THE ECONOMICS OF TAIWAN'S MEDICAL INJURY COMPENSATION SYSTEM

This section of the Article notes a bias favoring smaller compensation payments to patients and families, explains financial incentives relating to how lawyers are paid, and sets out how payments of compensation are made.

A. *Bias Favoring Smaller Compensation Payments*

One contrast between medical litigation in Taiwan and that in the United States relates to trends regarding compensation amounts for paid claims. In the U.S., one aspect of plaintiffs' attorneys' gatekeeper role is to filter out small-damage cases less profitable to the law firm, given the time and expense of working up the claims. Thus, the overall picture of compensation, either through settlement or judgment, tilts heavily toward more severe cases — a trend demonstrated by research from Paik, Black, and Hyman.¹⁹¹ In Taiwan, however, a reverse bias seems to favor smaller claims. Hospitals and physicians are often

fewer lawsuits against Ob-Gyns. Unfortunately, official data on the numerical trend of Ob-Gyn cases after the implementation of the Childbirth Fund are unavailable.

¹⁹¹ Myungho Paik, Bernard Black & David A. Hyman, *The Receding Tide of Medical Malpractice Litigation: Part I – National Trends*, 10 J. EMPIRICAL LEGAL STUD. 612, 619–622 (2013).

willing to pay a little to avoid bigger trouble, making compensation for medium and smaller cases more accessible, while serious cases more likely end up in court.¹⁹²

This feature of Taiwan's law in action is comparable to the situation in Japan, where only around 20% of disputes enter the court, while 60% or more of claimants are said to receive some, mostly modest, payment.¹⁹³ Claimants' difficulty in securing large compensation through court action in both countries puts them in a disadvantaged position in settlement negotiation. As a result, reaching a relatively speedy but relatively small monetary agreement may serve the interest of both parties. Taiwanese claimants' uncertain prospects for large recoveries in court also help explain why most healthcare institutions regard commercial liability insurance as unnecessary, since internal funding sources are sufficient to cover compensation payments in most, if not all, cases.

B. How Lawyers Are Paid

Unlike plaintiff-side personal injury lawyers in the United States who typically operate on a contingency fee basis, attorneys in Taiwan mostly require payment of an upfront retainer.¹⁹⁴ This retainer generally ranges from 80,000-150,000 NTD (3,000-5,000 USD), which covers both the trial and any subsequent appeal (at which stage new evidence may be introduced; the fee for litigating in the Supreme Court is generally lower because that process focuses only on issues of law).¹⁹⁵ For plaintiffs' attorneys, even a retainer of 150,000 NTD (5,000 USD) may not sufficiently cover time and expenses for the representation, since they must often develop both the legal and medical sides of the case by themselves. (This is less of a burden for defense lawyers, who

¹⁹² See Part III.A. Some hospitals, however, adopt a more combative posture even in cases involving less serious injuries, when they believe no breach of duty has occurred. Interview with Dr. Kun-Yun Yeh, Chief of the Internal Med. Dep't, Chang Gung Hosp., Keelung, Taiwan (Nov. 11, 2022).

¹⁹³ See, e.g., Interview with Tokyo defense attorney, in Tokyo, Japan. (July 3, 2015) (about seventy percent of malpractice claims filed with Tokyo Medical Association in 2011 received some compensation).

¹⁹⁴ Interview with attorney Ya-Yun Liu, *supra* note 175; interview with attorney Mu-Min Cheng, *supra* note 125. Technically speaking, Taiwanese law does not forbid contingency fees. In 2018, the Taipei Bar Association filed an official letter to the Ministry of Justice asking about the legality of such fees. The Ministry responded that it is not against the law to receive a fixed percentage of the plaintiff's recovery as part of the attorney's compensation. See Ministry of Justice, Official Letter Docket # Fa Jian Zi 10804503780 (法檢字 10804503780函). These kinds of arrangements remain the exception in medical malpractice cases, however, in part due to plaintiffs' low win rate.

¹⁹⁵ Interview with attorney Ya-Yun Liu, *supra* note 175; interview with attorney Mu-Min Cheng, *supra* note 125.

have the support of healthcare institutions and physicians.)¹⁹⁶ Because it is not rare for medical malpractice cases to be reversed and remanded multiple times during the appeal process, the amount of attorney fees can easily pile up and sometimes even exceeds the compensation plaintiff recovers from the judgment.¹⁹⁷

When injured patients and families cannot afford such a heavy burden, they can go to the Legal Aid Foundation (法律扶助基金會, *fa lu fu zhu ji jin hui*), established and funded by the government in 2004, to seek government-subsidized legal services.¹⁹⁸ All lawyers in Taiwan can register with the Foundation to provide legal aid to plaintiffs of lower socioeconomic status, and they generally are paid directly by the Foundation 20,000 NTD (700 USD) for criminal cases and 30,000 NTD (1,000 USD) for civil ones.¹⁹⁹ Many lawyers register to make extra money or accumulate experience with particular types of cases.²⁰⁰

Fee arrangements affect attorneys' incentives concerning whether and when to sue and settle. In the United States, attorneys hoping to obtain lucrative jury awards, thus maximizing the contingency fee, may discourage some clients from settling early. In Taiwan, however, due to the general absence of contingency fees, the difference between how much attorneys earn in trial and in settlement is relatively modest. For this reason, Taiwanese attorneys usually have no strong incentive to steer the client either way but mostly follow clients' preference, if any. Parties often make prior arrangements with their attorneys regarding situations where the case will be settled before any court filing, and where the

¹⁹⁶ *Id.* How much attorneys charge is often based on which side they represent, how long the process will take, the guesstimated success rate, etc. Theoretically, more experienced lawyers should be able to charge more, but plaintiffs do not necessarily know whether the lawyer is capable or experienced until later into the process. Bar associations do not provide information about individual lawyer specialization, perhaps due to the relatively low degree of specialization in Taiwan.

¹⁹⁷ Interview with attorney Ya-Yun Liu, *supra* note 175; interview with Dr./attorney Pin-Hsuan Chang (張濱璿), Taipei, Oct. 10, 2022.

¹⁹⁸ See LEGAL AID FOUND., <https://www.laf.org.tw/en/> (last visited Dec. 15, 2023).

¹⁹⁹ Interview with attorney Ya-Yun Liu, *supra* note 175. The Foundation reviews applicants' financial status. The Foundation pays the court fees for qualified applicants. Relatively better-off applicants must pay part of the fees.

²⁰⁰ *Id.* Most lawyers registered with the Foundation do not specialize in medical malpractice. But plaintiffs can do their own search and request the representation of particular lawyers, who in turn have the choice to turn down the request. In general, the lawyers do not select cases. Rather, they are assigned cases by the Foundation, and they do not know the details or have access to medical records before being notified of the assignment. See also interview with attorney Mu-Min Cheng, *supra* note 125; interview with attorneys Hsien-Hsun Wang and Meng-Syuan Lee, *supra* note 137.

case will be filed in court but may be resolved in the midst of litigation. Common arrangements include: (1) paying the same amount of retainer; (2) deciding a different, usually reduced, amount for resolution through settlement; and (3) coming up with alternative arrangements, such as hourly fees.²⁰¹

C. *How Payments of Compensation Are Made*

In the United States, commercial liability insurance plays an essential role regarding how compensation payments are made. In comparison, many healthcare institutions in Taiwan set up internal risk-sharing mechanisms to cover liability compensation.²⁰² Some institutions use their general budget to absorb liability payments. Others do so by setting up specific funds, colloquially referred to as “mutual aid money” (互助金, *hu zhu jin*).²⁰³ How these funds are financed varies significantly among institutions. Some require physician employees to pay monthly contributions,²⁰⁴ anecdotally in the range of low thousands or even hundreds of NTD (less than 100 USD). Other institutions, particularly private ones, incorporate the funding scheme into their physician payment mechanisms. Some even delegate to clinical departments the task of determining how risk should be shared internally within the department.²⁰⁵

Once payments are made, there are different ways to distribute liability between employees and institutions. In some situations, institutions make distributions based on pre-established principles or conventions. In other situations, institutions have ad-hoc meetings to discuss liability distribution in individual cases. The same institution may resort to different approaches depending on the nature of the case.²⁰⁶

²⁰¹ Interview with attorney Ya-Yun Liu, *supra* note 175.

²⁰² Interview with attorney Hsien-Hsun Wang, *supra* note 137; interview with Dr./attorney Chang, *supra* note 197.

²⁰³ A major public hospital system, for example, uses its general budget to absorb more than half of the liability amount. The mutual aid fund then kicks in to cover the majority of the remaining amount, with the rest (ten to twenty percent of the total amount) shouldered by individual physicians. Physician employees make an initial contribution of 20,000 NTD (roughly 670 USD) to the mutual aid fund when signing their employment contract with the hospital. They then make small monthly payments to the fund throughout their employment with the hospital. If no liability has been incurred upon retirement, the contribution is returned to the physician. Interview with Dr. Chen-Chi Wu, *supra* note 96.

²⁰⁴ Interview with attorney Meng-Syuan Lee, *supra* note 137.

²⁰⁵ *Id.* For example, hospitals may deduct contributions to the fund from fee payments to clinical departments, which in turn distribute the payments among their physicians.

²⁰⁶ *Id.*

While many hospitals rely on internal risk-sharing mechanisms for injury compensation, the role of commercial insurance has been expanding. According to statistics compiled by the Taiwan Medical Association (中華民國醫師公會聯合會, *zhong hua min guo yi shi gong hui lian he hui*) in 2020, there were 51,237 physicians actively practicing medicine.²⁰⁷ Cross-referencing the number with statistics provided by the Taiwan Insurance Institute, in the same year there were 19,009 physician liability insurance policies.²⁰⁸ Assuming that each physician purchased only one policy, the number accounts for thirty-seven percent of all practicing physicians. The total premiums collected were 150,000,000 NTD (5,000,000 USD) (Chart M).²⁰⁹ Among the 12,159 hospitals, clinics, and other healthcare institutions in 2020,²¹⁰ 3,522 institutional liability insurance policies were sold that year.²¹¹ A significant proportion of these policies was likely purchased by smaller hospitals and clinics, which generally lack the capacity to pool and distribute risk internally. Premiums collected that year amounted to 196,000,000 NTD (6,500,000 USD) (Chart N).²¹²

²⁰⁷ See *Annual Statistics*, TAIWAN MED. ASS'N, https://www.tma.tw/stats/index_AllPDF.asp (last visited Nov. 5, 2023) [hereinafter TAIWAN MED. ASS'N].

²⁰⁸ See Caituan Faren Baoxian Shiye Fazhan Zhongxon Hudong Zixun Chaxun Pingtai (財團法人保險事業發展中心互動資訊查詢平台) [*Taiwan Insurance Institute Interactive Statistical Information Search System*], <http://pivot.tii.org.tw/lifesta/DQPPFrame1.htm> [hereinafter *Taiwan Ins. Inst.*] A few healthcare institutions require affiliated physicians to purchase commercial insurance, and some subsidize the transaction.

²⁰⁹ *Id.*

²¹⁰ TAIWAN MED. ASS'N, *supra* note 207.

²¹¹ *Taiwan Ins. Inst.*, *supra* note 208.

²¹² *Id.*

Chart M: Yearly numbers of practicing physicians purchasing liability insurance and total premiums collected, 2014-2020

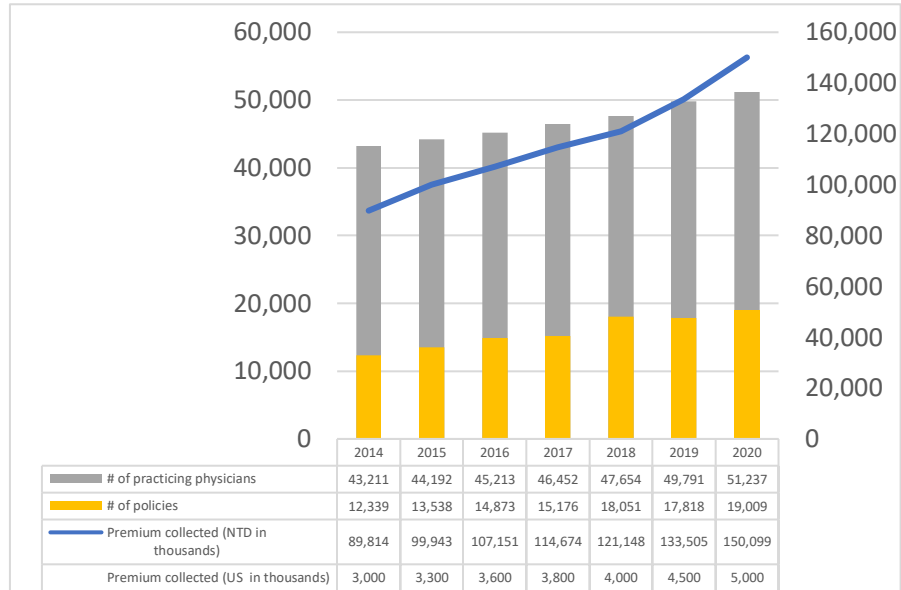
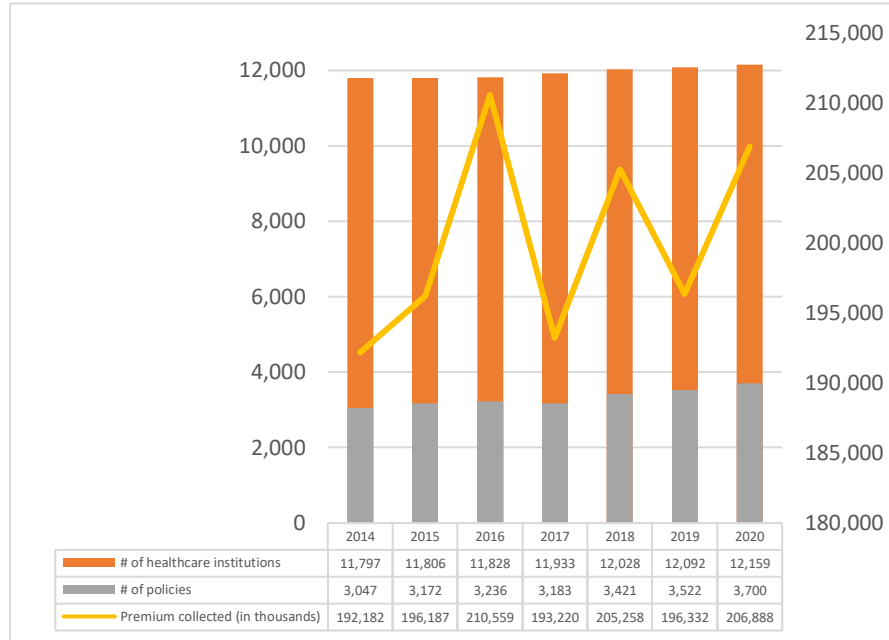


Chart N: Yearly number of healthcare institutions purchasing liability insurance and total premiums collected, 2014-2020



Information on institutional liability insurance premiums is publicly unavailable. As for policies for individual physicians, the Taiwan Medical Association signed a Memorandum of Understanding in 2018 with eleven commercial insurance companies to provide standardized contracts and lower insurance premiums. The premium level varies across specialties, the amount of insurance coverage, and the effective date of the policy. For insurance coverage of 3,000,000 NTD (100,000 USD), the monthly premium level is 10,521 NTD (350 USD) for general internal medicine, 12,859 NTD (430 USD) for pediatrics and ENT doctors, 15,782 NTD (530 USD) for general surgery, emergency medicine, and neurosurgery, and 22,991 NTD (770 USD) for anesthesiology and Ob-Gyn.²¹³

²¹³ Yishi Yewu Zeren Baoxian Hezuo Tuiguang Beiwanglu (醫師業務責任保險合作推廣備忘錄) [Memorandum of Understanding to Collaboratively Promote Physician Practice Liability Insurance], TAIWAN MED. ASS'N; Zi Fei Yi Shi Ye Wu Ze Ren Bao Xian Zhuan Qu (自費醫師業務責任保險專區) [Out-of-Pocket

Several possible explanations might explain the relatively low interest in and premium levels for commercial liability insurance. One is that the premium level for different specialties does not properly reflect actual litigation risk due to the difficulty of conducting community rating.²¹⁴ Another is that hospitals and physicians may not view civil liability as a serious threat, since the winning percentage of plaintiffs and the number of cases with sizable compensation remains low.²¹⁵ Moreover, under the National Health Insurance system setting universal prices for covered services, hospitals and physicians cannot pass the cost of insurance premiums on to consumers, further diminishing providers' financial incentive to purchase such products.

Due in part to the relatively low litigation risk, Taiwanese commercial insurance companies play a passive, back-seat role in the dispute resolution process. This is dramatically different from the perspective of liability insurance companies in the U.S., which typically lead providers' defense. Sometimes Taiwanese insurance company representatives attend the negotiation or mediation process. In general, however, they play a limited role, such as helping to clarify provisions of the insurance contract, and rarely interfere with clients' decision-making.²¹⁶

V. CRIMINAL LAW IN ACTION AND PHYSICIANS' PURSUIT OF CRIMINAL LIABILITY REFORM

Physicians' pursuit of criminal liability reform is the headline story of Taiwan's medical injury compensation law in action. Part V begins with the origin of medical malpractice as a politicized issue in Taiwan, followed by a discussion of how physicians' concern about medical malpractice litigation often intermingles with their dissatisfaction with the National Health Insurance

Physician Professional Liability Insurance], TAIWAN MED. ASS'N, https://www.tma.tw/others/index_risk01.asp (last visited Dec. 15, 2023).

²¹⁴ Interview with Dr. Chen-chi Wu, *supra* note 96. Another reason for the difficulty is that the number of physicians in each specialty is not large, and only a small proportion purchases liability insurance policies. *Id.* This makes effective community rating difficult to achieve.

²¹⁵ See *supra* Part II. To increase the appeal, some commercial policies provide free legal consultation and cover the expense of legal representation. See, e.g., Fubon, Life Brochure for Physician Liability, [http://365.mysoft.tw/OBJECT/DOWNLOAD/UPLOAD/1080411醫療責任險要保書\(DM\).pdf](http://365.mysoft.tw/OBJECT/DOWNLOAD/UPLOAD/1080411醫療責任險要保書(DM).pdf) (last visited Dec. 15, 2023).

²¹⁶ Three interviewees identified one insurance company that has been more active than its competitors in providing legal consultations for clients and encouraging early resolution of disputes by settlement. One of the interviewees, however, cautioned that the legal training of the company's representatives and the quality of their consultation leave much to be desired. Interviews with attorneys Hsien-Hsun Wang and Meng-Syuan Lee, *supra* note 137; interview with Dr./attorney Chang, *supra* note 197.

(NHI) system. This Part then examines efforts by physician groups to reform Taiwan's medical liability laws, culminating in the 2017 amendment of the Medical Care Act Article 82 and the 2022 reform of future mediation practice and procedure.

A. *The Politicization of Medical Malpractice*

The politicization of medical injury compensation law in Taiwan began around the turn of the century. The first battleground was over the standard of civil malpractice liability. The chief focus of concern then shifted to criminal liability of health care professionals.

At MacKay Memorial Hospital in Taipei, a baby suffered shoulder dystocia during delivery. The mother sued for damages. The central legal issue was whether statutory no-fault liability, based on the newly enacted Consumer Protection Act (消費者保護法, *xiao fei zhe bao hu fa*),²¹⁷ should apply to medical services. The Supreme Court in 2001 determined, to medical professionals' dismay, that statutory no-fault liability applied.²¹⁸ The decision triggered a vigorous legal and policy debate, resulting in legislation overruling the Supreme Court's decision and establishing negligence as the standard for medical liability.²¹⁹

Medical professionals' concern soon shifted to criminal law. The hospital staff at Bei-Chen Hospital in New Taipei City mistook muscle relaxants for hepatitis B vaccines for newborn infants, both of which were stored without proper labeling in the same refrigerator. The injections led to one death and six

²¹⁷ Consumer Protection Act Article 7 § 5 (Taiwan). Article 7 stated that “[t]raders shall be jointly and severally liable . . . [for] causing injury or damage to consumers or third parties, *provided that if traders can prove that they have not been negligent, the court may reduce damages.*” *Id.* (emphasis added). The statutory language implied that even if defendants proved they were not negligent, they would still be liable in a reduced amount. For historical background of judicial application of no-fault liability to medical services, see Wu & Liu, *supra* note 2, at 287.

²¹⁸ Zuigao Fayuan 90 Niandu Tai Shang zi di 709 Hao Minshi (最高法院90年度台上字第709號民事判決) [Supreme Court No. 709 Civil Judgment of 2001] (Taiwan S. Ct. 2001), *aff'g* Taipei District Court Su Zi No. 5125 Civil Judgment of 1996 (Taipei Dist. Ct. 1996) (Taiwan) (the “Shoulder Dystocia Case”).

²¹⁹ Medical Care Act Article 82 § 2 now reads: “Only in the event that medical personnel cause harm to patients in conducting medical practices intentionally or [in] breach of medical due care, which goes beyond reasonable exercise of professional clinical discretion, the medical personnel shall be bound to compensate for such harm” (醫療機構及其醫事人員因執行業務致生損害於病人，以故意或過失為限，負損害賠償責任). Wu & Liu observe that there remains a debate regarding whether cosmetic surgery is still arguably subject to the Consumer Protection Act's no-fault liability as a consumer “service.” See Wu & Liu, *supra* note 2, at 287.

injuries. The families brought both criminal charges and civil lawsuits, and in 2003 two nurses were found guilty of criminal negligence.²²⁰

These two highly publicized cases reflected a larger trend toward a more litigious medical malpractice environment. Medical circles, keenly aware of the rising threat of litigation, placed reform of medical injury law, especially its criminal aspect, at the top of their political agenda.

B. The NHI System as a Cause of Rising Litigation?

Many physicians have viewed the implementation of the National Health Insurance system (NHI, 全民健康保險, *quan min jian kang bao xian*) as a partial cause of the litigious malpractice environment.²²¹ Their belief does have some statistical basis. The number of MRC expert assessments, including requests made by judges and prosecutors in both civil and criminal cases, began climbing around 1994, just when the NHI was implemented (see Chart D above).²²²

The belief is reinforced by many physicians' strong dissatisfaction with the funding scheme of the NHI system. Taiwan's NHI system, lauded by scholars internationally²²³ and highly popular among the Taiwanese public, is loathed by

²²⁰ Taiwan Gaodeng Fayuan 92 Niandu Zhu Shangsu Zi di 1 Hao Xingshi Panjue (臺灣高等法院92年度囑上訴字第1號刑事判決) [Taiwan High Court Zhu Shang Su Zi No. 1 Criminal Judgment of 2003] (Taiwan High Ct. Nov. 4, 2003). The two nurses were also held civilly liable in Taiwan Gaodeng Fayuan 93 Niandu Zhong Su Zi Di 2 Hao Minshi Panjue (臺灣高等法院93年度重訴字第2號民事判決) [Taiwan High Court Zhu Shang Su Zi No. 2 Civil Judgment of 2004] (Taiwan High Ct. May 10, 2004). The criminal judgment revealed that the hospital had settled with the infants' families, so there was no civil judgment regarding the hospital's civil liability.

²²¹ The belief is part of a larger concern about the "collapse of healthcare" (醫療崩壞, *yi liao beng huai*). The rhetoric apparently drew from Japanese sources. See *Unnatural Deaths*, *supra* note 1, at 14–15.

Two popular nonacademic books written by physicians voiced that concern in the past decade. Both dedicated substantial attention to the issue of medical malpractice. See generally TAIWAN YI LAO LAODONG ZHENG YI YU BINGREN ANGUAN CUJIN LIANMENG (台灣醫療勞動正義與病人安全促進聯盟) [TAIWAN MEDICAL LABOR JUSTICE AND PATIENT SAFETY PROMOTION ALLIANCE], YILAO BENG HUAI! MEIYOU YISHENG JIUMING DE SHIDAI (醫療崩壞! 沒有醫生救命的時代) [THE COLLAPSE OF HEALTHCARE!: A TIME WITH NO PHYSICIANS TO SAVE YOUR LIFE] (2012); SHAO-JUNG LI (李紹榕), ZUI GUANGMING, YE ZUI HEJIAN DE YILIAO XIANCHANG: YI WEI XINZANG WAIKE YISHI, JIELU YILAO (最光明, 也最黑暗的醫療現場: 一位心臟外科醫師, 揭露醫療崩壞下最震撼的真相) [THE DARKEST, BUT ALSO THE BRIGHTEST MEDICAL FRONTLINE: A HEART SURGEON DISCLOSES THE ASTONISHING TRUTH OF THE COLLAPSE OF HEALTHCARE] (2014).

²²² *Matters Related to Medical Dispute Resolution and Assessment*, *supra* note 55.

²²³ See, e.g., EZEKIEL J. EMANUEL, WHICH COUNTRY HAS THE WORLD'S BEST HEALTH CARE 300–323 (2020); William C. Hsiao, Shou-Hsia Cheng & Winnie Yip, *What Can Be Achieved with a Single-Payer NHI System: The Case of Taiwan*, 233 SOC. SCI. MED. 265 (2019); Tsung-Mei Cheng, *Reflections on the 20th Anniversary of Taiwan's Single-Payer National Health Insurance System*, 34(3) HEALTH AFFAIRS 502 (2015);

many medical practitioners.²²⁴ The chief cause of their dissatisfaction is financial: the NHI's global budget system capping NHI yearly expenditures restrains fees for medical services,²²⁵ squeezing hospital budgets and sometimes requiring them to cut staffing, forcing physicians and nurses to work very long hours.²²⁶

The animosity of much of the medical community toward the NHI connects with the perception that the implementation of the NHI has driven the allegedly worsening malpractice environment. By this view, the global budget system has depreciated medical services dramatically, with the result that the respect in which health care professionals were once held has been undermined. Recipients of medical services now no longer see themselves as passive patients but as consumers entitled to expect unblemished quality. These developments in turn

Yue-Chune Lee et al., *The Impact of Universal National Health Insurance on Population Health: The Experience of Taiwan*, 10 BMC HEALTH SERV. RSCH. 225 (2010).

²²⁴ According to a 2015 questionnaire survey in *Global Views Magazine* (遠見雜誌, *yuan jian za zhi*), a whopping 92% of 8,777 total respondents, 97% of the 1,705 physician respondents, felt pessimistic about the future of Taiwan's healthcare system, and 62% thought the quality of Taiwanese healthcare was declining. As reasons, most respondents mentioned issues connected to the NHI system: 67% cited overuse of medical resources by the public, 67% noted the shortage of medical personnel, and 59% mentioned the continuous depreciation of medical services by the NHI. See Lien-yi Peng (彭漣漪) & Si-yu Lin (林思宇), Taiwan Yilao Guanjian Baogao (台灣醫療關鍵報告) [*Critical Report for Taiwan's Healthcare System*], GLOB. VIEWS MAG. (Feb. 17, 2015), <https://www.gvm.com.tw/article/20224>.

In contrast, other surveys show high public approval of the system. In a 2019 survey conducted by the National Health Insurance Administration (中央健康保險署, *zhong yang jian kang bao xian shu*), for example, 90% of the general public approved of the system. That survey also covered physicians and showed a rosier picture than the *Global Views Magazine* survey: 34% of physicians of western medicine were satisfied or very satisfied with the NHI system, while 47% registered a lukewarm attitude and only 19% were dissatisfied. See National Health Insurance Administration, Jianbao Quanmin Manyi du Chuang Lishi Zuigao Jilu 89.7% Yishi Dui Jianbao Manyi du Zhunian Gaishan (健保全民滿意度創歷史最高紀錄89.7% 醫師對健保滿意度逐年改善) [*Public Approval of the National Health Insurance at Historic High at 89.7%, with Physician Satisfaction Also Increasing Year by Year*], MINISTRY OF HEALTH AND WELFARE (Nov. 28, 2019), <https://www.mohw.gov.tw/cp-4251-50316-1.html>.

²²⁵ For an overview of the operation and financing of Taiwan's NHI system, see EMANUEL, *supra* note 223.

²²⁶ See, e.g., Peng & Lin, *supra* note 224; Ming-Ju Wang (王明鉅), Jianbao Minzhong Manyi du Gaoda Bacheng You Zenyang? Yiliao Renyuan Chaoguo Jiu Cheng Dui Weilai Gandao Beiguan (健保民眾滿意度高達八成又怎樣? 醫療人員超過九成對未來感到悲觀) [*Commentary: Does an 80% Public Approval Matter If Over 90% of Medical Professionals Are Pessimistic About Their Future?*], THE NEWS LENS (Nov. 9, 2016), <https://www.thenewslens.com/article/53612>; Chieh Chen (陳潔) & Hui-Chun Yang (楊惠君), Jianbao Geifu Zhong Zhunian Xia Jiang de Yishi Fei, Hui Dai Lai Shenme Yingxiang? (健保給付中逐年下降的醫師費，會帶來什麼影響?) [*What Are the Impacts of the Declining Diagnostic Fee in the NHI System?: On the Depreciation of Medical Services*], THE REP. (Sept. 28, 2020), <https://www.twreporter.org/a/health-insurance-system-diagnostic-fee>.

have emboldened injured patients to take legal actions against medical care professionals.²²⁷

Little research substantiates the claim that the NHI system has exacerbated the medical malpractice environment. It remains a belief based not on systematic data but rather mainly on personal experience and anecdotes. Chun-Ying Wu and colleagues, for example, conducted two questionnaire surveys across a fourteen-year span (1991 to 2005) and found that the percentage of physicians who had experienced medical malpractice claims decreased in the second survey: respondents reporting having such experience in the past five years dropped from 26% to 22%, countering the argument that the NHI had detrimental effects on the medical malpractice environment.²²⁸

In 2010, as a response to malpractice litigation pressures, physician groups began using the so-called “depletion of five major medical specialties” (五大皆空, *wu da jie kong*) phenomenon as a rallying cry to reform medical malpractice law. The term referred to the dwindling number of new entrants into five major specialties: internal medicine, surgery, obstetrics & gynecology, pediatrics, and emergency medicine.²²⁹ The Control Yuan (監察院, *jian cha yuan*), the constitutional branch responsible for auditing governmental actions,²³⁰ issued a “corrective measure” (糾正案, *jiu zheng an*) in 2012 to the Executive Yuan for its mismanagement of physician supplies in these major specialties.²³¹ The phenomenon was commonly attributed to factors such as long work hours and relatively low levels of reimbursement. The relatively high risk of medical malpractice litigation was also cited as a major cause.²³²

²²⁷ See *supra* notes 221, 224, and 226.

²²⁸ See WU ET AL., *supra* note 60, at 46–56.

²²⁹ See Press Release, Wuda ke Yishi Yin Laohua Deng Yinsu Kong Buzu, Weifu Bu Jiang Caiqu Duoxiang Cuoshi, Quebao Jiuyi Wu Ai (五大科醫師因老化等因素恐不足, 衛福部將採取多項措施, 確保就醫無礙) [*The Five Major Specialties May Face Physician Shortages Due to Factors such as Population Aging; the Ministry Is Taking Measures to Ensure Access to Healthcare*], MINISTRY OF HEALTH AND WELFARE (Dec. 20, 2013) [hereinafter *The Five Major Specialties May Face Physician Shortages*], <https://www.mohw.gov.tw/cp-3208-21234-1.html>.

²³⁰ The Control Yuan’s function in this respect is similar to that of the U.S. Government Accountability Office.

²³¹ CONTROL YUAN, JIANCHA YUAN GONGGAO YUAN TAI CAI ZI DI 1012230675 HAO (監察院公告院台財字第 1012230675 號) [2821 CONTROL YUAN PUBLIC REPORT 1 (OFFICIAL ANNOUNCEMENT DOCKET # YUAN TAI CAI ZI DI 10804503780)] (2012), [https://www.cy.gov.tw/AP_HOME/Op_Upload/eDoc/公報/101/1010000342821\(全, 本期原外網檔案、本室留存檔均無目次連結\).pdf](https://www.cy.gov.tw/AP_HOME/Op_Upload/eDoc/公報/101/1010000342821(全, 本期原外網檔案、本室留存檔均無目次連結).pdf). The Control Yuan’s “corrective measures” may be politically influential, but whether the Executive Yuan is legally required to act upon them remains in dispute.

²³² See, e.g., Po-Ting Chen (陳柏廷) & Hsiao-Wei Lan (藍孝威), Yi Jie You Rencai Liushi “Wuda Jie Kong” (醫界憂人才流失「五大皆空」) [*Physician Shortage and the “Depletion of Five” Phenomenon*]

The field of obstetrics and gynecology was ground zero for the “depletion of five” phenomenon.²³³ At the time, medical school graduates, after completing internships, chose their specialties and went directly on to receive specialist training.²³⁴ A government-determined quota set the number of new entrants for each specialty. The first decade of the twenty-first century witnessed a steady decline of new entrants choosing to become Ob-Gyns. In 2011, the number of new entrants bottomed out at less than thirty percent of the yearly quota.²³⁵

The situation sharply improved afterwards.²³⁶ The government attributed the improvement to the 2012 implementation of the no-fault compensation fund for childbirth-related incidents, which cut the risk of litigation by almost half.²³⁷ Superficially, this development seems to provide evidence that the pressure of malpractice litigation was indeed a major factor driving young physicians away from the Ob-Gyn field. Despite the popular narrative that the compensation fund saved Ob-Gyns, other factors probably contributed to the rebound. Some younger physicians likely avoided the specialty in anticipation of the upcoming low-fertility crisis that may make the specialty less profitable. The changing nature of the practice, shifting its focus away from delivery to other more

Concern the Medical Community], CHINATIMES (Oct. 3, 2013), <https://www.chinatimes.com/newspapers/20131003000921-260108?chdtv>; Ai-Li Wu (吳艾莉), Yi Jiu Shi Wuda Jie Kong de Yuan Xiong (醫糾是五大皆空的原凶) [*Medical Malpractice Dispute Is the Root Cause of the Depletion of Five Phenomenon*], 5678NEWS (Apr. 5, 2016), http://www.5678news.com/news_details.php?n=201604051306129044.

²³³ HUANG HUANG XIONG, CHEN MEI ZHAN & LIU XING SHAN, WOGUO QUANMIN JIANKANG BAOXIAN ZHIDU ZONG TIJIAN YI AN ZHI DIAOCHA BAOGAO (我國全民健康保險制度總體檢乙案之調查報告) [INVESTIGATION REPORT ON A GENERAL HEALTH EXAMINATION OF TAIWAN'S NATIONAL HEALTH INSURANCE SYSTEM] (Control Yuan Investigation Report Docket # 100 Cai Tiao 0007, 100財調0007) (Dec. 14, 2016), <https://www.cy.gov.tw/CyBsBoxContent.aspx?n=133&s=1084>.

²³⁴ In Taiwan, internship training used to be the last (seventh) year of medical school. Beginning in 2020, the system was reformed into post-graduate year (PGY) training. Under the new system, medical school students graduate one year earlier (after six rather than seven years) and use the seventh (post-graduate) year to receive training at certified teaching hospitals. After completing PGY training, young physicians still must receive specialist physician training, which is still subject to a government-determined quota.

²³⁵ See Tzu-Shan Peng (彭子珊), Gaobie Wuda Jie Kong! Fu Chan Ke Yishi Da Fanshen, 20 Ren Qiang 1 Ge Que (告別五大皆空！婦產科醫師大翻身，20人搶1個缺) [*Say Goodbye to the Depletion of Five Major Medical Specialties: The Comeback of Ob-Gyns as Now Twenty Applicants Are Trying to Fill One Opening*], COMMON WEALTH MAG. (Sept. 5, 2018), <https://www.cw.com.tw/article/5091972>.

²³⁶ *Id.*; see also Shu-Fen Teng (滕淑芬), Taiwan Yiliao “Wuda Jie Kong,” Jin Sheng Xia Yikongle? (台灣醫療「五大皆空」，僅剩下一空了?) [*Is There Only One Major Specialty Depleted Now?*], GLOB. VIEW MAG. (Apr. 30, 2018), <https://www.gvm.com.tw/article/44106>.

²³⁷ See Press Release, Shengyu Shigu Jiuji Shi Ban ji Hua Chengxiao Feiran, Jiangdi Chanke Yilao Jiufen, Gaishan Zhiye Huanjing (生育事故救濟試辦計畫 成效斐然，降低產科醫療糾紛，改善執業環境) [*The Impressive Achievement of the Birth-Related Incident Relief Pilot Plan to Lower Medical Malpractice Disputes and Improve Ob-Gyns' Work Environment*], MINISTRY OF HEALTH AND WELFARE (May 8, 2015), <https://www.mohw.gov.tw/cp-2644-20603-1.html>.

profitable services such as genetic testing, cord blood storage, and egg freezing, may also help explain the recent rebound in the number of new Ob-Gyns.²³⁸

System-wide factors may help explain the rebound as well. The government offered an annual stipend of 120,000 NTD (4,000 USD) to resident physicians receiving training in the five major specialties.²³⁹ The government also lowered the quota of new entrants into non-major specialties, thus forcing more medical graduates to enter major ones. As a result, other than internal medicine, four of the five major specialties saw a sharp rebound in the number of new entrants since 2013.²⁴⁰

The “depletion of five” phenomenon can be further understood as part of a larger critique, mostly by young physicians, of the current medical practice environment. The critique raised the rhetorical banner of the “collapse of healthcare” (醫療崩壞, *yi liao beng huai*),²⁴¹ warning that the healthcare system under the NHI is heading toward a future where there will no longer be enough qualified medical professionals to carry out even routine medical services.²⁴² The standard list of causes includes the depreciation of medical expertise by the NHI system and the threat of malpractice litigation that dampens medical professionals’ passion.²⁴³ The attribution pattern shows how physicians’ dissatisfaction with the NHI system and medical malpractice law has been closely intertwined, a relationship that has helped frame and sustain the medical community’s goal of reforming medical malpractice law.

²³⁸ The observation comes from this article’s co-author, Chih-Cheng Wu, based on his extensive experience as an Ob-Gyn.

²³⁹ *The Five Major Specialties May Face Physician Shortages*, *supra* note 229.

²⁴⁰ See Teng, *supra* note 236; Liang-Yi Wu (吳亮儀) & Hui-Chin Lin (林惠琴), Wuda Jie Kong Gaishan? Beiyi Shuzi Haokan (五大皆空改善? 被疑數字好看) [*Making Progress on the Depletion of Five? The Ministry of Health and Wealth Is Criticized as Playing the Numbers Game*], LIBERTY TIMES NET (Mar. 27, 2017), <https://news.ltn.com.tw/news/focus/paper/1089228>.

²⁴¹ This is the same phrase popularized by critics within the Japanese medical profession. See Leflar, *supra* note 1, at 14–15.

²⁴² See Taiwan Alliance for Medical Labor Justice and Patient Safety, *supra* note 221, at 29–33 (discussing the potentially catastrophic aftermath of the “collapse of healthcare”).

²⁴³ *Id.* at 55–67, 119–180 (discussing the role of medical malpractice disputes and the National Healthcare Insurance system in causing the deterioration of physician-patient relations and the “collapse of healthcare”).

C. *The Politics of Reform*

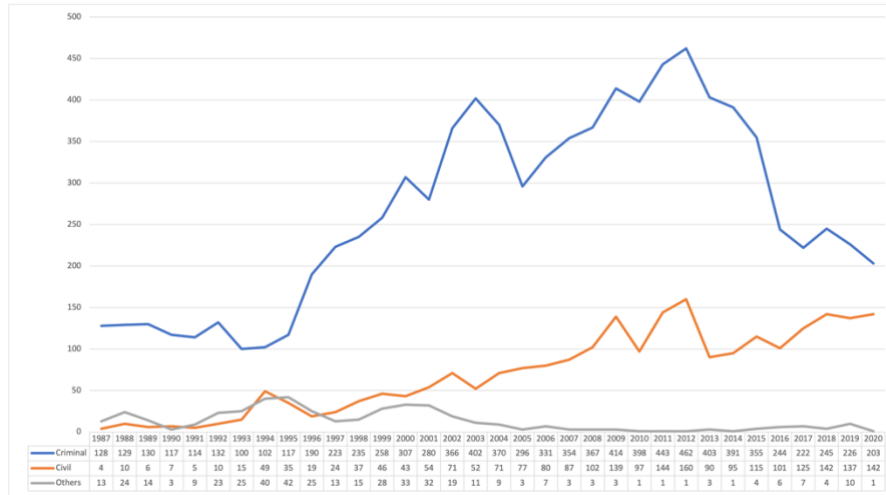
1. *Criminal Medical Liability at Center Stage*

Against this background, reforming medical malpractice litigation law had risen to the top of the medical community's political agenda by the early 2010s, with criminal medical liability occupying center stage.²⁴⁴ The key driver for this focus was physicians' traumatizing experience of having to face prosecutors and judges in criminal proceedings. Physicians are among the top academic achievers in Taiwanese society. Accusations of criminality challenge their self-esteem and professional pride and also generate intense emotions that often include frustration and anger.

The central focus on criminal liability was a direct reaction to the key role played by criminal law in Taiwan's medical law system. As explained above, a common option for those claiming injury from malpractice is to file complaints with prosecutors directly before taking civil law actions. The frequency of this approach is evident from the number of judicial requests for MRC expert assessment in criminal cases, which has been two to five times that for civil cases (Chart O).²⁴⁵

²⁴⁴ A key stakeholder in the reform process was the Taiwan Medical Association. The Association's think tank, the Medico-Legal Affairs Council (醫事法律智庫, *yi shi fa lu zhi ku*), advises on legislative strategies. Interview with Dr. Chen-chi Wu, *supra* note 96.

²⁴⁵ Yishi Zhengyi Chuli Jianding Deng Xiangguan Yewu (醫事爭議處理、鑑定等相關業務) [*Affairs Relevant to Medical Disputes Resolution and Assessment*], MINISTRY OF HEALTH AND WELFARE, <https://dep.mohw.gov.tw/DOMA/cp-2712-7681-106.html> (last visited Dec. 15, 2023). The actual number of civil judgments, however, consistently outnumbered criminal judgments (see Chart H). The discrepancy between the MRC data and statistics of actual court cases is mainly caused by the relative paucity of criminal indictments, as most expert assessments of criminal cases yield favorable results for defendants.

Chart O: Number of civil and criminal requests for MRC assessment, 1987–2020

The reform campaign began with the idea of decriminalizing medical negligence altogether. That provoked fierce opposition from the legal community and patient advocacy groups, mainly on equality grounds. In a high-profile 2012 public hearing hosted by the Ministry of Justice on criminal liability of medical practice, for example, several participants from a legal background argued that in interpreting the Criminal Code, it would be difficult to justify discrimination favoring particular professional groups.²⁴⁶ Others questioned whether such favorable treatment would violate Article 7 of the Constitution: “All citizens . . . irrespective of sex, religion, race, class, or party affiliation, shall be equal before the law.”²⁴⁷

Medical circles shifted their efforts to the goal of a clearer definition of “negligence.” As discussed above, judicially developed concepts of violations of “medical norms” and “medical standards” have served as criteria for

²⁴⁶ See MINISTRY OF JUSTICE, Fawu bu “Yilao Xingwei Xingshi Zeren Zhi Tanta” Gong Ting Hui Huiyi Jilu (法務部「醫療行為刑事責任之探討」公聽會會議紀錄) [Record of the Public Hearing on Criminal Liability of Medical Practice] (July 12, 2012).

²⁴⁷ See Yu-An Ting (丁予安) & Pei-Ching Huang (黃珮清), Haojiao Xiangqi, Tuidong Yiliao Shushi Chuzuihua Zhi Jincheng (號角響起，推動醫療疏失除罪化之進程) [Sound the Trumpet! Progression on the Legislative Effort to Decriminalize Medical Errors], 55(12) TAIWAN MED. J. 50 (2012); Yang & Huang, *supra* note 74, at 23-24 (arguing that decriminalization of medical negligence does not violate the constitutional principle of equality).

determinations of “negligence” in both criminal and civil cases.²⁴⁸ The medical community has long criticized the two concepts as excessively vague.²⁴⁹ For physician groups, the concern is often expressed through the phrase “medical practice has no norms” (醫療無常規, *yi liao wu chang gui*).²⁵⁰ The phrase reflects a common physician sentiment that judicial interpretation of “medical norm” leaves ample room for biases and manipulation, and symbolizes the hate-physician mentality that many physicians believe is prevalent in the legal community.²⁵¹ Deepening their distrust in the system, the evidentiary process judges employ to apply these concepts to actual cases—the expert assessment system—is confidential and nontransparent; neither party has access for cross-examination purposes.²⁵²

In response, the medical community settled on the strategy “to make medical criminal liability more clear and reasonable” (醫療刑責明確化和合理化, *yi liao xing ze ming que hua he he li hua*).²⁵³ After years of debate, the strategy eventually came to fruition in late 2017. The Legislative Yuan amended Article 82 of the Medical Care Act to include the concept of “reasonable clinical professional discretion” (合理臨床專業裁量, *he li lin chuang zhuan ye cai*

²⁴⁸ See *supra* Part I.B.

²⁴⁹ The frustration is influenced by the work of Yat-Che Cheng of National Taipei University College of Law. See Yat-Che Cheng (鄭逸哲), ‘Lin Chuang Cailiang Quan’wei Ru Fa, Dengyu Mei Xiu—Pingxi Yiliao Fa Di Bashi’er Tiao Zhi Yi Tiaowen Xiuzheng Cao’an (「臨床裁量權」未入法，等於沒修——評析醫療法第八十二條之一條文修正草案) [An Amendment without Incorporating the Right to Clinical Discretion Equals No Amendment: On the Draft Bill to Amend the Medical Care Act Article 82-1], 59 MILITARY L. J. 98 (2013) (arguing “medical norm” is a fictional concept).

²⁵⁰ See Taiwan Yiliao Laodong Zhengyi Yu Bingren Anquan Cujin Lianmeng (台灣醫療勞動正義與病人安全促進聯盟) [Taiwan Medical Alliance for Labor Justice and Patient Safety (TMAL)], Yi Lao Meng Guanyu <Yiliao Jiufen Chuli Yu Yiliao Shigu Buchang Fa Caoan >Shengming (醫勞盟關於<醫療糾紛處理與醫療事故補償法草案>聲明) [Announcement on the Legislative Proposal of the Medical Dispute Resolution and Adverse Events Compensation Act], FACEBOOK (Apr. 21, 2015), <https://www.facebook.com/TMAL119/posts/645805105550901/>.

²⁵¹ *Id.*

²⁵² For the procedure of MRC assessment, see *supra* Part III.C and Articles 8, 9, 11, and 15 of the Operational Guideline, *supra* note 71.

²⁵³ See Ting & Huang, *supra* note 247, at 52-53; TAIWAN MEDICAL ASSOCIATION (TMA), Tuidong Yiliao Xing Ze Helihua Zhuanqu (推動醫療刑責合理化專區) [Special Section on Making Medical Criminal Liability More Reasonable], https://www.tma.tw/Medical_Dispute/index-MedRational-P01.asp (last visited Nov. 5, 2023). An earlier version of the strategy had attempted to limit criminal medical liability to intentional and grossly negligent acts. That attempt also failed to gather legislative momentum, partly because Taiwan’s criminal law does not explicitly recognize the concept of gross negligence. See Ting & Huang, *supra* note 247, at 52; Ministry of Justice, *supra* note 246 (referring to the criticism that “if the concept of gross negligence were to be included . . . it could potentially create conflicts with the existing legal framework in the application of the Criminal Code”).

liang) in the judicial criteria for determination of medical negligence in both criminal and civil cases.²⁵⁴

2. *The Amendment of Article 82 of the Medical Care Act*

The 2017 amendment of Article 82 was chiefly the result of the medical community's efforts to alleviate the threat of criminal medical liability. On its surface, the revision inserted the concept of "exceeding reasonable clinical professional discretion" (逾越合理臨床專業裁量, *yu yue he li lin chuang zhuan ye cai liang*) in §§ 2 (civil liability) and 3 (criminal liability) as the new guiding criterion to determine the existence of negligence liability of medical personnel in both criminal and civil cases.²⁵⁵ Under § 4 of amended Article 82, "medical norm" and "medical standard" now become *supplementary* concepts, which courts can employ to determine whether the treatment exceeded "reasonable" professional clinical discretion.²⁵⁶ The authors' translation of the statutory language, more faithful to the original Chinese text than the official English translation,²⁵⁷ is set out here:

§ 1. Medical practices shall adhere to the medically necessary duty of care.

§ 2. Medical personnel causing damage to patients when conducting medical practices are liable for compensation only in the event that: (1) the medically necessary duty of care is intentionally or negligently breached; *and* (2) the medical practices exceed reasonable clinical professional discretion. (Emphasis added.)

§ 3. Medical personnel causing death or injury to patients when conducting medical practices are criminally liable only in the event that: (1) the medically necessary duty of care is intentionally or negligently breached; *and* (2) the medical practices exceed reasonable clinical professional discretion. (Emphasis added.)

§ 4. The extent of the breach of the duty of due care and professional clinical discretion, as set forth in the preceding two paragraphs, shall be determined based on objective conditions *such as the medical norm, medical standard, medical facilities, working conditions, and the*

²⁵⁴ The concept of "reasonable clinical professional discretion" can be traced to Yat-Che Cheng (鄭逸哲). See Cheng, *supra* 249, at 103-105.

²⁵⁵ The official English text of Article 82 can be accessed at Medical Care Act art. 82 (2020), <https://law.moj.gov.tw/Eng/LawClass/LawAll.aspx?PCode=L0020021>. The official translation, which omits the key conjunction "and," deviates significantly from the literal meaning of the Chinese text.

²⁵⁶ *Id.*

²⁵⁷ *Id.*

urgency of the situation at the time and locality of the practice in the medical field concerned. (Emphasis added.)

§ 5. Medical care institutions causing damages to patients when conducting medical practices shall be liable for compensation only in the event that the medically necessary duty of care is intentionally or negligently breached.²⁵⁸

Compared to earlier failed reform efforts, the passage of the Article 82 amendment benefited primarily from two new factors: a political alliance between the medical community and the ruling Democratic Progressive Party (DPP), and growing physician mobilization through social media.

Many physician groups supported the victorious DPP presidential nominee, Ing-Wen Tsai, in the 2016 presidential election.²⁵⁹ In return, the DPP nominated several party-list legislators with medical backgrounds, including the president of the Taiwan Medical Association, Tai-Yuan Chiu, and the prior director of the Department of Women's Development of the DPP who had been a practicing Ob-Gyn, Ching-Yi Lin.²⁶⁰ Although the practice of nominating candidates with a medical background is not unique to the DPP, these two legislators, responding to demands from physician groups, led the charge for the amendment and played a key role in its passage.²⁶¹

Physicians' political mobilization gained momentum through the use of social media. A landmark event was a 2013 workplace violence incident against a nurse in a medical center's emergency room.²⁶² The aggressor was a township councilwoman. The incident escalated into a viral online solidarity event for nurses, organized in part by the Taiwan Medical Alliance for Labor Justice and

²⁵⁸ In defining civil liability of healthcare *institutions* (as opposed to medical personnel), § 5 does not include the term "exceeding reasonable clinical professional discretion." *See id.* Whether this further opens the door for courts to incorporate the concept of corporate negligence, whereby institutions can be held independently liable without first finding that individuals committed negligent acts, remains to be seen. *Cf.* Supreme Court No. 1593 Civil Decision of 2018, *supra* note 13 (contract liability).

²⁵⁹ *See generally* News Release, Office of the President, Republic of China (Taiwan), President Tsai's remarks at the 2016 Global Health Forum in Taiwan (Oct. 23, 2016), <https://english.president.gov.tw/NEWS/5012>.

²⁶⁰ For information on Dr. Chiu and Dr. Lin, see *Chiu, Tai-Yuan*, LEGISLATIVE YUAN, REPUBLIC OF CHINA (TAIWAN), <https://www.ly.gov.tw/EngPages/List.aspx?nodeid=12184>; *Lin, Ching-Yi*, LEGISLATIVE YUAN, REPUBLIC OF CHINA (TAIWAN), <https://www.ly.gov.tw/EngPages/List.aspx?nodeid=12101> (last visited Dec. 11, 2023).

²⁶¹ *See* TAIWAN MEDICAL ASSOCIATION, *supra* note 253.

²⁶² *See* Wen-Lin Liu (劉汶霖), Wangguifen Tiaokuan Guai Yihu Zhong Pan 3 Nian (王貴芬條款 擱醫護重判3年) [*The Kuei-Fen Wang Provision: Three-Year Sentence for Slapping Physicians and Nurses*], Feng Chuanmei (風傳媒) [THE STORM MEDIA], (Jan. 14, 2014), <https://www.storm.mg/article/26331>.

Patient Safety (TMAL, 台灣醫療勞動正義與病人安全促進聯盟, *taiwan yi liao lao dong zheng yi yu bing ren an quan cu jin lian meng*).²⁶³

TMAL played a decisive role in defeating the legislative proposal to establish a comprehensive public compensation fund for medical injuries modeled on the Birth-Related Incident Relief Pilot Plan in 2015. That bill was titled the “Medical Dispute Resolution and Adverse Events Compensation Act” (the “Medical Dispute Act” or “MDA”, 醫療糾紛處理及醫療事故補償法, *yi liao jiu fen chu li ji yi liao shi gu bu chang fa*).²⁶⁴ It had five major policy components: (1) requiring hospitals to set up communication and care groups;²⁶⁵ (2) adopting a U.S.-style apology law;²⁶⁶ (3) consolidating and strengthening existing extrajudicial mediation venues; (4) establishing a public compensation fund; and (5) requiring healthcare institutions to conduct patient safety activities such as incident reporting and root cause analysis.

The Bill had gone deep into the legislative process, but the momentum stalled when TMAL tried to torpedo the bill by criticizing as unjust the Bill’s design to require the medical profession to cover roughly one-third of the cost of the proposed compensation fund.²⁶⁷ The critique triggered a heated, high-

²⁶³ TMAL, founded in 2012, consists mostly of younger medical professionals, perhaps reflecting a generational divide in physicians’ attitudes toward the issue of labor conditions. Its central mission is to address the issue of overwork in healthcare (醫護過勞, *yi hu guo lao*), and it operates mostly online. See Taiwan Medical Alliance for Labor Justice and Patient Safety, *Labor Justice and Patient Safety*, TAIPEI TIMES (May 23, 2015), <https://www.taipeitimes.com/News/editorials/archives/2015/05/23/2003618934>.

²⁶⁴ The Medical Dispute Act was first developed by the Executive Yuan and submitted to the Legislative Yuan in 2012, when concern about the “depletion of five” phenomenon was at its peak. Scholars such as Wu and Liu viewed the MDA as integrating two competing approaches to legislative reform at the time, the mediation camp and the compensation camp. The former prioritized consolidating and modernizing third-party mediation processes; the latter emphasized the importance of no-fault or quasi-no-fault compensation regimes. Both ideas were incorporated into the MDA. Wu & Liu, *supra* note 2, at 299-300.

²⁶⁵ The proposed policy was the expansion of a 2010-2012 demonstration project. The idea was to prevent escalation of medical disputes by providing patients emotional and information support. Different hospitals set up multi-disciplinary groups differently. Some focused only on providing emotional support. Others treated it like an extension of the existing system of medical malpractice dispute resolution that helps detect patients’ complaints. A common feature, however, was that most hospitals avoided disclosing any incident-related information for fear that disclosure might put the hospital in a disadvantaged position later in court.

²⁶⁶ The statutory language of Article 6 of the Executive Yuan’s original draft stated that “during the process of explaining, communicating, offering assistance, or providing caring services, sympathetic, apologetic, or other remarks of similar nature made by medical professionals or their representatives should not be admitted as evidence for subsequent litigation or be used as a basis for judgment.” Lifayuan Yian Guanxi Wenshu (立法院議案關係文書) [Legislative Yuan Bill-Related Documents], Yuan Zong Di 1631 Hao Zhengfu Tian Di 13479 Hao (院總第 1631 號 政府提案第 13479 號) [Yuanzong No. 1631 Government Proposal No. 13479] 41, 46 (Dec. 18, 2010).

²⁶⁷ TMAL, *supra* note 250.

profile policy debate. Many physicians agreed with TMAL that the proposal was an attempt to establish no-fault compensation mechanisms similar to those in New Zealand and Scandinavian countries.²⁶⁸ This critique viewed such mechanisms as tools for collective risk distribution, arguing that their funding therefore should come 100% from the government, rather than requiring physicians to pay part.

Physicians' unwillingness to finance even a third of the total cost was likely rooted in their widespread sentiment that society, through both the NHI and malpractice litigation, has kept trying to take advantage of their profession. It did not help the bill's prospects that DPP legislator Wen Zhi Yao (姚文智) had incorrectly accused Taipei Veterans General Hospital of mishandling a child delivery.²⁶⁹ Yao publicly apologized, but the damage had been done. The debate became more emotional and confrontational, and the proposal was eventually shelved.

The defeat of the 2015 legislation was a display of force by the medical community, increasingly self-identified as a political power. The episode further strengthened the medical community's political clout and probably contributed to the 2017 passage of the Article 82 amendment.²⁷⁰

²⁶⁸ The Executive Yuan's original draft of the proposal (on file with authors) referred to New Zealand and Sweden as examples of countries that had achieved successful no-fault compensation systems. The proposal's critics seized on this point, as our co-author Chih-Ming Liang, who followed the debate closely, observed.

²⁶⁹ The facts turned out to be much more complicated than Yao depicted, and his Facebook page was flooded with angry posts from enraged medical professionals. See Wei Zhen Tseng (曾韋禎), Zhikong Yiliao Shushi Yi Jie Tafa Yaowenzhi, Xieweizhou Jugong Zhiqian (指控醫療疏失醫界撻伐 姚文智、謝維洲鞠躬致歉) [*The Accusation of Medical Error Got Fierce Pushback from the Medical Community: Yao Wen Zhi and Hsieh Wei Zhou Bowed in Apology*], Ziyou Shibao (自由時報) [LIBERTY TIMES] (May 18, 2015), <https://news.ltn.com.tw/news/politics/breakingnews/1320629>.

²⁷⁰ The Medical Dispute Act eventually failed due to physicians' resistance to the public compensation fund. As a consolation prize for the medical community, in 2015 the Legislative Yuan passed the Childbirth Accident Emergency Relief Act, recycling most MDA policy components except for the medical dispute mediation committee. After the Democratic Progressive Party won the 2016 election, MDA supporters took another shot, attaching a supplementary resolution to the Article 82 amendment demanding that the executive branch reform medical dispute mediation and incorporate patient safety measures.

The Executive Yuan submitted the bill to the Legislative Yuan in 2018, removing the controversial idea of the compensation fund. The new bill received only tepid support from physicians, probably because they had already gotten what they wanted in the Article 82 amendment. The 2018 bill eventually died as well, again revealing that physician groups' key priority for medical malpractice reform has always been criminal liability.

The proponents finally passed the Medical Accident Prevention and Dispute Resolution Act in May 2022. This time around the proponents engaged the medical community right from the beginning. The retirement of a party-list legislator of the ruling party associated with patient advocacy groups, Man-Li Chen (陳曼麗), also made it easier for the medical community to get concessions necessary for them to support the law. For Chen's personal

3. *The Intended and Actual Impact of the Article 82 Amendment*

Proponents had high hopes for the amendment to reduce physicians' litigation risk. Early signs indicated that the courts understood the motivation behind the amendment. The Supreme Court in 2018 recognized the purpose of the Article 82 amendment as to "limit the scope of negligence liability for physicians and reduce the possibilities that physicians are subject to criminal prosecution for their medical practice."²⁷¹

A deeper look into post-amendment decisions, however, suggests that the amendment has not changed judicial practice much, but rather has confused the courts. In particular, use of the conjunction "and" in §§ 2 and 3 defining civil and criminal liability of medical personnel²⁷² has caused considerable confusion about whether "exceeding reasonable clinical professional discretion" constitutes a new independent element of negligence separate from "breach of the duty of care," or is something that functions more like a modifying clause simply clarifying the meaning of "breach of duty."²⁷³

information, see *Chen, Man-Li*, LEGISLATIVE YUAN, REPUBLIC OF CHINA (TAIWAN), <https://www.ly.gov.tw/EngPages/List.aspx?nodeid=12132>.

²⁷¹ *Zuigao Fayuan 107 Nian Tai Shang Zi Di 4587 Hao Xingshi Panjue* (最高法院 107 年台上字第 4587 號刑事判決) [Supreme Court No. 4587 Criminal Decision of 2018] (Taiwan S. Ct. Apr. 2, 2018). The original Chinese statement is "限縮醫師過失責任範圍，減少其因執行業務而受刑事訴追風險" ("xian suo yi shi guo shi ze ren fan wei, jian shao qi yin zhi xing ye wu er shou xing shi su zhui feng xian").

²⁷² As mentioned above, *supra* note 255, the law's official English translation fails to include the word "and," so it is unfaithful to the Chinese text. See *supra* Part V.C.2.

²⁷³ Legislative history may offer some clues on this issue. However, courts in interpreting the amendment are not bound by and have rarely explored its legislative history. Records of legislative committee meetings suggest that the insertion of "exceed[ing] reasonable clinical professional discretion" was intended to function as a mere clarification of "breach of duty," rather than as a separate element of the plaintiff's claim. The purpose of adding the clause was apparently viewed as a way to circumvent the doctrinal debate on whether the concept of gross negligence is compatible with Taiwan's criminal law jurisprudence. In the Social Welfare and Environmental Hygiene Committee of the Legislative Yuan (立法院社會福利及衛生環境委員會, *li fa yuan she hui fu li ji wei sheng huan jing wei yuan hui*) meeting on Nov. 6, 2017, for instance, the Ministry of Health and Welfare representative stated that "[w]e have two recommendations for the criminal part of the amendment. First, our position is to narrow medical criminal liability of healthcare professionals to only patient deaths and injuries caused by intentional acts. If this cannot be achieved, then considering there is no gross negligence in criminal law, we suggest that we revise section 3 as: 'Medical personnel causing death or injury to patients when conducting medical practices are criminally liable only in the event that the medically necessary duty of care is intentionally or negligently breached, in a way that obviously exceeds reasonable clinical professional discretion. But systemic errors or medically tolerable risks are not punishable.'" The second sentence on systemic errors was later deleted. The first sentence, after deleting "obviously" and inserting the conjunction "and," became the final language. Records of the Social Welfare and Environmental Hygiene Committee of the Legislative Yuan Meeting, *Lifayuan Gongbao Di 106 Juan Di 104 Qi Weiyuanhui Jilu* (立法院公報 第 106 卷 第 104 期委員會紀), Nov. 6, 2017 (on file with authors).

The new law does not provide a clear definition of “reasonable clinical professional discretion.” Rather, amended Article 82 takes an indirect route in Section 4 by including existing concepts such as “medical norm” and “medical standard” as matters that courts should *consider* when evaluating the scope of both the duty of care and clinical professional discretion.²⁷⁴ As a result, the amendment created a tautological distinction. It seemingly distinguishes “the breach of the duty of care” from “exceeding reasonable clinical professional discretion” as two separate matters, but in defining the latter resorts back to concepts traditionally associated with the former, thus making judicial application of the new criteria problematic.

The confusion triggered different responses from civil and criminal courts. Civil courts so far have been hesitant to apply the new concept directly, but rely more on familiar and comfortable concepts such as “medical norm” and “medical standard.”²⁷⁵ A common judicial strategy is to pay lip service to the new criteria by recognizing that Article 82 has been amended, but then to revert quickly to § 4 requiring the court to *consider, among other matters*, “medical norm” and “medical standard” as the basis for judgment.

That lip-service strategy is evident in a 2020 Supreme Court civil decision. The case involved an obstetrician accused of failing to monitor fetal heart sounds and conduct a differential diagnosis on tachycardia, leading to an emergency caesarean section causing permanent cerebral palsy. The Supreme Court, after recognizing that Article 82 had been amended, turned its focus to the lower court’s interpretation of “medical norm” and “medical standard.” The lower court had rejected an MRC report concluding the practice in dispute was consistent with the “medical norm,” and held that the practice also needed to meet the “medical standard” to be non-negligent. This view was likely influenced by the two 2017 Supreme Court civil decisions that viewed the

²⁷⁴ See *supra* note 255. One new contribution of Section 4 is the addition of “working conditions,” which is likely a response to the rampant social problem of overwork of healthcare professionals. Courts had already noticed the problem before the amendment’s passage. In Supreme Court No. 1048 Civil Judgment of 2017, *supra* note 38, the Court listed, among other factors, “whether medical personnel have received regular and necessary on-the-job training according to regulations, the personnel arrangement of the day, the number of patients, and whether medical personnel have sufficient time to practice care” as factors to consider in deciding whether the “medical standard” has been violated.

²⁷⁵ A potential reason for the hesitation may be that, in Taiwanese civil law, the concept of negligence is often used interchangeably with the concept of breaching the duty of care. The odd addition of “exceeding reasonable clinical professional discretion” therefore created something that has no clear doctrinal position within existing civil law jurisprudence.

“medical norm” as just a lower bar.²⁷⁶ The 2020 Supreme Court decision rejected this interpretation, holding that the lower court’s refusal to accept the MRC report’s conclusion constituted a hasty judgment requiring further deliberation.²⁷⁷

In criminal cases, judges have been more adventurous in interpreting the new statute.²⁷⁸ A 2018 Supreme Court criminal decision exemplifies the point.²⁷⁹ The case involved a cosmetic surgery clinic accused of conducting autologous fat graft breast augmentation without equipment for monitoring vital signs and first aid, causing the patient to die of hypoxic encephalopathy.²⁸⁰ The Court reversed and remanded the lower court’s judgment of guilt. The Court defined “professional clinical discretion” as “physicians’ freedom of treatment,” in particular in situations involving rare, new, or terminal diseases, where medical norms are often lacking due to unsurmountable uncertainties.²⁸¹ However, constrained by the statutory language, the Court still maintained that whether physician clinical discretion has been exceeded should be evaluated against the elements listed in § 4. Thus the decision still fails to escape the tautological distinction inherent in the amendment’s structure.²⁸²

²⁷⁶ *Supra* note 38.

²⁷⁷ Zuigao Fayuan 109 Niandu Di 2795 Hao Minshi Panjue (最高法院109年度第2795號民事判決) [Supreme Court No. 2795 Civil Judgment of 2020] (Taiwan S. Ct. March 11, 2020). The Court referred to Article 16 of the Operational Guideline for Medical Malpractice Disputes Assessment, *supra* note 71, which states that “[for] medical assessment, members of the medical assessment team and the preliminary review physicians shall provide fair and objective opinions . . . based on medical knowledge and *medical norms*, as well as taking into account local medical resources and *medical standards* . . .” (emphases added). The Court reasoned that the MRC’s report had already considered factors like “medical knowledge” and “medical norm.” The lower court’s refusal to accept the MRC report, based not on substantive reasons but solely on the doctrinal idea that meeting the medical norm is not enough to avoid liability, therefore was unfounded.

²⁷⁸ One possibility is that some judges may privately agree that medical criminal liability should be held to a higher negligence standard but are nevertheless constrained by the lack of gross negligence in Taiwanese criminal law. For them, the amendment may have provided an opening to carve out new directions. One support for this theory is Wu & Yeh’s study, which observed that more than 90% of criminal cases where the defendants are held criminally liable involve medical interventions that, from the perspective of physician reviewers recruited by the study, can be categorized as involving gross negligence. *See* Wu & Yeh, *supra* note 24, at 1137-40.

²⁷⁹ Zuigao Fayuan 107 Niandu Di 4587 Hao Xingshi Panjue (最高法院107年度第4587號刑事判決) [Supreme Court No. 4587 Criminal Judgment of 2018] (Taiwan S. Ct. Apr. 2, 2018).

²⁸⁰ *Id.*

²⁸¹ *Id.* The Court did not elaborate on whether “physicians’ freedom to treatment” is limited to these situations.

²⁸² The Court also touched upon “medical standard” as another criterion for determining “clinical professional discretion” other than “medical norm.” *Id.*

Perhaps closer attention to careful statutory drafting might have avoided judicial confusion in interpreting amended Article 82. Ultimately, however, the doctrinal debate may be insignificant. As shown in Part II, the rate of indictment and the overall number of criminal cases began to decline long before the passage of the amendment, indicating that the lack of doctrinal clarity has not prevented the legal system from responding to the angst of the medical community. Furthermore, regardless of which concepts courts eventually employ, the actual evaluation of these concepts will still rely heavily on the expert assessment system—a system that has long evaded stakeholders' attention in debates about reforming medical injury law.

4. *What Comes Next?*

Following the Article 82 amendment, the Legislative Yuan enacted the Medical Accident Prevention and Dispute Resolution Act in May 2022.²⁸³ (See Diagram 5 for the legislative history of both laws.) The central purpose of the 2022 law is to consolidate existing third-party mediation processes into one-stop forums, called “medical dispute mediation committees,” at the local jurisdiction level.²⁸⁴ Agreements achieved via the new forums will be afforded enforceable legal effect.²⁸⁵ The new law also addresses parties' lack of access to expert opinions during the ADR process by institutionalizing systems of both medical expert consultation, for requests filed directly by patients and families, and medical dispute evaluation, for requests forwarded by local health bureaus.²⁸⁶ The new structure further allows mediators to invite experts with medical, legal, psychological, and social work backgrounds to express their opinions.²⁸⁷ In addition, a patient safety component in previous versions of the bills was refined and included in the new law.²⁸⁸

²⁸³ *Supra* note 118.

²⁸⁴ *See* Medical Accident Prevention and Dispute Resolution Act, art. 12; *see generally* Part VII, the Statutory Appendix for English translations.

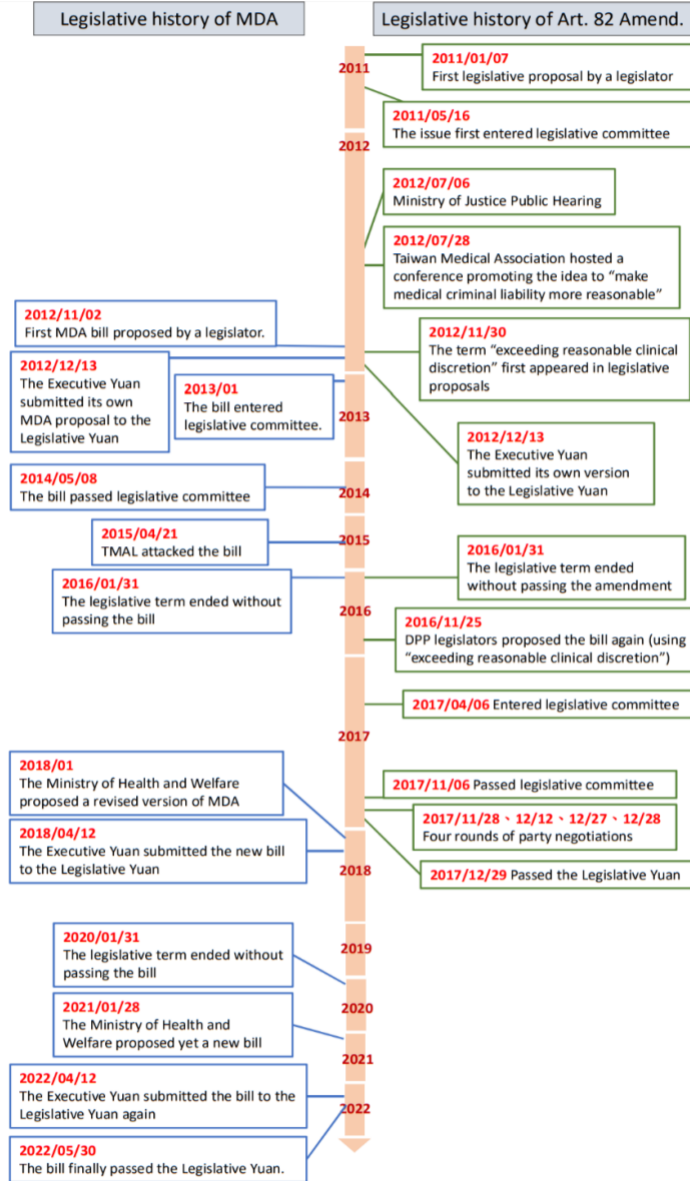
²⁸⁵ Medical Accident Prevention and Dispute Resolution Act, art. 28 § 4.

²⁸⁶ *Id.* art. 4.

²⁸⁷ *Id.* art. 21 § 2.

²⁸⁸ *Id.* art. 33-37.

Diagram 5: Legislative History of the Medical Disputes Act and the Article 82 Amendment



We surmise that the passage of the 2022 legislation reflects a significant alleviation of the collective anxiety of the medical community toward medical malpractice law subsequent to the 2017 Article 82 amendment. Though the 2017 amendment might not have swayed judges much, it may well have had a psychological effect, reassuring physicians that the legal system is now better equipped to protect their interests.²⁸⁹ By addressing their key concern, the issue of criminal liability, the 2017 amendment may have nudged the medical community toward becoming more receptive to other reform proposals.

The Ministry of Health and Welfare may build on the legislative momentum of both the Article 82 amendment and the 2022 legislation to make another push toward implementing a general compensation fund—the policy idea that doomed the 2015 Medical Dispute Act. Whether powerful physician interests will continue to oppose that idea is yet unknown.

SUMMARY AND CONCLUSION

Taiwan's medical injury laws and practice contain distinct features that outside observers will find noteworthy. The first is the interplay between the criminal and civil justice systems. "Negligence" causing injury or death is both a crime and a civil offense. Patients alleging medical injury frequently file initial complaints in the criminal justice system, and these must be investigated. Prosecutors call on Medical Review Committees composed of medical, legal, and other specialists to review the medical records and draw conclusions, sometimes adverse to the medical providers. Patients in many cases thereby obtain investigation results at public expense. They may use these results in civil actions ancillary to the criminal cases, if the providers are indicted.

Physicians have bewailed this system as one cause of the "collapse of healthcare," echoing similar rhetoric previously employed in Japan.

The number of prosecutorial investigations of alleged medical negligence, relatively constant during the 1980s and 1990s, climbed steadily from 2002 to a peak around 2015, but has since diminished; a much smaller proportion of investigations now results in indictments. However, the percentage of tried cases resulting in findings of guilt increased from 19% in 2002–2004 to 29% in 2017–2019.

²⁸⁹ Interview with Dr. Chen-Chi Wu, *supra* note 96.

On the civil litigation side, official statistics charting the number of cases filed over time and the percentage of cases in which compensation is made are lacking. Scholars' estimates from the past twenty years are set out at the end of Part II. Two notable features of medical litigation are that courts occasionally shift the burden of proof to defendants to justify their acts and omissions, and that informed consent doctrine has moved in recent years toward acceptance of what in the U.S. is called the "reasonable patient" standard.

A critically important aspect of Taiwanese medical law in action is the role of Medical Review Committees (MRCs). Prosecutors and judges seldom reject MRC conclusions (except in criminal trials, in which in a substantial proportion of reports critical of providers, defendants are nevertheless acquitted). The MRC system is criticized for lack of transparency—no one knows who the committee members are—and for lack of accountability, since they cannot be cross-examined in court.

Alternative dispute resolution, especially mediation, has rapidly become a central feature of Taiwan's medical injury law in action. At present ADR takes place in a multiplicity of forums, and mediations can occur at almost any stage—both before any court filings and during the trial process. A law enacted in 2022 but not yet implemented, the Medical Accident Prevention and Dispute Resolution Act, will consolidate existing third-party mediation processes into one-stop forums at the local jurisdiction level.

No-fault administrative compensation systems cover injuries and deaths from vaccines and from defined categories of adverse drug reactions and of childbirth-related damage. These systems have channeled many disputes away from the courts.

The politics of medical law reform have been chiefly driven by physicians' chagrin over the threat of criminal prosecution. Physicians have had a strong advocate in Tai-Yuan Chiu, former president of the Taiwan Medical Association and a power in the Legislative Yuan, Taiwan's parliament. A series of bills brought before the Legislative Yuan culminated in enactment in 2017 of an amendment to Article 82 of the Medical Care Act. This amendment added the phrase "exceeding reasonable clinical professional discretion" (逾越合理臨床專業裁量, *yu yue he li lin chuang zhuan ye cai liang*) as the new guiding criterion to determine the existence of negligence liability of medical personnel in both criminal and civil cases. However, courts have had difficulty interpreting the amended language.

As a matter of law, it is difficult to discern any significant change in the outcomes of court decisions after the 2017 Article 82 amendment. However, noting the marked decrease in prosecutions and the slight decrease in civil cases over the past years, and the 2022 enactment of improvements to the ADR system, we suspect that physicians' dismay about the legal system is somewhat alleviated. Taiwan's medical injury law has approached a state of equilibrium.

STATUTORY APPENDIX²⁹⁰**Civil Code**

Article 184: A person who, intentionally or negligently, has wrongfully damaged the rights of another is bound to compensate him for any injury arising therefrom A person, who violates a statutory provision enacted for the protection of others and therefore prejudice to others, is bound to compensate for the injury, except no negligence in his act can be proved.

Article 188(1): The employer shall be jointly liable to make compensation for any injury which the employee has wrongfully caused to the rights of another in the performance of his duties. However, the employer is not liable for the injury if he has exercised reasonable care in the selection of the employee, and in the supervision of the performance of his duties, or if the injury would have been occasioned notwithstanding the exercise of such reasonable care.

Article 224: A debtor shall be responsible for the intentional or negligent acts of his agent and of the person performing the obligation for him to the same extent as he is responsible for his own intentional or negligent acts. Unless otherwise agreed upon by the parties.

Article 227(1): If a debtor incompletely performs his obligation by reason of a circumstance to which the debtor is imputed, the creditor may execute his right according to the provisions of the default or the impossibility of the performance.

Article 736: A . . . settlement is a contract whereby the parties by making mutual concessions terminate an existing dispute or prevent the occurrence of a future dispute.

Code of Civil Procedure

Article 377(1): The court may seek settlement at any time irrespective of the phase of the proceeding reached. A commissioned judge or an assigned judge is also authorized to do so.

Article 380(1): A final settlement shall have the same effect as a final judgment with binding effect.

²⁹⁰ Official translations employed in the Laws & Regulations Database.

Article 403: Except in cases provided in the subparagraphs of the first paragraph of Article 406, the following matters shall be subject to mediation by the court before an action is initiated: . . . 7. Disputes arising from a traffic accident or medical treatment . . .

Article 406(1): In case of any of the following, a court may by a ruling immediately dismiss the application for mediation: 1. Where . . . or other circumstances, the mediation is considered infeasible or plainly and manifestly unnecessary, or there is clearly no prospect of a successful mediation; 2. Where mediation by another legally authorized mediatory agency has been sought with no successful result . . .

Article 416(1): A successful mediation is reached upon the agreement of the parties; a successful mediation shall take the same effect as a settlement in litigation.

Code of Criminal Procedure

Article 238: In a case chargeable only upon complaint, the complaint may be withdrawn at any time before the conclusion of the argument in the trial of the first instance. A complainant who withdraws a complaint shall not file it again.²⁹¹

Article 248-2(1): During the investigation stage the public prosecutor may order the case to undergo mediation . . .

Article 271-4(1): The court may order the case to undergo mediation any time before the conclusion of oral argument.

Compulsory Enforcement Act

Article 4: Compulsory enforcement can be carried out on the grounds of the following enforcement titles: . . . 3. A settlement or mediation pursuant to the Code of Civil Procedure.

Criminal Code

Article 14(1): A conduct is committed negligently if the actor fails, although not intentionally, to exercise his duty of care that he should and could have exercised in the circumstances.

²⁹¹ The term “case chargeable only upon complaint” is a different English translation of “prosecution requiring complainant.”

Article 276: A person who negligently causes the death of another shall be sentenced to imprisonment for no more than five years, short-term imprisonment, or a fine of not more than five hundred thousand dollars.

Article 284: A person who negligently causes injury to another shall be sentenced to imprisonment for no more than one year, short-term imprisonment, or a fine of not more than one hundred thousand dollars; if serious physical injury results, he shall be sentenced to imprisonment for no more than three years, short-term imprisonment, or a fine of not more than three hundred thousand dollars.

Medical Care Act

Article 63(1): Medical care institutions shall explain the reasons for surgical operation, success rate, possible side-effects and risks to the patient or his/her legal agent, spouse, kin, or interested party, and must obtain his/her consent and signature on letter of consent for surgery and anesthesia before commencing with surgical procedure. However, in case of emergency, the provisions above shall not apply.

Article 64(1): Medical care institutions shall explain the invasive examination or treatment regulated by the central competent authority to the patient or his/her legal agent, spouse, kin, or interested party, and must obtain his/her consent and signature on the letter of consent before commencing with the procedure. However, in case of emergency, the provisions above shall not apply.

Article 71: Medical care institutions shall provide a copy of the patient's medical records or Chinese summary of medical records when necessary in accordance with the patient's requests, and shall not delay or refuse without cause. The fee for the copy of medical records shall be paid by the patient.

Article 81: When treating the patient, the medical care institution shall inform the patient or his/her legal agent, spouse, kin, or interested party of his/her condition, course of treatment, disposition, medication, expected condition, and possible ill effects.

Medical Accident Prevention and Dispute Resolution Act

Article 4: The competent central authority shall commission government funded foundations to conduct medical professional consultations under Article 9 and medical dispute analyses under Article 21 Paragraph 2. As necessary, the competent central authority may provide funding for foundations to conduct

these activities. When the foundations referred to in the preceding paragraph conduct medical professional consultations and medical dispute analyses, they shall be fair-minded, objective, and neutral, and they must abide by conflict of interest rules. The operational procedures, qualifications of personnel, fee basis, conditions for no-fee service, regulations for conflicts of interest rules, and other related matters are established by the competent central authority. Unless all parties involved in the medical dispute agree, the medical professional consultation and the medical dispute analysis provided by a foundation established under Paragraph 1 may neither be used as evidence in or as the basis for litigation related to a case concerning the same dispute, nor be used as basis for relevant administrative sanctions.

Article 12: Competent authorities of municipal governments and county (city) governments shall establish a medical dispute mediation committee (hereinafter referred to as the “Committee”) to mediate medical disputes. The Committee shall consist of 9 to 45 neutral individuals with medical, law, or other professional knowledge and an honest reputation. Members without a medical background or members of either gender may not constitute less than one-third of the total number of the members. Committee members shall serve 3-year terms, and they may serve consecutive terms. When there is a vacancy during one term, a new member may be hired, and the term of the new member is until the end of the original term. The competent authorities of municipal governments or county (city) governments shall provide financial budget for the expenses to implement the Committee. The central competent authority may prioritize subsidies based on the financial rating of the municipal governments or county (city) governments.

Article 14 (1): Regarding mediation of the medical dispute, a mediation meeting shall be held within 45 days of the day on which the application documents are completed and accepted and shall be completed within 3 months. When necessary, the parties may apply for a one-time extension of 3 months. However, when all involved parties agree, an additional extension is permitted.

Article 16: Criminal cases involving medical disputes investigated by prosecutors or tried by courts shall be transferred to the Committee with jurisdiction for mediation first. During the process of mediation, investigation and trials are stayed. When the prosecutor or court seeks to transfer a case referred to in the preceding paragraph, the defendant, the complainant, the patients and their family, the private prosecutor, and the prosecutor shall be informed. As necessary, the prosecutor or the court may transfer relevant

documents to the Committee. When a party applies for a mediation and the mediation is unsuccessful, a complaint in criminal case has been filed within 6 months from the day following the party receipt the unsuccessful mediation certificate is deemed as initiating an action when applying for a mediation. Medical dispute criminal cases that have followed the Act and failed to achieve resolution through mediation or that meet the regulations of the Code of Criminal Procedure Article 161 Paragraph 2, Article 252 Subparagraphs 1 to 9, Articles 302 to 304, Article 326 Paragraph 1 and Paragraph 3, Article 329 Paragraph 2, Article 334 and Article 335 are not subject to the provisions of the first half of Paragraph 1 regarding first going through mediation.”

Article 17: When the Committee receives the mediation application or receives cases transferred by prosecutors or the court for mediation, within 7 working days from the day after receiving the case, they shall contact both parties to give notice of the fact that the mediation case has been accepted. The Committee may ask the involved parties to provide a list of names and the contact information of people with the right to make a claim for injuries and ask them to participate in the mediation. A third person having an interest in the subject matter of the mediation may be informed by the Committee of the mediation and allowed to participate in the mediation. When there are several mediation cases based on the same type of accident or incident, the Committee may consolidate them into one case. The date of receiving the case is the date when the cases are consolidated.

Article 22 (2): During the mediation process, if the involved parties, their agents, or other people disturb the tranquility or order of the mediation venue or its surroundings by violence, threat, intimidation, public insults, or other illegal methods, the mediation committee members may ask the police to remove or stop them.

Article 28 (4): The civil mediation approved by the court shall have the same effect as a binding judgment under the civil litigation. Regarding the criminal mediation approved by the court, for the monetary payment, other substitutes, or certain amount of securities as the object of the litigation, the mediation agreement may be the ground for execution.

Article 33: Hospitals shall establish the patient safety management system and the promotion plan to encourage their internal staff members to report patient safety events, and shall also analyze, prevent, and control medical accident risks to increase medical quality and ensure patient safety. Medical care institutions

shall maintain the confidentiality of the identity of the reporter of patient safety events and may not take action to punish or retaliate against the reporter, such as terminating their employment or declining to renew their contract. The report, analysis, and other relevant prevention and control measures concerning patient safety events described in Paragraph 1 may neither be used as evidence or as the basis for associated litigation or relevant administrative sanctions. For hospitals conducting patient safety management systems and promotion plans with outstanding results pursuant to Paragraph 1, competent authorities may reward them.

Article 34: For major medical accidents, medical care institutions shall analyze the fundamental causes, propose improvement plans, and report to competent authorities. What qualifies as a major medical accident subject to reporting requirements in the preceding paragraph, reporting procedures, reporting content, and other matters to be followed are determined by the central competent authority. The major medical accident reports, the analysis of fundamental causes, and the improvement plans described in Paragraph 1 may not be used as evidence or as the basis for associated litigation or relevant administrative sanctions.

Article 35: In the event of a medical accident at a medical institution and the occurrence of one of the following conditions, the task force shall established, by the competent central authority themselves or by commission a foundation established by government funding, to conduct an investigation, to make a report, and to release the report : 1. During a certain period, medical accidents repeatedly occur or are expected to occur. 2. Medical accidents occur or are expected to occur across medical institutions or across municipalities or counties (cities). 3. Public health and safety is endangered or at risk. 4. Other situations identified by the competent central authority. To conduct the investigation described in the preceding paragraph, related personnel of medical accident may be asked to explain and provide information. Medical institutions, juridical entities, groups, and relevant personnel under investigation may not evade, obstruct, or refuse to participate in an investigation. The content of the investigation report in Paragraph 1 is for the purpose of discovering the truth and discerning facts, not for attributing individual responsibility. It shall not be used as the only basis for conviction. The organization, operation, investigatory procedure, and report of the task force convened under Paragraph 1 and other matters to follow are determined by the competent central authority.

Article 36: The competent central authority shall establish or commission a foundation, established by government funding, to establish an autonomous medical accident reporting system to receive reports by the public. The reporter's identity and the source of information shall be kept confidential. The reporting conditions, methods, procedures, content, handling, and other related matters shall be established by the competent central authority.

Article 37: When individuals involved in a medical accident implicated in an acted in violation of administrative or criminal responsibilities prescribed by law, whether they actively reported the case and whether they proactively cooperated in the investigation or provided information shall be considered in determining penalties or sentencing.

Physicians Act

Article 12-1: When diagnosing and treating patients, a physician shall inform the patient or the patient's family of the status of the disease, treatment principles, treatment, medication, prognosis and possible unfavorable reactions.