

MEDICAL NEGLIGENCE DISPUTE RESOLUTION IN CHINA: SOCIAL STABILITY AND PREVENTATIVE MEASURES

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Abstract

Medical negligence is an important issue in China today, threatening to undermine the party-state policy objectives of social stability and the right to health, thus requiring effective solutions. China's response includes a dispute resolution regime for issues of medical negligence, structured as a bifurcated administrative and court regime and supplemented by mediation. This Note examines this dispute resolution regime, its difficulties and possible ways of reform. More specifically, it explores whether the current assignment of liability is appropriate when considered in the context of the system's relationship to the policy objective of social stability and suggests that social stability may be more efficiently achieved by greater utilization of preventative measures.

Keywords: medical negligence; medical disputes; China; mediation; social stability; right to health.

[A] INTRODUCTION

Currently, medical negligence is an active problem in China, where several state and party policy objectives are simultaneously at play: firstly, maintenance of overall political and social stability; and, secondly, the citizen's right to health. A dispute resolution regime has been created which is a bifurcated administrative and judicial system, supplemented by mediation.

Here, it is observed that current legal research evaluating China's medical negligence dispute resolution regimes tends to focus on

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addressing regime effectiveness in terms of serving the patient's right to health, suggesting an underlying assumption that patient welfare is a primary concern of the Chinese party-state as the policy maker, where social stability is an incidental by-product of positive patient outcomes (Harris & Wu 2005; Ding 2009; Xi & Yang 2011; Biddulph 2015; Ding 2015; Fu & Palmer 2017).

In the context of the current literature, this Note primarily addresses the question: *does the current assignment of liability in China's medical negligence dispute resolution regimes, as set out in its written rules and policies, properly serve its own intended policy objectives?* This Note attempts to answer this question by analysis of written rules, party policies and reasoning based on the following views.

- ◇ First, from the Chinese Communist Party's (CCP) perspective and conceptualization of rights and policy objectives, the right to health is likely less important than the prime objective of social stability. This will be explored through examination of current regimes, as constructed by written rules and party policies, to illustrate and explain why, in instances when the two policy objectives in question interact, the current regimes are intended and designed to favour social stability, even at the expense of health outcomes.
- ◇ Secondly, the current regimes are nonetheless essentially reactive measures in nature, targeting *suppression* of social instability, and that suppression is an approach inherently limited in securing the prime policy objective of social stability.
- ◇ Thirdly, that instead of the current approach involving reactive measures, in terms of the system's and regimes' congruency with the policy objective of social stability, the more efficient solution would be the introduction of and reliance on preventative measures.

This Note attempts to add value through examining China's medical negligence problem from an alternate perspective: in that, while suggestions for dispute resolution regimes aimed at improving patient outcomes may be desirable and even viable in the abstract, they will be disagreeable to the party-state if such suggestions detract from the goal of maintaining social stability. Therefore, in exploring practical options for reforming the system, it is important to bear in mind the hierarchy of policy objectives: to begin by actively seeking out solutions which further the social stability agenda, as well as examining whether they assist patient outcomes. It is only logical that these are the only types of solutions that the party-state will seriously consider and accept, and that other solutions are likely relatively undesirable. It is hoped that this Note

provides some perspective in identifying practical and realistic solutions for policy-related legal issues in China.

The structure of this Note is as follows. First, the Note explains the implications of medical negligence for the state and party policy objectives of social stability and the right to health, justifying China's view of medical negligence as a problem that demands effective solutions, and explaining why the CCP views the importance of the right to health as secondary to social stability. Secondly, building on existing literature and through the lens of themes such as fairness and consistency—being the tools of the primary objective of social stability—this Note critically examines China's medical negligence dispute resolution avenues. Thirdly, it examines the current system's lop-sided and primary focus on dealing with social instability through reactive measures as solutions and suggests why this is inefficient. Fourthly, the contribution suggests that social stability is more efficiently achieved by greater utilization of preventative measures. Possible preventative measures which may be introduced are also explored, such as by regulating healthcare culture through assigning greater non-compensation-based personal accountability on medical workers. Finally, the Note concludes by summarizing how, through examining preventative solutions complementary to the current system, it might contribute to current academic discussions on China's medical negligence problem.

[B] MEDICAL NEGLIGENCE IN THE CONTEXT OF PARTY-STATE OBJECTIVES

In addition to physical injuries and economic losses, especially for the individual, medical negligence disputes are particularly concerning for the state and the CCP that leads it, as the party-state considers such disputes as detracting from its policy objectives of social stability and the right to health.

Social Stability

Deng Xiaoping, the paramount leader of China during the first decade or so of the reformist policies introduced in the late 1970s, advised that China has to 'preserve stability above all other concerns' (Trevaskes & Ors 2014). Social stability has remained a top concern of the party-state and is viewed as a precondition for successful economic development. Stability and unity under China's one-party-state are considered as preconditions for necessary economic growth. Social stability maintenance is seen by the Party as critical for preserving the CCP's power, especially as social

instability is believed to have created the circumstances which enabled the CCP itself to assume power in 1949 (Trevaskes & Ors 2014; Biddulph 2015). For the CCP, not only is social stability maintenance a critical component of economic success and a guarantee for the Party's preservation of power, but it also facilitates day-to-day socio-political control.

The paramount importance of social stability as a policy objective is clearly evident and very pervasive in China's legal system (Harris & Wu 2005; Chen 2011). Western ideals of the rule of law are seen as a 'tool' by means of which ruling-class dictators oppress the people (Chen 2011). In contrast, the CCP sees itself as a representation of the will and interests of the people, and thus the CCP is the embodiment of the people. Being one and the same as the people, there is no need for law to assist the people to keep the Party in check. This encourages a paternalistic view of the role of government, in which the state is expected to deal with a wider range of difficulties than might be expected of governments elsewhere. In addition, China has deep-rooted traditional reservations about law's effectiveness in governing disputes and giving fair outcomes, stressing instead the importance of mediation as a form of third-party intervention.

Today, law is viewed by the party-state leadership essentially as a tool for administering, achieving and maintaining social stability 'in accordance with the law', through regulating and managing citizen behaviour (Central Committee of the Communist Party of China 2006; Trevaskes & Ors 2014). Since the early 2000s, the goal has been to ensure a socialist harmonious society with orderly, conflict-free social interactions, where confrontational relationships amongst individuals or between individuals and the state, including those brought about by medical negligence disputes, are prevented or halted 'above all other concerns', even at the expense of fairness to individuals (Trevaskes & Ors 2014). This can be seen in the administrative and court-focused avenues of justice which are geared towards eliminating disputes and ensuring social stability, prioritizing positive 'communal' outcomes over fairness, due process and procedural justice. In this spirit, China has also strongly encouraged mediation, which is a process seen to give firmer control over outcomes and more effectively harmonize relationships between parties (Trevaskes & Ors 2014).

The Intersection of Social Stability and the Right to Health

China is also well aware of the importance of individual citizens' right to health and has corresponding international healthcare obligations, for

example in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the United Nations Millennium Declaration (Biddulph 2015). Promises for the right to health are also entrenched within the Constitution of the People's Republic of China (as amended in 2018) in Articles 21, 33 and 45. In domestic implementation, China has set itself healthcare outlines and targets, such as in the Human Rights Action Plan 2012-2015 (Biddulph 2015).

In some situations, tension arises when attempting to balance social stability and the right to health: social stability is about harmonizing relationships for the benefit of society as a whole, whereas the right to health has roots in the interests of individual patients. Medical negligence disputes highlight the conflicting interests between these two policy objectives: when citizens' right to health has been violated, their expressions of grievance are threats to social stability. The way China resolves this tension when it comes to medical negligence disputes evidences the fact that social stability—and prevention of disorder—is prioritized ahead of the right to health, representing citizens' individual rights and quality of life.

Even if reconciliation and prioritization of the two conflicting policy objectives can be resolved, medical negligence disputes will nonetheless continue to impose a double threat towards both policy objectives: first, as an actual source of social unrest, threatening social stability and party survival; and, second, as a display of China's inadequacies in complying with international obligations and constitutional promises. Hence, regardless of how China's policy objectives are conceptualized, medical negligence, the disputes to which it gives rise and their subsequent effects are problems that demand effective solutions.

[C] MEDICAL NEGLIGENCE DISPUTE RESOLUTION REGIMES AND ISSUES

China deals with medical negligence mainly based on a fault-based compensation model. An integral part of this model is fault-finding and granting compensation through dispute resolution processes that are located either in administrative or court systems, and, in many cases, mediation is also utilized. Examination of these regimes will in part borrow from existing literature and commentary (Harris & Wu 2005; Ding 2009; Xi & Yang 2011; Biddulph 2015; Ding 2015; Fu & Palmer 2017). Through this, I attempt to further establish that the regimes, as intended by design, are more concerned with social stability than individual patients' right to

health. The support of this will therefore rely on the CCP's written rules and policies, which are manifestations of its subjective intentions.

The Administrative Regime: Its Issues

The two key items of legislation for the administrative regime are the Regulations on Handling Medical Accidents 2002 (RHMA) and the Regulations on Prevention and Handling of Health Care Disputes 2018 (RPHHCD). There is no express statement in the RPHHCD that it supersedes the RHMA, and hence an overarching issue is that it is uncertain whether the RPHHCD was intended to supersede, clarify, or run in parallel with the RHMA. This will be further explored below in comparing the two legislative documents.

The RHMA, at Article 1, states its purpose as follows: first, to correctly handle medical accidents; second, to protect the lawful rights and interests of patients and medical institutions, as well as their medical work; third, to maintain the order and safety of medical practice; and, fourth, to promote development of medical science. In comparison, the RPHHCD, at Article 1, is different in its purposes, as it aims, first, to properly (instead of correctly) handle medical disputes (instead of accidents) and to prevent such medical disputes, with the second and third purposes remaining the same in substance and the removal of the fourth purpose—to promote development of medical science. It is not entirely clear whether medical disputes and medical accidents are analogous, distinct categories, or if one is the subset of the other.

From their stated purposes, the ambitions of the RHMA and the RPHHCD are not only to provide administrative-conducted arbitration for handling medical negligence disputes and granting compensation, but also to describe a wider comprehensive regulatory framework for healthcare quality assurance, reporting requirements, regulatory supervision and administrative disciplinary actions (Harris & Wu 2005). For our focus and for an aggrieved patient harmed by alleged medical negligence, the most practically useful components of the RHMA and the RPHHCD are their arbitration frameworks, theoretically capable of granting compensation to patients and hopefully alleviating their dissatisfaction towards any harm done to them. However, due to various issues discussed below, it is questionable whether the administrative regime is earnest in fairly and sufficiently compensating patients, or whether it is intended as a 'box-ticking' display that China has administrative-conducted recourse for medical negligence.

Scope and Threshold

RHMA arbitration has been characterized as light touch and highly protective of healthcare workers (Harris & Wu 2005; Xi & Yang 2011; Biddulph 2015). Article 2 gives the definition of ‘medical accidents’ but also provides a hurdle for aggrieved patients, where they must prove: first, ‘breach’—violation of legal requirements or regulations, or a breach of standards of care; and, second, ‘causation’—such violation or breach has caused personal injuries to the patient. Article 33 also exempts a wide range of adverse medical outcomes from being ‘medical accidents’, mostly to do with unforeseen or emergency situations.

In addition, Article 4 also heightens the threshold for eligibility, excluding injuries which are insufficiently serious. Article 4 classifies ‘medical accidents’ into four grades in accordance with personal injury seriousness. Even Grade IV, the least serious, requires the medical accident to have caused obvious/substantial/tangible injury.

Through the combination of Articles 2, 4 and 33, for the purpose of resolving medical negligence disputes through fault-based compensation, the RHMA’s arbitration framework has a narrow scope and a high threshold.

In comparison, the RPHHCD at Article 2 is also used to provide definitions, here for ‘medical disputes’, to mean disputes between healthcare workers and patients caused by diagnosis and treatment activities. The RPHHCD therefore has a lower threshold as compared to the RHMA, since there is no requirement to prove causation or breach (unlike the RHMA at Article 2). The classification methods under the RHMA at Article 4 and the exemptions in Article 33 also appear to have been removed in the RPHHCD, shifting the identification of damage and fault onto the arbitration process, as seen from the RPHHCD at Articles 34 and 36.

It also appears that the RPHHCD is wider in scope as compared to the RHMA, since the definition of ‘medical disputes’ appears to cover situations of ‘medical accidents’ as well. However, there is uncertainty of applicability as between the RHMA and the RPHHCD when a situation qualifies as both a ‘medical dispute’ and a ‘medical accident’. The RPHHCD at Article 55 perhaps sheds light on this issue, stating that ‘handling administrative investigations of diagnosis or treatment related medical accidents’ must be in accordance with the RHMA. However, the phrase ‘administrative investigation’ cannot be found in the RHMA, making it unclear which RHMA procedures are referred to by the RPHHCD at

Article 55 and therefore leaving unclear when the RHMA has exclusive jurisdiction.

Conflict of Interest

The RHMA's arbitration review process, determining whether a 'medical accident' occurred and its classification under Article 4, has been criticized as being overly protective of healthcare workers (Harris & Wu 2005; Xi & Yang 2011; Biddulph 2015). Under Articles 21, 23 and 24, the arbitration review process is conducted by an expert panel selected randomly from city-level medical association-established databases of experts. Under Article 21, the decision of city-level expert panels may be appealed only once, in which case a new panel will be selected from provincial-level expert databases. These panels have been widely perceived as lacking in independence, impartiality and fairness, since experts within databases are hand-picked by medical associations, and experts are essentially investigating and determining liability of colleagues and medical institutions within their local medical community, meaning decisions risk becoming tainted with extraneous conflicting considerations of personal reputational and relationship management (Harris & Wu 2005; Xi & Yang 2011; Biddulph 2015). Even though expert panels' determination and classification are not binding on courts, in practice courts will almost always defer to panel decisions (Xi & Yang 2011; Biddulph 2015). In effect, once a patient has chosen to pursue their claim through the RHMA, a panel with conflicting interests becomes the gatekeeper for whether they receive compensation in both the administrative and judicial regimes.

One key difference in RPHHCD arbitration as compared to the process under the RHMA is that expert databases are no longer established by medical associations. Instead, perhaps in an attempt to address the criticisms of the RHMA's expert databases' lack of independence, under the RPHHCD at Article 35, databases are now jointly established by the governmental health departments and the courts. However, the role of expert databases has been substantially reduced under the RPHHCD at Articles 34 and 41, since the starting point for arbitrations is to instead appoint medical associations or the courts, with no indication of who has the right to elect between medical associations and the courts. Only in situations where medical associations or the courts have no available personnel should arbitrating parties turn to the expert databases. Additionally, there are no appeal procedures against expert decisions under the RPHHCD. As such, in terms of patient protection in the selection of arbitration-conducting personnel, the RPHHCD addresses some of the problems in the RHMA, but at the same time itself creates problems.

Compensation

On top of the difficulty in initiating the RHMA's arbitration process and the bias in its review mechanisms, compensation amounts recovered under the RHMA at Articles 50 and 51 have been characterized as grossly inadequate, even given China's low living standards (Xi & Yang 2011; Biddulph 2015). On the other hand, the only mention of compensation in the RPHHCD, at Article 44, is one which states that the amount is to be determined in accordance with the law, without specifying which law is to be relied on. It is therefore unclear, under the RPHHCD, whether eligibility for compensation and the amount should be guided solely by the principles of fairness, justice and timeliness as mentioned in Article 4 without elaboration; or whether it should also refer to the RHMA at Articles 2, 4, 33, 50 and 51 or elsewhere.

Low compensation amounts have been justified by the rationale that most medical institutions in China are state-owned, and compensation should be kept low to prevent resources being diverted away from the improvement and stability of the state, which the CCP views as higher in priority than the vindication of individual rights (Xi & Yang 2011). However, this rationale is defeated by the fact that patients can in practice opt to claim through the court system, which provides generally higher amounts of compensation and is perceived as relatively fair and impartial, meaning that the low compensation amounts of the RHMA and the inadequate compensation provided for in the RPHHCD have in effect deterred arbitration and also encouraged forum-shopping (Biddulph 2015).

The Judicial Regime: Its Issues

In lieu of the administrative regime, aggrieved patients may seek from the court system compensation for damages caused under the Tort Liability Law 2010 (TLL) which operates within the General Principles of the Civil Law 1986. The basis of claims for medical treatment damages are set out within Chapter 7—Liability for Damages Caused by Medical Treatment—of the TLL, with specific issues clarified by the Supreme People's Court's 2017 Interpretations on Several Issues Concerning the Application of Law in the Trial of Cases of Medical Negligence Liabilities (hereafter, the Interpretations).

A More Patient-friendly Regime

The TLL has been characterized as more patient-friendly than administrative arbitration (Xi & Yang 2011; Biddulph 2015). The reversed burden of proof in Article 4(8) of the Several Regulations on Evidence in

Civil Proceedings 2002, which required defendant healthcare workers to prove that their treatment was not negligent nor causative of medical harm, has been done away with by the TLL, albeit with the onus of proving causation of loss or injury shifted back to claimant-patients. The TLL offers safeguards, putting claimant-patients in control of establishing their own case (Xi & Yang 2011; Biddulph 2015). Article 58 sets out situations where fault on the part of the medical institution is presumed. Thus, Article 58(2) presumes fault when the medical institution hides or refuses to provide medical records in connection with a dispute, in effect creating a duty of disclosure. Article 58(3) also presumes fault if the medical institution forges, falsifies, or destroys medical records, providing further safeguards towards claimant-patients' access to records critical to their claims. The Interpretations at Article 6 give further clarification by defining 'medical records'.

In comparison to the administrative regime, the court system in practice awards higher compensation amounts, with surveys showing that courts have awarded up to three times the amount of the administrative regime for patients in comparable situations (Xi & Yang 2011). Furthermore, the TLL provides a wide scope and definitive identification for types of damage eligible for compensation, including personal injuries, disabilities and death, along with expenses for all these damages, under Article 16, and damages for mental injury and distress, under Article 22. The Interpretations clarify that patients may submit evidence of damage or seek Article 9 appraisal of damages for claims in relation to: diagnosis and treatment; insufficiency of explanation and seeking of consent by healthcare workers; and drug defects—respectively under Articles 4, 5 and 8.

The Court's Role: Ambiguous, Confusing and Uncertain?

Despite its strengths, the TLL is not without its problems. Even though it has favourable compensation amounts and clearer headings of losses compared to the administrative regime, the TLL is uncertain in its principles and methods for calculating the compensation quantum (Xi & Yang 2011; Biddulph 2015). Moreover, since the TLL does not seek to replace administrative arbitration, on a literal reading of the two together, the role of the court becomes ambiguous, providing two different measures for assessing medical negligence harm and compensation without clarification on how to reconcile situations where there is overlap. There are varying court practices across different parts of China in relation to damage assessment, some courts choosing to rely on the TLL and pre-existing judicial rules, while other courts apply the provisions of the RHMA instead (Xi & Yang 2011; Biddulph 2015).

Possible clarification of the court's role in medical negligence disputes may be found in examining another issue in the court regime, namely its high litigation costs. Legal fees and evidence gathering are expensive for ordinary citizens, with lengthy trial processes and compensation award procedures (Biddulph 2015). Admittedly, this is an issue prevalent in numerous other jurisdictions as well. However, in recent years, the concern of elevated costs caused through delays has been somewhat exacerbated by China's push for mediation, where the courts have actively participated in encouraging mediation (Biddulph 2015; Guangzhou Intermediate People's Court 2019). Court officials, bound by oath to be subservient towards the CCP and its policies, are mandated to support the party-state's policy objective of social stability, under which mediation, a harmonious non-confrontational process, has been favoured. As a result, courts have been increasingly inclined to discourage litigation and may even delay filing claim applications, because a decrease in cases tried and appealed and more cases resolved through mediation are objective quantitative measures of their locality's peacefulness and harmony, which translates to positive indications of their performance and societal management prowess. As such, being consistent with social stability coming first over the right to health, the proper question to answer in assessing the judicial regime and the role of the courts is not whether the courts successfully protect the rights of aggrieved patients, but what their role is in protecting social stability, whether they are successful in this regard and only then examining if this incidentally protects patients.

Here, the courts are bound to steer their decision-making towards the best outcomes for suppressing the roots of instability and dissatisfaction. On the other hand, in fulfilling this obligation towards social stability, there seems to be no express prohibition of discretionary departure from protecting the rights of aggrieved or harmed patients. For example, the White Paper on Medical Disputes in Guangzhou Courts 2015-2017 (the White Paper) begins at Chapter 1(1) with the comment that 'the number of cases received has declined steadily, and the relationship between doctors and patients has developed relatively harmoniously and improved'. The quantitative measures examined first within the Chapter are the number of first instance trial and appeal cases, where a fluctuating number of trial cases per year² is described qualitatively as 'steadily declining' and the number of increased cases appealed³ is described as 'basically keeping

² Number of accepted trial cases by year (year, cases): (2012, 299); (2013, 353); (2014, 555); (2015, 342); (2016, 255); (2017, 298).

³ Number of appealed cases by year (year, cases): (2012, 46); (2013, 67); (2014, 99); (2015, 80), (2016, 82); (2017, 127).

steady'. These 'steadily decreasing' and 'basically keeping steady' case numbers are then conclusively equated with the improvement of doctor–patient relationships and the success of pre-trial mediation.

Chapter 2(1) goes on to state that 'the main practice of the Guangzhou court is to adapt to the situation and continue to improve the medical dispute mediation', setting out in the first paragraph the observation that:

The Guangzhou courts have made various efforts to improve and optimise the medical dispute mediation mechanism, to accurately grasp the basic laws of doctor–patient conflicts, to fully integrate various types of resources such as justice and administration, and to guiding patients to rationally safeguard their rights.

There are two points of interest in the White Paper. First, there is no mention of court litigation during discussion of the Guangzhou court's 'main practice'. The implication is that Chinese courts' role, at least for medical disputes, is not confined to administering justice objectively within courtrooms but is also inclined to pro-active dispute management in handling cases of medical negligence.

Secondly, guiding patients to safeguard their rights effectively is mentioned as one of the Guangzhou court's efforts in relation to medical dispute mediation, where mediation is part of Guangzhou court's main practice, but litigation is not. This seems to suggest that a patient choosing litigation, a contentious confrontational path, is seen to be irrational, while the CCP- and court-approved option to compromise and co-operate through mediation is rational. At the level of the individual, this suggestion is illogical, as there are situations where litigation is the more beneficial and hence the better choice, for example when wronged patients have favourable prospects of winning in litigation, and where courts may award full compensation, in contrast to receiving possibly lower amounts as a result of mediating, compromising and settling. The Guangzhou Court's statement can therefore likely be seen to mean that 'rational safeguarding of rights' includes the interests of the party-state, with mediation serving the greater good of delivering a harmonious resolution beneficial for social stability. The implication is that Chinese courts, through their perception of the utilitarian value of mediation, are endorsing an approach and societal framework where individuals should compromise their individual rights, in the interests of wider society—and in practice the courts may even actively encourage such compromise.

The courts' preference for mediation is reiterated in the RPHHCD at Article 6(2), where it states that the courts are responsible for guiding the mediation of medical disputes, raising question of whether this means

the courts should refrain from applying the TLL and instead solely rely on mediation to resolve the parties' differences.

In light of all this, aggrieved patients, even when well-informed that litigation is costly and lengthy but are still willing to pursue it, are faced with three uncertainties: first, they are uncertain whether courts will accept their claim application, since case numbers is one of the courts' important performance measures and from the judges' point of view is preferably kept low; second, knowing that courts prioritize the CCP's interests over individual rights, patients are uncertain whether courts will be aggressive or forceful in persuading them to settle through mediation, or whether they even have any real choice in the matter; and, third, they are uncertain what measures and rules courts will in practice apply in assessing damage.

Therefore, and overall, even though the court system is relatively patient-friendly compared to the administrative regime, the combined effect of the express role and implicit attitude of the court in steering patients towards mediation, together with the inherent uncertainties of the adjudicative process, means that, realistically speaking, under the current system, aggrieved patients stand the best chance of getting any sort of compensation through mediation. This is not necessarily because mediation will sufficiently protect their right to health, but because the alternative avenues of redress are less compatible with the party-state's policies and, hence, less viable for the aggrieved patient. So, while the courts have indeed successfully played their part in maintaining social stability, this has been at the cost of patients' prospects of securing their legal rights.

Medical Mediation Issues

As noted above, China's current preferred resolution process in medical negligence (and many other types of case) is mediation (Ministry of Justice & Ors 2010; Ding 2015; Fu & Palmer 2017). Unlike the administrative and court-based adjudicative remedy systems, mediation is not focused on fault-finding and assigning compensation. Instead, it is about patients and medical institutions negotiating, co-operating and then compromising to find a settlement. The CCP and the state strongly prefer mediation over arbitration and litigation, as they view mediation as non-confrontational and harmonious, thus in line with their ideals of social stability and a conflict-free community.

Operating under the People's Mediation Law 2010, mediation has been the most popular dispute resolution mechanism (Biddulph 2015).

Despite this, China's medical dispute mediation is still in its embryonic stages, where mediation models have been separately developed and implemented by individual provincial and municipal governments, with noticeable variations (Ding 2015; Fu & Palmer 2017). Depending on patient locality, the mediatory system and approach may vary.

The People's Mediation Law 2010 and mediation models across regions are uncertain because they do not stipulate clear step-by-step procedures (Ding 2015; Fu & Palmer 2017). For example, for the model operating under the Shanghai Hospital Patient Disputes Prevention and Mediation Measures 2014, mediation applications may be refused on the ground that 'the case is otherwise considered unsuitable', without elaboration on what constitutes 'unsuitable', giving a possibly free-standing power for rejecting applications.

Patients also mistrust the mediation process's fairness, feeling that the regime facilitates hospitals' goal of minimizing compensation during negotiations, as ultimately the regime and hospital are both state-owned (Biddulph 2015). If settlement is overly aggressively encouraged, it becomes *de facto* imposition of the CCP's socialist policies on individuals, since settling requires a certain degree of abrogation of an individual's rights to health and access to justice, for the sake of the greater common good of social stability. In fact, China's settlement and mediation success rate does indicate signs of over-encouragement for settlement, being unnaturally high when benchmarked against international standards of 70-80 per cent success rate (Hong Kong Mediation Centre 2015; Cheng 2019; International Dispute Resolution and Risk Management Institute 2019; United Kingdom Centre for Effective Dispute Resolution 2019).⁴ In comparison, China had an 88 per cent success rate for medical mediation from 2010 to 2013. Looking at three cities specifically, Shenzhen, the most modest, had an 80 per cent success rate from 2010 to 2013; followed by Shanghai at 82 per cent from 2011 to 2013; and Ningbo with 91 per cent for centres, and 93 per cent for committees from 2008 to 2013 (Wang 2014; Wenhuibao 2014; Wu 2014; Xinhua Net 2014; Ding 2015; Fu & Palmer 2017).

Although it is possible that China has a magical formula for mediation, making it a significantly more successful process than it is in other

⁴ Teresa Cheng, Hong Kong's Secretary for Justice, expressed the view that the 'result is encouraging' for the 62% success-rate of the West Kowloon Mediation Centre. The Hong Kong Mediation Centre, and the International Dispute Resolution and Risk Management Institute both suggest that international success rates for mediation can be as high as 70-80%. In the United Kingdom, the Centre for Effective Dispute Resolution claims a success-rate of 80%.

countries, there seems to be nothing unique about its mediation framework that might justify such a possibility. The most plausible explanation seems to be that success rates have been artificially driven up. Particularly eye-catching is that in 15 per cent of cases within the 82 per cent success rate of Shanghai the parties settled without the aggrieved patient receiving *any* compensation, begging the question of what exactly motivated those patients when they decided to settle. The observation here is that China's civil mediation situation may be similar to its very high 99.9 per cent criminal conviction rate, which has been criticized as 'a deeply flawed' justice system without procedural fairness (Connor 2016; Huang 2016). Arguably, driving up the success rate is more detrimental to mediation than it is to the criminal justice system, as mediation has emphasized harmony and reconciliation through better communication between disputing parties. Overemphasis on success rates and results-based measurements puts form over substance and defeats the instrumental value and major benefits of mediation in achieving substantive social stability.

[D] THE BIGGER PICTURE: REACTIVE MEASURES

Administrative and Criminal Sanctions

Apart from compensation liability, two other major outcomes in medical negligence disputes are criminal penalties and administrative disciplinary sanctions. Key rules regarding criminal measures include the Special Action Plan on Severely Cracking Down on Medical Crimes (National Health and Family Planning Commission (NHFPC) & Ors 2016); the Supreme People's Court's 2014 Opinions on Punishing Crimes Involving Medical Disputes and the Maintenance of Order in Medical Institutions; the Special Action Plan on Maintaining the Order of Health Care Practice and Penalizing Violation and Crime Targeting Doctors (NHFPC & Ors 2013); the Notice on Maintaining the Order in Health Care Institutions (Ministry of Health & Ministry of Public Security 2012); and the Notice on Further Strengthening the Administrative Work for Hospital Safety (National Health Commission 2009). The common denominator in these rules is that they are aimed at protecting medical institutions and workers by focusing on what is seen officially as the deviant conduct of patients, reiterating the possible criminal sanctions under the Criminal Law 1997 and the Security Administrative Punishment Law 2005. However, while there is a focus on punitive deterrence towards patients, these rules are silent regarding negligent healthcare workers' accountability. Criminal sanctioning of healthcare workers seems to be only available for extremely

serious cases, with a maximum three-years' imprisonment for the high threshold of gross negligence causative of death or severe harm under Criminal Law 1997, Article 335 (Harris & Wu 2005).

Outside of criminal punishment, Chinese hospitals' management cannot discipline or terminate individual healthcare workers for misconduct, as this is instead a power entirely vested in the light-touch administrative regime (Harris & Wu 2005; Xi & Yang 2011). Under the RHMA at Article 53, in the event of a breach of administrative laws where the consequence is not serious enough for criminal punishment, healthcare workers face sanctions such as demotion or lawful dismissal. The RPHHCD perhaps has the intention to give greater accountability to healthcare workers, introducing the concept of prevention in its purposes under Article 1, with Chapter 2 devoted to 'Medical Dispute Prevention'. The RPHHCD at Chapter 2 stipulates responsibilities for institutions and workers, such as abiding by medical and health laws and professional ethics, provision of training and management, proper communication regarding disclosure and management of risks, protection of medical records, and dispute resolution. The RPHHCD at Chapter 4 stipulates that the possible tangible consequences for breach of specific expressly mentioned conduct may be fines ranging from RMB10,000 to RMB100,000 together with the confiscation of illegal profits, suspension of practice for one to six months, or licence revocation. However, Chapter 4 does not make clear how the expressly mentioned conducts correspond to Chapter 2 responsibilities, or how the disciplinary sanctions of suspension and licence revocation are to be exercised.

The principles under which discretion is exercised in the imposition of disciplinary sanctions are largely unavailable for public perusal. However, reference can be taken from one publicly available draft for consultation, the Accumulated Scoring Method for Medical Institutions and Physicians in Shenzhen (Consultation Draft) 2019 (Shenzhen City Health Committee 2019). Under this draft, doctors are given 12 penalty points when a medical institution is held to be responsible in full due to the doctor's medical negligence; six points when the institution is primarily responsible because of the doctor's conduct; four points for secondary responsibility; and two points for minor responsibility. Scoring is to be reset every calendar year, and when doctors in any given year accumulate 12, 18 or 24 points they are to be issued a warning, suspended for three months, or deregistered, respectively. If a doctor is held to be fully liable for the negligent death of only one patient, they will merely receive a warning letter. For such a doctor to be deregistered, they must be fully liable in negligence for the death of two patients in a single calendar year. If this draft consultation

is representative of the administrative disciplinary framework, then it seems the disciplinary regime is extremely light touch.

All Reactive Measures?

Viewing the system's entire suite of measures in the round, the two main forms of outcome are, first, monetary compensation for which medical institutions are vicariously liable and, second, criminal, or administrative sanctions imposed on patients. In addition, disciplinary and criminal sanctions for individual medical workers are exercised only in rare circumstances (Xi & Yang 2011; Ding 2014).

Even if we assume that all the issues discussed above are somehow resolved without compromises supportive of maintenance of social stability, the direction which the current system has taken will tend to be inefficient. The current system does not effectively deliver prevention of medical negligence, since monetary liability is vicariously borne by medical institutions, and, although they are motivated to prevent negligence in hopes of reducing liability, they lack the disciplinary powers by which to hold individual medical workers accountable for misconduct. Likewise, the light-touch administrative disciplinary framework does little to deter medical workers from negligent conduct, with a lack of motivation to minimize their own negligence.

[E] A SUGGESTION FOR REGULATING IN CONGRUENCE WITH POLICY OBJECTIVES: GREATER NON-COMPENSATION-BASED ACCOUNTABILITY FOR HEALTHCARE WORKERS

It is appreciated that there have been monumental improvements to China's healthcare provisions, with vast resources invested into medical research, increasing quality and calibre of doctors, and the expansion of the healthcare network infrastructures. Nonetheless, regarding preventative measures, improvements in administrative regulations and supervision of healthcare culture is overdue. The benefit in regulating healthcare culture is that, even when rules are not fully stated and spelled out, workers will still take responsibility for applying them in a way that makes sense and take the initiative in patient care (Zaring 2017). The broad-brush method of regulating healthcare culture is simple: to have pull-factors incentivizing behaviour consistent with patient care and, at the same time, have push-factors deterring and penalizing misconduct.

In the context of global financial risk-culture regulation, it has been suggested that this culture may be driven by disincentivizing misconduct through greater tangible personal accountability, complemented with tangible incentives for compliance (Zaring 2017). The same suggestion can be made for China in developing healthcare culture regulation: imposing meaningful consequences for individual medical healthcare workers when they are negligent while, at the same time, having tangible incentives such as discounted professional licensing fees, or altering the structure of remuneration-based incentives to award compliance with healthcare culture instead of profit-linked performance measures.

In exploring possible meaningful consequences, it is likely that monetary accountability tied to patient compensation is sub-optimal, as this has the undesirable effect of patients being unable to fully recover awarded compensation if the individual liable cannot afford it. The straightforward suggestion here is to create a stricter, standardized set of administrative disciplinary rules which are prescribed by law, transparent and available to the public, eliminating the discretion of local administrators in exercising disciplinary sanctions, with lower-threshold meaningful consequences through longer suspensions and deregistration.

[F] CONCLUSION

China's healthcare system has progressed far, at a very rapid rate. However, medical negligence and disputes are still perceived as threats to social stability, with China focused on optimizing the effectiveness of dispute resolution regimes as reactive measures. It is suggested that, as compared to reactive measures, preventative measures are more congruent with efficient safeguarding of social stability and may be implemented by regulating healthcare culture through imposition of greater non-compensation-based accountability for individual healthcare workers. China can take a leaf from the metaphorical book of Han dynasty idioms, and to 'mend the fence after the sheep are lost'. It is important to remember that overemphasis on damage control and suppressing dissent is not effective in the long run, and that stability may be better achieved by addressing, in the first place, the root causes of dissent.

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