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## ABBREVIATIONS

CHI	Compulsory health insurance
CL	Criminal law
GP	General practitioner
GPs	General practitioners
HC	Healthcare
HI	Health insurance
HIF/HIFs	Health insurance fund/Health insurance funds
HRA	Human Right Act
LCP	Law on Consumer Protection
LMET	Law on Medical Examination and Treatment
MM	Medical malpractice
MMLI	Medical malpractice liability insurance
MoH	Ministry of Health
NHS	National Health Service
PCTs	Primary care trusts
PHI	Private health insurance
PLI	Professional liability insurance
PMI	Private medical insurance
SHI	Social health insurance
SS	Social security
UHC	Universal health coverage

# CHAPTER 1: INTRODUCTION

## 1. Background

1. The world knows Vietnam because of:
  - the wins in the wars fought against the powerful countries such as China (1979)<sup>1</sup>, France (1946-1954),<sup>2</sup> and the United States (1955-1975);<sup>3</sup>
  - the abundance of rice, seafood, fruit, and minerals and
  - the beautiful landscapes of the country.
2. Nevertheless, these things may not be enough to build a safe and prosperous country. It needs more contributions such as a proper education system, a reliable transport system, an easily accessible health system, a reliable legal system, etc.
3. People will get distressed whenever they open a magazine and get bombarded with bad news about the appalling state of the medical sector in Vietnam. Many people have fallen victim to professional malpractice in Vietnam. For example, a doctor once amputated the healthy leg of a patient instead of the disease-stricken one<sup>3</sup>; another doctor removed the healthy kidney instead of the weak one.<sup>4</sup> Expectant mothers have died because of delays in administering the necessary emergency aid,<sup>5</sup> children have

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<sup>1</sup>Ho, T.N., *Vietnam Fought against Chinese Aggression throughout History*, Kim Dung, 2017;

<https://kimdunghn.wordpress.com/2017/02/18/viet-nam-da-phai-chong-trung-quoc-xam-luoc-trong-suot-chieu-dai-lich-su/>

<sup>2</sup>Vu, N.H., *The First Invasion of French Colonialism in Vietnam*, Dien Bien Phu Museum;

<http://btctlsdienbienphu.svhttd Dienbien.gov.vn/Article/320/Cuoc-chien-tranh-xam-luoc-Viet-Nam-lan-thu-nhat-cua-Thuc-dan-Phap.html>

<sup>3</sup>Hoang Nguyen, *Vietnam War Seen by the US*, Viet Bao, 2006;

<http://vietbao.vn/The-gioi/Chien-tranh-Viet-Nam-nhin-tu-phia-My/40076626/159/>

<sup>4</sup>Chi Quoc, *Wrongly Kidney Operation, Hospital Compensates Lifetime for Patient*, Tuoi Tre, 2017;

<http://tuoitre.vn/tin/phap-luat/20170629/cat-nham-than-benh-vien-boi-thuong-suot-doi-cho-benh-nhan/1340662.html>

<sup>5</sup>T. Luy, *The Hospital Caused Deaths of Mother and Child was Sued*, Soha, 2016;

died after being injected with wrong vaccines,<sup>6</sup> patients have died because of negligence during the installation and testing of kidney dialysis machines,<sup>7</sup> etc.

4. Concurrently, there is a series of problems that occur, such as low access to health care services and health insurance, lack of medical facilities, low skilled and insufficient medical resources, and corruption in the health sector. Although the Vietnamese government has tried to find and deploy the relevant solutions, all these problems have continued to bedevil the healthcare sector in the country.
5. Mainly, lack of or ineffectiveness of the current medical legal provisions makes Vietnam a poorly regulated country in the health sector. Evidently, in the meantime, although the health sector is a core sector in the country, there is the existence of the laws which are not incoherent or insufficient. They are Law on Insurance Business (2000), Law on Medical Examination and Treatment (2009), Law on Administrative Sanctions (2012), Civil Code (2015), Criminal Code (2015), etc. Most laws only regulate general derogation but not in medical malpractice (MM). Even if the law relates to medical MM such as the Law on Medical Examination and Treatment, it is not sufficient to adjust MM when combined with other Laws. Therefore, if MM occurs, it will be solved as a general fault.
6. The Laws mentioned above do not specialise in the regulations concerning to MM. For instance, Civil Law does not define what a duty of care is; breach of a duty of care (standard of care); causation (loss of chance) in MM as done in the other countries (Belgium, France, and England), etc. A question is put forward: Will the judgment of MM be impartial and accurate if the cases of MM are solved under the general laws?

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<http://soha.vn/gia-dinh-to-benh-vien-tac-trach-lam-chet-ca-me-va-2-con-20160912204507444rf20160912204507444.htm>

<sup>6</sup>Quoc Nam, *Five 5 Years in Prison for the Nurse Caused Three Children's Deaths due to Mistaken Vaccination*, Tuoi Tre, 2015;

<http://tuoitre.vn/tin/phap-luat/20150327/xet-xu-bon-bi-cao-vu-ba-tre-tu-vong-sau-tiem-vaxin/726095.html>

<sup>7</sup>*Eight People Died of Dialysis: Chemicals Uncleansed*, VietnamNet, 2017;

<http://vietnamnet.vn/vn/thoi-su/vu-8-benh-nhan-chay-than-tu-vong-quen-rua-hoa-chat-trong-duong-nuoc-380065.html>

The Civil Code clarifies tort into two kinds: intentional tort and unintentional tort (negligent tort) but not strict liability tort. The Civil Code does not define what negligent tort is. As a result, the whole regulations of unintentional tort are applied in negligent tort (in fact there are some differences between unintentional tort and negligent tort). This point brings challenges in the judicial process.

7. Concomitantly, insurance law is rather flat. The Law on Insurance Business only focuses on establishing insurance companies and providing insurance products. Attached to this Law, the Government enacted the Decree concerned with Medical Liability Insurance. However, it has not yet played its role adequately. The Decree states that all physicians must have Medical Liability Insurance by latest 31st December 2017.<sup>8</sup> However, it seems that cannot be carried because only 20% of hospitals have purchased medical malpractice liability insurance (MMLI). There are many reasons for the hospitals and physicians to purchase MMLI. Mostly, those reasons stem from high insurance premiums, inadequate insurance policy, and insecure medical insurance law.<sup>9</sup>
8. Also, compensation schemes have not adequately compensated for mental and physical damage to patients. Remarkably, the law of Vietnam admits fault compensation in MM. However, proving fault in MM in Vietnam is a problem. Moreover, not much attention is paid to compensation without proving fault. Therefore, many victims fall into the situation of not being compensated satisfactorily.
9. Another problem is that patients' rights protection has still been a challenge, notably in Mekong Delta of Vietnam. Hence, the author surveyed to find out the status of patients' rights protection. The results of the survey will form a foundation for suggesting solutions to improve patients' rights not only in the Mekong Delta but also in the country.

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<sup>8</sup> V. Thu, *Quick Survey: 20% of Hospitals Purchased Insurance for Medical Treatment*, Giadinh.Net.Vn, 2017;

<http://giadinh.net.vn/y-te/khao-sat-nhanh-20-benh-vien-mua-bao-hiem-trach-nhiem-trong-kham-chua-benh-20171103220445602.htm>

<sup>9</sup> Kim Lan, *The Hospitals are "Ambiguous" about Liability Insurance*, Dautuchungkhoang, 2015;

<http://tinnhanhchungkhoan.vn/bao-hiem/benh-vien-van-mo-ho-ve-bao-hiem-trach-nhiem-133958.html>

10. In other words, the crisis of MM has become a catastrophe. That pressure pushed the researcher to look for answers on how to solve the stated problems from a legal perspective. The researcher believes that a well-constructed legal system is one of the most powerful instruments to stabilise society. At the very least, it is a guiding tool for healthcare professionals as they practice as well as a tool for preserving the rights/interests of patients.
11. As a citizen and also a researcher in Vietnamese law, the researcher did ask herself what she could do to contribute to the country. Initially, the researcher spent two years in Belgium for a master's degree and wrote a thesis that dealt with MM liability.<sup>10</sup> The researcher was determined to go back to Belgium by applying for and eventually being granted a P.h.D. Scholarship by the Vietnamese Government. The researcher undertook a comparative study of ***“Vietnamese medical malpractice law in comparison with medical malpractice laws in Belgium, France, and England.”***
12. MM emanates from an injury or an adverse outcome to a patient occurring during medical care. Patients and families suffer from emotional and financial burdens as a result of the adverse outcomes or injuries and seek compensation for their economic loss, medical costs, pain, and suffering. However, not all injuries result from malpractice or substandard care. MM may arise from medical injuries, some of which involve physician or hospital negligence or medical errors and some result from the nature of care (e.g., a complication of treatment procedures, new and complex medical technologies, and lack of adequate equipment). As a result, not all injuries meet the conditions to receive compensation.<sup>11</sup> MM is a type of professional negligence and, as

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<sup>10</sup> The subject of my thesis was: *“Wrongful Birth and Wrongful Life Action: Analysis and Comparison”*, 2009.

<sup>11</sup> Health, Nutrition and Population (HNP), *Medical Malpractice Systems around the Globe: Examples from the US- tort Liability System and the Sweden- no Fault System Document of the World Bank*, (1989), p.4;

[Siteresources.worldbank.org/.../Resources/Malpractice\\_Systems\\_eng.pdf](http://Siteresources.worldbank.org/.../Resources/Malpractice_Systems_eng.pdf)

such, forms part of the law of tort.<sup>12</sup> Medical liability is at present mainly a national affair.<sup>13</sup>

13. To have a comprehensive overview, a MM system may involve three core majors such as medical care, tort laws, and liability insurance.<sup>14</sup>
14. MM can occur in any and every healthcare facility by any medical personnel, including interns, surgeons, nurses, and support staff.<sup>15</sup> Professional liability insurance indemnifies physicians and hospitals as well as provides compensation to the injured patients. In consideration of an insurance premium, an insurer will protect a physician against claims of malpractice and provide legal defence, investigation, and indemnification to the extent of the policy, against any recovery made.<sup>16</sup>
15. In this time, the patients' rights highly draw the social attention. Therefore, the need to reaffirm the rights to improve the protection of the patients is necessary. In particular, Vietnam needs to look at the shortcomings of protecting the rights of patients by comparing with the legitimate interests that patients in the world are enjoying.
16. Also, the primary intention of such proceedings is to compensate a patient for the material and/or non-material damage sustained as a result of MM. In most countries, the liability of health professionals is based on general rules of contract or tort law, but some special rules exist.<sup>17</sup>
17. The author's selection of the countries of Belgium, France, and England for research in MM laws springs from objective and subjective reasons. Objectively, firstly, Belgium,

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<sup>12</sup> Deakin, S., Johnston, A. and Markesinis, B., *Tort Law*, Clarendon Press - Oxford, 2003, p.261.

<sup>13</sup> Hondius, E., *Comparative Medical Liability in Europe*, 2001, p.187;

[https://dspace.library.uu.nl/bitstream/handle/.../hondius\\_01\\_comparative\\_medical.PDF](https://dspace.library.uu.nl/bitstream/handle/.../hondius_01_comparative_medical.PDF)

<sup>14</sup> Sage, W., *The Forgotten Third: Liability Insurance and The Medical*, Health Affairs, 2004, p. 10.

<sup>15</sup> Leenen, H., Gevers, S., and Pinet, G., *The Rights of Patients in Europe*, Kluwer, 1993, p. vi

<sup>16</sup> Oster, B., *Medical Malpractice Insurance*, Insurance Counsel Journal, 1978, p.288.

<sup>17</sup> Nutt, A., *Negative Effects of Medical Malpractice*, Ezines Articles, 2009;  
<http://ezinearticles.com/?Negative-Effects-of-MedicalMalpractice&id=2317877>.

France, and England are the countries that have a long history of MM under civil law and common law from which Vietnam may learn from the similarities and differences. Based on the research's results, the author would have recommendations to apply in Vietnam's MM law. Secondly, for Belgium and France, although Vietnam got independence from the French invasion (1858-1954), the Vietnamese's Civil Code has still been influenced by French Civil Law. Besides that, Belgium has a civil law that is similar to French civil law, but it has introduced some differences such as the health system, no-fault system, and liability insurance, etc. With this in mind, the author would like to point out the similarities and differences between the laws of the two countries. On the other hand, England applies the common law which is different from Vietnam. Nevertheless, there are several benefits of common law which Vietnam can learn when reforming the judicial system.<sup>18</sup> Subjectively, it is to discover new, advanced and applicable MM laws in Belgium, France, England, and Vietnam

## **2. Sources and methods**

18. The sources of the thesis include legislation, cases, and legal literature as well as published research including books, articles, and reports. In addition, the official news is a source of the thesis material.
19. The research will focus on analysing and comparing MM laws in Belgium, France, England, and Vietnam. The primary focus of the work is not to compare the laws among Belgium, France, and England themselves but between Vietnam and the three countries. From this method, the research aims to show the similarities and differences among the said legal systems.
20. In Chapter 6, the researcher did an oral survey about patients' rights protection in four selected provinces in the Mekong Delta in Vietnam. By analysing the results, the research concludes the status of patients' rights protection in the provinces.

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<sup>18</sup> Hanh Thien, *Applying Case law: A Positive Progress in Judicial Reform*, Thu Vien Phap Luat, 2016;

<https://thuvienphapluat.vn/tintuc/vn/an-le/14476/ap-dung-an-le-buoc-tien-tich-cuc-trong-cai-cach-tu-phap>.

### **3. Research questions**

21. The thesis focuses on research on the legal systems related to health care systems, MM laws, compensation systems, liability insurance, and patients' rights of the four countries Belgium, France, England, and Vietnam. The author mainly does comparison and analysis of the similarities and differences between the laws of Belgium, France, England, and Vietnam. By this work, the author intends to answer the following research questions:
1. What are the gaps in MM law in Vietnam?
  2. Which necessary MM provisions of Belgium, France, and England should Vietnam adopt?
  3. Which other MM provisions and other related factors that Vietnam should change, supplement, and modify to fit Vietnam' context?
22. At all, if the framework is applicable, the author hopes to derive tangible benefits for patients and their families, for physicians and healthcare institutions, and jurists in Vietnam. Shortly, firstly, patients can access health services more freely and fairly if health services and health care insurance are reformed. They will enjoy their patients' rights if current rights are respected more, and they are granted additional rights. Secondly, improving MM law will help the patients as well as health professionals to have a strong legal base to ensure their benefits. The patients can seek compensation equal to what they suffer in both fault and no-fault systems. The health professionals feel secure to work once they comply with the obligations. Also, the jurists will have a strong legal foundation to give their conclusions in the courts. Lastly, the face of the country then will thrive because the comprehensive change and reform is not merely in MM law but also in other relevant areas such as health education, health services, liability insurance, and patients' rights.

### **4. Organisation**

23. The structure of the thesis includes seven chapters. Chapter 1 is the introduction which introduces the background, sources and methods, research questions and structure. Chapter 2 is about the health systems. This one compares health services, health

financing, payment mechanism and health insurance between Belgium, France, England, and Vietnam. Chapter 3 is the essential one in which MM laws of the four countries are analyzed and compared. As confirmed, MM law is professional negligence under the framework of the tort of negligence. This chapter discusses the elements to establish an MM case and forms of MM. A very important part of this chapter is the analysis and comparison among MM laws of Belgium, France, England, and Vietnam. The no-fault system, administrative liability (in Vietnam) and criminal liability are also presented. Chapter 4 talks about medical liability insurance under which the insured (physicians) can shift the economic burden from the third party (patients) to insurers. In this chapter, the elements of a liability insurance contract are described and compared. The insurable interest, the insured risk, the insured premium, the indemnification, the third party, the kinds of MM liability insurance, and MM liability insurance market will be introduced. Chapter 5 will discuss a no-fault system as an alternative to fulfil the shortcomings of the tort system. Chapter 6 focuses on patients' rights protection in the four provinces in the Mekong Delta of Vietnam. The survey was done to determine whether the patients' rights in these provinces are well-protected. Chapter 7 is to answer the statement of purpose of the thesis. The chapter is the author's recommendations for the framework of reforming MM law in Vietnam after analysing the MM laws of Belgium, France, and England.

## CHAPTER 2: HEALTH SYSTEMS

### 1. Introduction

1. It can be said that the high and sustainable development of the health system is considered as a measurement of the level of development of that country. The Government of the country seeks innovative ways of harnessing and focusing the energies of communities, non-governmental organisations, and the private sector.<sup>19</sup> Explaining for that trial is that the health system plays an important role and dominates other areas in every country.
2. There are several ways to understand the meaning of health. According to WHO and UNICEF, health is described as a complete physical, mental and social well-being and not merely the absence of disease and infirmity. It is a fundamental human right which is widely recognised.<sup>20</sup>
3. A “system” can be understood as an arrangement of parts and their interconnections that come together for a purpose.<sup>21</sup> Generally, a health system consists of all organisations, people, and actions whose primary intent is to promote, restore or maintain health. The system includes efforts to influence the determinants of health as well as more direct health-improving activities. A health system is, therefore, more than the pyramid of publicly owned facilities that deliver personal health services. It includes private providers, behaviour change programmes, vector-control campaigns, health insurance organisations, occupational health, and safety legislation. It includes inter-sectoral action by health staff as well-known determinants of better health.<sup>22</sup>

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<sup>19</sup> Every Body’s Business, *Strengthening Health Systems to Improve Health Outcomes: Who’s Framework for Action?*”, World Health Organization, 2007, p. 1;

[www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

<sup>20</sup> WHO & UNICEF, *Declaration of Alma Ata*, 1978.

<sup>21</sup> *What is Health System?* 2007, The World Bank Strategy for HNP Results;  
[documents.worldbank.org](http://documents.worldbank.org)

<sup>22</sup> Every Body’s Business, *Strengthening Health Systems to Improve Health Outcomes: Who’s Framework for Action?*”, World Health Organization, 2007, p. 2.

4. A health system, mainly, health insurance as part of the health system in a country has an active link to understanding MM law. For example, by having health insurance, patients access to the health care to obtain benefits from the nation's health care system. Also, patients can be aware of the healthcare standards, patients' rights (free choice of doctors, private or public hospitals, and access to primary care or secondary care. Additionally, they know more about the existing relationships between patients and health providers whether contractual or other kinds. All the above examples may be a part of the regulations of the health care services based on which patients can institute MM claims if they are infringed upon.
5. Similarly, the health systems in Belgium, France, England, and Vietnam also have common factors in the health system and MM law.

## **2. Belgium**

### **2.1. General overview**

6. The Belgian Constitution admits the right to social security, protection of health, and medical assistance under Article 23 (2). The provision of healthcare appears in different ways.<sup>23</sup> The Economic and Social Rights distinguishes between social security (SS), health care (HC) and social aid was based on the International Covenant on Economic and Social Rights. The which distinguishes between the right to SS (Article 9), the right to an adequate standard of living and the right to the best possible physical and mental health (Articles 11 and 12).<sup>24</sup>
7. Belgium's healthcare system is funded through the state sickness fund. Belgium operates the healthcare system by four tiers. They consist of central government, national associations, federations of local societies, and local mutual aid societies. It is

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[www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf)

<sup>23</sup> Funck, F., *Droit de la sécurité sociale (Social Security Code)*, De Boek and Larcier, 2006, p. 241;

Langendonck, J., Stevens, Y., and Van Regenmortel, A., *Handboek socialezekerheidsrecht (Social Security Handbook)*, Intersentia, 2015, p.331.

<sup>24</sup> ILO Global Study, *The Right to Social Security in the Constitutions of the World: Broadening the Moral and Legal Space for Social Justice*, International Labour Organization, Vol. 1, 2016, p.11

said that this power-sharing motivates each local fund to work hard to attract and satisfy its members.<sup>25</sup>

8. Although all levels keep their important roles, the federal level plays more responsibilities. For example, responsible for SS, CHI, pharmaceutical policy, and hospital legislation. The Belgian HC participates in several stakeholders in the management of the system. Besides, the federal and federated governments keep an important part of the health system regulated by the national collective agreements between representatives of HC providers and sickness funds.<sup>26</sup>
9. HC is provided by the public health services, independent ambulatory care professionals, independent pharmacists, hospitals and specific facilities for the elderly form the HC. Either private non-profit-making or public hospitals provide hospital care. Most medical specialists work independently in hospitals or private practices on an ambulatory basis. General practitioners (GPs) provide ambulatory or primary care. Dentists and pharmacists also generally work independently.<sup>27</sup>
10. Belgium does not allocate an overall budget to HC. However, there is a fixed annual budget for the CHI system and sectoral target budgets within it. Budget allocation takes place at federal and regional levels. The government controls the allocation of the financial budget for capital investments in the HC sector and health insurance. The federal gives subsidies to regions and their communities and this constitutes their main source of income as their ability to raise taxes is insufficient.<sup>28</sup>

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<sup>25</sup> *Healthcare in Belgium*;

<http://www.europe-cities.com/destinations/belgium/health/>

<sup>26</sup> Sophie Gerkens and S. Merkur, *The Health Systems and Policy Monitor: Belgium*, World Organization, 2010, p.2.

<sup>27</sup> Gerkens, S. and Farfan, M., M-I., *The Belgian Health System in 2010*, Belgian Health Care Knowledge Centre, 2010, p. 15.

<sup>28</sup> *European Observatory on Health Care Systems*;

<http://www.lse.ac.uk/LSEHealthAndSocialCare/aboutUs/europeanObservatory/home.aspx>

11. Finance is categorised into different sections. (1) Hospital services, whether private or public, are directly financed by the sickness funds. Payment of services is based on a draft budget, which is calculated by bed capacity, the activity of the previous year, and hospital-specific features. Services of the nursing staff and doctors are paid via a combination of per-diem rates and fee-for-service. The state finances the majority of capitals costs. Co-payment for inpatients care is tiered according to the length of stay. (2) Private practitioners mainly provide ambulatory care. They are paid directly by patients, who are then reimbursed for most of the cost of their sickness funds. The patients bear the rest (25-40%).<sup>29</sup> (3) Pharmaceuticals are reimbursed according to a positive list. Prices are fixed. On average, 29% of the price is paid by the patients. (4) Dental services payments are made by the patients, who then claim reimbursement. Patients' co-payment amount to 25% on average.<sup>30</sup>
12. The fee-for-service payment is mainly characterised as a mechanism. There are two systems of payments. Firstly, the patients can pay directly. By this way, the patient pays for the full cost of the service, and then they will obtain a refund from the sickness fund as part of the expense. Secondly, the payment will be carried by a third-party payer system. By this way, the sickness fund pays the provider directly, and the patient is only responsible for paying any co-payments, supplements or non-reimbursed services. Reimbursement depends on the type of service provided as well as the patient's status.<sup>31</sup>

## 2.2. *Health insurance*

13. The health insurance in Belgium is based on the principles of equal access and freedom of choice, with a *Bismarckian-type*<sup>32</sup> of compulsory national health insurance. This

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<sup>29</sup> Funck, F., *Droit de la sécurité sociale (Social Security Code)*, De Boek and Larcier, 2006, p. 263;

Langendonck, J., Stevens, Y., and Van Regenmortel, A., *Handboek socialezekerheidsrecht (Social Security Handbook)*, Intersentia, 2015, p.390.

<sup>30</sup> European Parliament: Directorate General for Research Working Paper, *Health Care Systems in EU: A Comparative Study*, Public Health and Consumer protection Series, SACO 101 EN, 1998, p.37;

<http://www.europarl.europa.eu>

<sup>31</sup> Gerkens, S. and Farfan, M., M-I., *The Belgian Health System in 2010*, Belgian Health Care Knowledge Centre, 2010, p.75.

<sup>32</sup> Summary of International Health Systems, Compiled by PNHP California, 2011.

system brings a comprehensive benefits package that covers almost the entire population.<sup>33</sup> Health insurance (HI) is one of the six sectors of the SS system. The six sectors include old age and survivor's pensions, unemployment, insurance for accidents at work, work-related health and occupational diseases, family allowances, health, and disability insurance.<sup>34</sup>

14. There are two main goals of Belgium's HI. Those include the protection to the health of citizens by reimbursing health care costs and the replacement income for those unable to work due to sickness or disability.<sup>35</sup> The mutual insurance funds are responsible for both kinds of benefits. These funds are ideologically oriented corporations recognised by the State. They also offer social services to their members, apart from HI.<sup>36</sup>
15. To benefit from the HC system in Belgium, residents have to join *a health insurance fund (HIF) (mutuelle/ziekenfonds)*<sup>37</sup>.<sup>38</sup> In Belgium, both the country and the regions are

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This model uses an insurance system; the insurers are called "sick funds", usually financed jointly by employers and employees through payroll deduction. Bismarck-type health insurance plans have to cover everybody, and they do not make profit. Doctors and hospitals tend to be private. Tight regulation gives government much of the cost control clout that the Beveridge model provides;

<http://pnhpcalifornia.org/>

<sup>33</sup> Corens, D., *Belgium Health System Review. Health Systems in Transition*, European Observatory on Health System and Policies, 2007, p.9.

<sup>34</sup> Gerkens, S. and Farfan, M., M-I., *The Belgian Health System in 2010*, Belgian Health Care Knowledge Centre, 2010, p.75.

<sup>35</sup> Funck, F., *Droit de la Sécurité Sociale (Social Security Code)*, De Boek and Larcier, 2006, p. 263;

Langendonck, J., Stevens, Y., and Van Regenmortel, A., *Handboek socialezekerheidsrecht (Social Security Handbook)*, Intersentia, 2015, p. 332.

<sup>36</sup> Nys, H., *Medical Law: Belgium, International Encyclopedia of Laws: Medical Law*, Kluwer Law International, Vol.1, 2005, p.35.

<sup>37</sup> *Health Insurance in Belgium*;

The various insurance schemes, known as a *mutuelle*, are state sponsored and are mandatory for any residents wishing to receive Belgian health cover;

<http://www.expatica.com/>

<sup>38</sup> Funck, F., *Droit de la Sécurité Sociale (Social Security Code)*, De Boek and Larcier, 2006, p. 270;

Langendonck, J., Stevens, Y. and Van Regenmortel, A., *Handboek socialezekerheidsrecht (Social Security Handbook)*, Intersentia, 2015, p. 98;

*Health Matters: the Belgian Healthcare System*, the Bulletin, 2013;

responsible for health policy. The government is responsible for financial aspects, accredited criteria, legislation connected with occupations, drug policy, among others. Regions are responsible for prevention, mother and children treatment, coordination of benefits on the basic treatment level, and others. Decisions connected to insurance and finance are made by government representatives, HIF, employees, and employers. Expenditures are financed mainly from traditional insurance and taxes (together 66%), subsidies (10%), and value-added taxes (14%). A list of refunded benefits includes about 800 items in nomenclature. The level of refund depends on many factors such as; income, social status and the purpose of medical treatment. There is a maximum level of fees paid by the patient: the government regulates these payments. GPs are not gate-keepers. The publicly financed HI scheme covers almost 100% of the population of Belgium. Belgium is ranked sixth in the Health Power House index of 2013. It is described as the country, with the most generous and best quality HC system in Europe.<sup>39</sup>

16. With *mutuelles* covering up to 60 -75% of medical costs, private health cover remains a popular choice for many residents looking to cover the outstanding amounts. Some employers also provide additional health cover as part of their employee, as a benefit package. The private cover can be a useful way of topping up a *mutuelle*. This situation is particularly so if patients have an existing medical condition which is likely to require regular treatment. As the patient will pay for at least 25% of the medical cost, it can be beneficial to find a private package which can supplement the state cover. However, it should be noted that the cost of private health insurance (PHI) varies. Hence, it is important to thoroughly research patient's options before committing to a specific package. If the patient has a family, then he has to inquire about specific family packages which may help lower the overall cost.<sup>40</sup>

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<http://www.xpats.com/>

<sup>39</sup> Glowik, M. and Smyczek, S., *Health Care: Market Dynamics, Policies and Strategies in Europe*, Walter de Gruyter, 2015, p. 26.

<sup>40</sup> *Health Insurance in Belgium*;  
[https://www.expat.com/be/healthcare/Health-insurance-in-Belgium\\_445867.html](https://www.expat.com/be/healthcare/Health-insurance-in-Belgium_445867.html)

### 3. France

#### 3.1. General overview

17. The Belgium system is similar to the French system, which is also modelled on *Bismarck system*.<sup>41</sup> In France, the government plays a powerful role to ensure coverage and regulation of the health system, *la medecine liberale*, cost sharing and a public/private mix in both financing and provision of services. These distinguishing characteristics are grounded in three guiding principles: solidarity, liberalism, and pluralism.<sup>42</sup>
18. The health system in France is dominated by solo-based, fee-for-service private practice for ambulatory care and public hospitals for acute institutional care among which patients are free to navigate and be reimbursed under National Health Insurance. The French residents are automatically enrolled in an insurance fund based on their occupational status.<sup>43</sup>
19. HI payroll taxes should be calculated on the basis of ability to pay, not an actuarial risk. The attachment to *la medecine liberale* and to cost sharing rests on the principle of liberalism - the notion that there should be freedom of choice for both physicians and patients. There should be some direct responsibility for payment by patients.<sup>44</sup>
20. The public-private mix creates the complexity. The public hospitals and commercial hospitals as well as a large ambulatory sector composed of independent practitioners, of whom 53% are GPs, and 47% of specialists provide the healthcare services. For payment

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<sup>41</sup> Durand-Zaleski, I., *The French Health Care System*, International Profiles of Health Care Systems, 2015, p. 59.

<sup>42</sup> Rodwin, V.G., *The Marriage of National Health Insurance and La Medecine Liberale (The Liberal Medicine) in France: A Costly Union*, Milbank Memorial Fund Quarterly, 1981, p.16-43.

<sup>43</sup> Victor G. R., *The Health Care System under French National Health Insurance: Lessons for Health Reform in the United States*, American Journal Public Health, 2013, p.31.

<sup>44</sup> Rodwin, G.R and Sandie, S., *Health Care under French National Health Insurance*;

<https://www.nyu.edu/projects/rodwin/french.html>

policy, the government sets payment rates for hospital care whereas the independent doctors negotiate collective agreements with the HIF.<sup>45</sup>

21. To payment mechanism, the patients pay directly for the physicians in private practice and proprietary by a national fee schedule. Their local HIFs then reimburse patients.<sup>46</sup> Primarily, HC in France is private. In addition, private clinics offer secondary health care.<sup>47</sup> Alongside the private sector, the public sector operates the national health care service in the hospitals by offering secondary care. The public health service represents 78% of secondary care available in France.<sup>48</sup>

### 3.2. *Health insurance*

22. French SHI provides nearly universal coverage, with 99.9% of the population was covered in 2013. Individuals are generally covered on an employment basis, and any dependents of the insured person are also covered. Employees cannot opt-out. The Universal Health Coverage (UHC) Act, offers SHI coverage to individuals who legitimately reside in France and who are not covered through one of the obligatory social health insurance (SHI) schemes on an employment basis. UHC is free for individuals with household revenues up to an established ceiling; other beneficiaries must pay an annual premium equal to 8% of revenues above the ceiling. Thus, coverage criteria have progressively moved from an employment basis to residency status.<sup>49</sup>
23. SHI forms an integral part of France's social security system which is typically depicted as a set of 3 sprouting branches. They are (1) pensions, (2) family allowances, and (3) HI and workplace accident cover. The national manage the pensions and family allowances while NHI funds run the third one by three main sources include salaried

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<sup>45</sup> Steffen, M., *Universalism, Responsiveness, Sustainability-Regulating the French Health Care System*, The New England Journal of Medicine, 2016, p.403.

<sup>46</sup> Rodwin, V.G., *The Health Care System under French National Health Insurance: Lessons for Health Reform in the United States*, International Perspectives Forum, Vol.93, 2003, p. 34.

<sup>47</sup> Hondius, E., *The Development of Medical Liability*, Cambridge, Vol. 3, 2010, p.71.

<sup>48</sup> Hondius, E., *The Development of Medical Liability*, Cambridge, Vol. 3, 2010, p.71.

<sup>49</sup> Chevreul, K., Brigham, K., Durand-Zaleski, I., Hernández-Quevedo, C., *Health Systems in Transition: France*, European Observatory on Health System and Policies, Vol.17, 2015, p. 71.

workers, farmers and agricultural workers, and independent professions. In addition, there are other smaller funds for workers in specific occupations, and their dependents all of whom defend their “rightfully earned” entitlements.<sup>50</sup>

24. NHI in France provides financial cover for comprehensive services. The financial cover can be inpatient hospital care to outpatient services, maternity care, prescription drugs (including homoeopathic products), thermal cures in spas, long-term care, cash benefits, and to a lesser extent, dental and vision care. However, there are still small differences in benefits among occupational groups. For instance, the self-employed pay higher co-payments for ambulatory care while some of the smaller schemes (like those for railway workers and miners).<sup>51</sup>
25. NHI is financed by employer and employee payroll taxes (64%); a national earmarked income tax (16%); tax levied on tobacco and alcohol, the pharmaceutical industry, and voluntary with HI companies (12%); state subsidies (2%); and transfers from other branches of SS (6%). Insurance cover is universal and compulsory provided to all residents by non-competitive NHI. NHI eligibility is either gained through employment or granted, as a benefit, to students, to retired persons, and unemployed adults who were formerly employed (and their families). The State covers the insurance costs of residents who are eligible for NHI, such as the long-term unemployed, and finances health services for undocumented immigrants who have applied for residence.<sup>52</sup>
26. Although France has a universal public HI, its coverage is incomplete. Therefore, the vast majority of the French population has private complementary health insurance. Unlike other countries, private health insurance (PHI) is not purchased to avoid public

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<sup>50</sup> Rodwin, V.G., *The Health Care System under French National Health Insurance: Lessons for Health Reform in the United States*, American Journal Public Health, 2013, p.32.

<sup>51</sup> Rodwin, G., *The Health Care System under French National Health Insurance: Lessons for Health Reform in the United States*, American Journal Public Health, 2013, p.32.

<sup>52</sup> Durand-Zaleski, I., *The French Health Care System*, International Profiles of Health Care Systems, 2015, p.59.

sector queues or to access a different type or quality of care than what is available to patients with only public coverage.<sup>53</sup>

27. Similar to Belgium, PHI in France is complimentary. It mainly covers the co-payments for usual care, balance billing, and optical and dental care (minimally covered by SHI). Complementary insurance is provided mainly by not-for-profit, employment-based mutual associations or provident institutions which are allowed to cover only co-payments for care provided under SHI. There are 95 % of the population covered either through employers or via means-tested vouchers. Private for-profit companies offer both supplementary and complementary HI but only for a limited list of services. The extent of complementary health coverage is wide, but all complementary health coverage contracts cover the difference between the SHI reimbursement rate and the service according to the official fee schedule.<sup>54</sup>
28. The complimentary insurance is now also funded entirely by a tax levied. Furthermore, beginning in January 2016, all employers are legally obliged to negotiate a collective contract with a complementary insurer for all their employees. Complementary insurance has become an important policy tool for raising new health care funding, with interesting outcomes. First, it is no longer obvious what percentage of their income people contribute to health coverage. Second, management costs are high for the two-tiered insurance system. Various scenarios are currently being explored for merging parts of the system or unifying the entire system-a politically sensitive topic.<sup>55</sup>

## **4. England**

### **4.1.Overview**

29. While Belgium and France run *Bismarckian* model, England, on the other hand, applies *Beveridge* one<sup>56</sup> in HC. England has a system of State funded and private healthcare

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<sup>53</sup> Buchmueller, T and Couffinhal, A., *Private Health Insurance in France*, OECD Health Working Papers, 2004, p. 8.

<sup>54</sup> Durand-Zaleski, I., *The French Health Care System*, International Profiles of Health Care Systems, 2015, p.59.

<sup>55</sup> Steffen, M., *Universalism, Responsiveness, Sustainability - Regulating the French Health Care System*, The New England Journal of Medicine, 2016, p.404.

provision. The vast majority of patients are treated by the State-funded National Health Service (NHS) although the number of patients who have signed up for and are receiving treatment on a contractual basis with a private physician (as opposed to an NHS doctor) is rising.<sup>57</sup>

30. The Parliament at Westminster is responsible for health legislation and general policy matters. The NHS is administered by the NHS Executive and Department of Health, and locally it is provided through a series of contracts between commissioners of health care services (primary care trusts) and providers (hospital trusts, GPs, independent providers).<sup>58</sup> The Department of Health allocates 80% of the NHS budget to primary care trusts (PCTs) using a weighted capitation formula that takes account of population size, age distribution and various indicators of health care need as well as certain differences in costs between different geographic areas. Most publicly funded health services are commissioned by PCTs.<sup>59</sup>
31. NHS-funded primary care is provided in a range of different ways. The first point of contact for general medical needs is usually self-employed GPs and their practices, who are typically engaged through a general medical services contract or a personal medical services contract although GPs may also be employed directly by alternative providers (e.g. the voluntary sector, commercial providers, NHS trusts, PCTs). In addition, community health services (e.g. district nursing, physiotherapy), NHS Direct (a telephone and Internet service), NHS walk-in centres, dentists, opticians, and pharmacists are also part of NHS primary care services. NHS-funded secondary care is provided by salaried specialist doctors (known as consultants), nurses and other healthcare professionals (e.g., physiotherapists and radiologists) who work in

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<sup>56</sup> PNHP California, *Summary of International Health Systems*, 2011;

<http://caphysiciansalliance.org/wp-content/uploads/2011/11/International-Comparison.pdf>

<sup>57</sup> De Cruz, P., *Comparative Healthcare Law*, Cavendish Publishing Limited, 2001, Xlviii.

<sup>58</sup> Boyle, S., *The UK Health Care System*, 2008, p. 3-4;

<http://www.commonwealthfund.org>

<sup>59</sup> Boyle, S., *Health Systems in Transition: United Kingdom (England)*, *Health System Review*, Vol.13, 2011, p.23.

government-owned hospitals known as “trusts.” A small private sector exists alongside the NHS; funded through private insurance, direct payments from patients or publicly funded payments by PCTs and the Department of Health; this mainly provides acute elective care.<sup>60</sup>

32. The NHS accounts for 86% of total health expenditure. Its fund includes not only general taxation (76%) but also by national insurance contributions (19%° and user charges (5%). The perception of drugs and dentistry services to the general population also form the NHS’s income.<sup>61</sup>
33. The NHS also receives income from co-payments, people using NHS services as private patients, and some other minor sources. Coverage is universal and largely free at the point of use. The “ordinary residents” in England are automatically entitled to NHS care and also the non-residents with a European Health Insurance Card. Non-European visitors or illegal immigrants receive free treatment only in an emergency department and for certain infectious diseases.<sup>62</sup>
34. NHS care is mostly free at the point of access. Nevertheless, in some cases, patients do have to make co-payments (for goods and services covered by the NHS but requiring cost sharing) and direct payments (for services not covered by the NHS or for private treatment). Some populations, such as children, pensioners over 65, and those on low income have recourse to reimbursement or exemption for some co-payments.<sup>63</sup>

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<sup>60</sup> Boyle, S., *Health Systems in Transition: United Kingdom (England)*, *Health System Review*, Vol.13, 2011, p.23.

<sup>61</sup> Boyle, S., *The UK Health Care System*, 2008, p. 1-2;

<http://www.commonwealthfund.org>

<sup>62</sup> Thorlby, R. and Arora, S., *The English Health Care System*, *International Profiles of Health Care Systems*, 2015, p.49.

<sup>63</sup> Boyle, S., *Health Systems in Transition: United Kingdom (England)*, *Health System Review*, Vol.13, 2011, p.55.

#### 4.2. *Health insurance*

35. Although the NHS in England provides free medical services for its citizens and does not collect premiums, it is not a type of health insurance but a universal health coverage.<sup>64</sup>
36. The private sector has been viewed as complementary to the NHS since 1948. This rooted from that the patients have changed their health expectation to the health services. The public system may not even attempt to meet some of these demands - for example, removing anxiety over unresolved symptoms, treatment for conditions mainly affecting the quality of life, and the achievement of personal life aims such as fertility.<sup>65</sup>
37. The principal type of voluntary health insurance operating in England is supplementary or PHI. PHI delivers healthcare services that duplicates many of the services provided by the NHS (to which PHI subscribers retain full access). The key attractions of PHI about the NHS are faster access to treatment, a more comfortable care environment, and a wider choice of specialists, treatment facilities, and timing of treatment. Although the public and private sectors are relatively well integrated on the delivery side of the health care system, PHI and public funding operate as distinct, unrelated streams of healthcare finance. PHI provides cover for the costs of treatment for acute conditions and for the costs of related services such as accommodation, nursing and - where relevant outpatient services. PHI products may offer cover beyond these core benefits. However, it reflects a broader scope being reflected in a higher price.<sup>66</sup>
38. There are 82% of the population in England are covered by PHI as employer-based and the remaining purchase PHI individually. Insurance companies charge premiums based on the scope of coverage, product options such as fixed-price or excess-charge policies,

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<sup>64</sup> *Health Insurance*;

<http://www.medicalnewstoday.com/>

<sup>65</sup> Doyle, Y. and Bull, A., *Role of Private Sector in United Kingdom Healthcare System*, Education and Debate, Vol. 321, 2000, p. 564.

<sup>66</sup> Foubister, T., Thomson, S., Mossialos, E., McGuire, A., *Private Medical Insurance in the United Kingdom*, World Health Organization, 2006, p. 11.

the nature, and degree of risk the insurer takes on and the loading charge related to the insurer's profits.<sup>67</sup>

## 5. Vietnam

### 5.1. Overview

39. Vietnamese HC system has undergone different development stages. Before 1989, the Vietnamese HC system was publicly funded. Citizens could access HC services free of charge. Notably, it has developed positively since *Đổi Mới* in 1986.<sup>68</sup>
40. Currently, the HC system is made up of public and private service providers similar to France and Belgium. Despite the Government putting much effort to promote the quality and equity of health care services, there still exist some problems in the system. At the moment, HC services cannot meet the overall health needs of people regarding quality and quantity due to a constrained health budget.<sup>69</sup>
41. Vietnam has a mixed delivery system, with the public sector dominant in the provision of hospital care services while the private sector dominant among smaller ambulatory care providers and the sale of pharmaceuticals. The public sector delivery system consists of central, provincial and district hospitals, commune health stations, and village health workers. On the other hand, private providers of primary care consist of drug vendors, general practitioners, private pharmacies, and nursing homes. The private hospital sector is relatively underdeveloped, with private hospital bed numbers accounting for 4% of the total beds.<sup>70</sup>
42. Recently, Vietnam has socialised its HC system. It has mobilised all available and possible resources in society toward HC. Subsequently, individuals directly finance a larger proportion of health care costs out of their own pockets when they use health

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<sup>67</sup> Boyle, S., *Health Systems in Transition: United Kingdom (England)*, Health System Review, Vol.13, 2011, p.55.

<sup>68</sup> Economic renovation.

<sup>69</sup> Nguyen, T., Tran, Bach., Waye, A., Harstall, C., *Socialization of Health Care in Vietnam: What is it and What are its Pros and Cons?* Value in Health Issues, 2014, p. 24.

<sup>70</sup> Somanathan, A., Tendon, A., Dao, L., Hurt, K., and Fuenzaliada-Puelma, H., *Moving toward Universal Coverage of Social Health Insurance in Vietnam*, Health System Overview, 2014, p. 141.

services (mostly based on the fee-for-service basis) or by paying for health insurance premiums monthly or annually. Private actors also finance a larger part of an investment in HC. They do this by opening a clinic or private hospital, partner with a public hospital open to a “service-on-demand” ward (with pricier and higher quality health care services for patients who are willing and capable of paying). The private actors also purchase hi-tech diagnostic equipment, to share the profits with public hospitals.<sup>71</sup>

43. The HC administration in Vietnam is organised in a three-tier system. The tertiary level is the Ministry of Health (MoH)-the main national authority in the health sector-which formulates and executes health policy and programs in the country. At the provincial level, 63 provincial health bureaus follow MoH policies but are in fact organic parts of the provincial local government under the Provincial Committees (PPCs). The primary level-or basic health network-includes district health centres, commune health stations, and village health workers.<sup>72</sup> In recent year, the private sector appears to have developed, with drug vendors and general practitioners clinics being the largest groups of registered private providers. However, the private hospital sector has grown unequally. The private hospitals are principally located in major cities. There is an uneven distribution of human resources with shortages in some regions, facilities, and specialisations. The most qualified health workers are concentrated in urban areas.<sup>73</sup>
44. Unlike Belgium, France, and England, where the populations are generally free to access the health care system-in fact, there is the free choice of physicians and hospitals, the population in Vietnam has to follow the rules of the Law of Health Insurance. There are four levels of primarily examination and treatment:

1. The commune level (family doctors, ward clinics, commune);

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<sup>71</sup> Nguyen, T., Tran, B., Waye, A., Harstall, C., *Socialization of Health Care in Vietnam: What is it and What are its Pros and Cons?*, Value In Health Issues, 2014, p. 24.

<sup>72</sup> Tran, T., Hoang, P., Mathauer, I. and Nguyen, P., *A Health Financing Review of Vietnam with a Focus Social Health Insurance*, World Health Organization, 2011, p. 4.

<sup>73</sup> Rousseau, T., *Vietnam: Social Health Insurance, Report of Study Visit*, Project Collaborator COOPAMI, 2014, p.6.

2. The district level (public district general hospitals, private district general hospitals ranked III and IV<sup>74</sup>), district health centres, district general clinics, and specialised district hospitals);
  3. The provincial level (city public general hospitals, provincial private general hospitals ranked I and II);
  4. The central level (central general hospitals, specialised hospitals, and central institutes).
45. Insured members can only register for primary examination and treatment at the levels of commune and district.<sup>75</sup> The information written in Health Insurance Cards states the primary hospital where the insured member was registered.<sup>76</sup> According to the new Law, the members can access health services in a different hospital. However, the hospital should be at the same level as the primary hospital.<sup>77</sup> When members' use their funds while seeking health care in other commune health centres or district hospitals, their funds are reimbursed later at their place of residence or offered free of charge for emergency care. If the insured members want to use the services at a level higher than that where they are primarily registered (not in emergency cases), they get a lower reimbursement. For example, the Health Insurance covers 40% of the fee for inpatient treatment at the national level and 60% at the city level.<sup>78</sup> Moreover, patients cannot choose the physician to examine and treat them in public hospitals unless they wish to pay for particular services themselves. Health financing has been considered by all

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<sup>74</sup> The ranks of hospital levels based on the standard of the hospital such as number of beds, facility technology and human resource of the hospital under the Circular on Guiding Classification of Hospitals, No. 03/2004/TT-BY, Health Ministry of Vietnam.

<sup>75</sup>Article 8: Circular on Primary Medical Examination and Treatment Covered by Health Insurance and Transfer to Other Levels for Health Examination and Treatment covered by Health Insurance, No. 40/2015/TT-BYT, Health Ministry of Vietnam.

<sup>76</sup>Decision on Establishing the Codes Written on Health Insurance Card, No. 1071/QD-BHXH, Social Health Insurance of Vietnam.

<sup>77</sup>Article 24.4: Law on Amending and Supplementing Some Articles of Law on Health Insurance, No. 46/2014/QH13, Parliament of Vietnam.

<sup>78</sup> Article 22. 3 of Law on Amending and Supplementing Some Articles of Law on Health Insurance, No. 46/2014/QH13, Parliament of Vietnam.

health system stakeholders in Vietnam as an essential building block of a health system and has a crucial role in promoting universal health coverage in the country.<sup>79</sup>

46. Like other developing countries, Vietnam is now using both public financial sources (state budget, social health insurance fund, and international aids) and private contributions (direct out-of-pocket payments by households and other private health expenditure) to finance health care service provision.<sup>80</sup> The total health expenditure as a percentage of GDP has been consistent at about 6.6%.<sup>81</sup> Therefore, it is not easy to place Vietnam in any model of HC system. It is a mixed public and private system, and the Government would like to cover everybody as *Bismarck* model. However, a high percentage of the population has to use their own money to pay for the services although the Government has a structured non-profit system.
47. The more significant part of the government health expenditure is provided in the form of direct budget subsidy to health providers. The state budget for health is allocated to the central budget and local budgets. The national level accounted for 36.8% of total state health budget expenditures, while the provincial level accounted for 44.7%, the district level 16.2% and the commune level 2.3%.<sup>82</sup> Another part is channelled to the SHI in the form of premium subsidies for defined and targeted population groups such as the poor, children, and other vulnerable groups. This way of financing has become more significant since 2006.<sup>83</sup>

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<sup>79</sup> Van, H., Juhwan, O., Tran, Anh., *Patterns of Health Expenditures and Financial Protections in Vietnam 1992-2012*, Journal of Korean Medicine, Vol. 30, p.1.

<sup>80</sup> Tran, T., Hoang, P., Mathauer, I. and Nguyen, P., *A Health Financing Review of Vietnam with a Focus on Social Health Insurance*, World Health Organization, 2011, p. 4.

<sup>81</sup> WHO, *Health Financing Profile in Vietnam*, 2016.

<sup>82</sup> Nguyen, T., Duong, L., Nguyen, L., Pham, T., Bales, S., Duong, T., *Joint Annual Review: Health Financing in Vietnam*, Health Partnership Group, 2008, p.41-42.

<sup>83</sup> Tran, T., Hoang, P., Mathauer, I., and Nguyen, P., *A Health Financing Review of Vietnam with a Focus on Social Health Insurance: Bottlenecks in Institutional Design and Organizational Practice of Health Financing and Options to Accelerate Progress towards Universal Coverage*, World Health Organization, 2011, p.10-11.

48. Vietnam's desire to modernise the health care system should generate plenty of business opportunities in the upcoming years. The first area Vietnam will need to improve the network of hospitals. Modernizing hospitals will require massive investment and funding, which Vietnam will not be able to fulfil through traditional sources alone. The master plan, clearly indicates that the government is encouraging the creation of new privately funded hospitals and clinics. The new private healthcare infrastructure may position itself to service the high-end segment of the healthcare market, tapping into the significant spending by local patients who travel abroad for operations and other treatments that could be handled.<sup>84</sup> Corruption is an evil that has bedevilled the Health Care System in Vietnam.
49. Firstly, as the author mentioned in the "Healthcare system" section, there are four different levels of health care services. Mostly, medical equipment in the high-level hospitals is better than that in low-level hospitals. In the case of patients with severe conditions, especially the ones covered by public health insurance, they have to be approved by the primary hospital to be transferred to a higher-level hospital. Otherwise, they may not be refunded by the insurer or a minimal amount if they are refunded. Consequently, they have to bribe health care providers to recommend them to be transferred to a higher-level hospital.
50. Secondly, the professional qualifications of health practitioners are very different. This problem originates from the educational system. Vietnamese medical schools prefer exploiting weaknesses in the education system by offering a high-quality education. As a result, they accept unqualified students to study medicine. These students are also allowed to graduate so long as they bribe the lecturers. As a result, they graduate without meeting the standards of health practitioners. For patients to be treated by a well trained professional or one of their choice, they have to bribe healthcare providers; otherwise, they have to accept the ones arranged by the hospital, whether qualified or not.
51. Finally, patients have to bribe to be treated with "kindness" or "good behaviour" by medical practitioners. For example, if a patient would like to inquire about his health or

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<sup>84</sup> Gaskill, S., and Nguyen, H., *The Vietnamese Healthcare Industry: Moving to Next Level*, PWC, 2017, p.5.

how to use medication, a doctor may be unpleasant to him, prompting the patient to bribe the doctor to be served well. Also, a nurse may fail to change a patient's dirty beddings unless she is bribed.

## 5.2. *Health insurance*

52. Alongside the HC system, HI also underwent different stages and had been upgraded since *Đổi Mới*. In 2009, the Vietnamese government declared the implementation of universal health insurance by 2014, and since 2010, the government has been working towards universal coverage with the Vietnam Social Security, a government-affiliated agency responsible for implementing health insurance policy. Although the coverage rate has increased steadily, the government is currently struggling to reach the entire population due to issues surrounding the designed scheme. While the government has tried to reform SHI, PHI has not changed significantly. Despite the government enacting some laws to regulate the issues of PHI, some problems still exist.<sup>85</sup>
53. Vietnam has made a policy change to health finance care primarily through Social Health Insurance Law (SHIL) that was passed in 2009, creating a national SHI program. This Law also stipulates that all children under six years of age, the elderly, the poor, and the near-poor (with an income of less than 65\$/month and cannot afford some essential social services<sup>86</sup>) would be compulsorily enrolled. Under the Law, the government is responsible for fully subsidising the HI premiums for children under six years old, the elderly, the poor, and ethnic minorities, students, for partially subsidising premiums and for the near-poor.<sup>87</sup>
54. In June 2014, the National Assembly passed a new version of the insurance law, which was effected on January 2015. The Law was designed to make participation compulsory. This amended health insurance law categorises membership of health insurance into five

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<sup>85</sup> Rousseau, T., *Vietnam: Social Health Insurance*, Report of Study Visit, Project Collaborator COOPAMI, 2014, p.7.

<sup>86</sup> Article 2. Standards to estimate to be called the poor, near-poor households, households with average living standards applicable for the period 2016-2020, Decision on issuing the standards multidimensional approached to be called the poor which applied in the period 2016 – 2020, No: 59/2015/QĐ-TTg

<sup>87</sup> Van, H., Oh, J. and Tran, Anh., *Patterns of Health Expenditures and Financial Protections in Vietnam 1999-2012*, The Korean Academy of Medical Sciences, 2015, p. 134.

groups based on contribution responsibility. These are Group 1: Salaried employees, Group 2: People entitled to Social security benefits, Group 3: Commissioned and non-commissioned officers, Group 4: Members of households and Group 5: Voluntary insured.<sup>88</sup>

55. According to the confirmed information from the MoH, in June 2016, the national health insurance scheme currently covers an estimated 71% of the population.<sup>89</sup> Recently, more than 27 million Vietnamese have been uninsured and at high risk of falling into poverty when they encounter significant medical expenses. The 70 million people who are insured can in principle benefit from their HI.<sup>90</sup> It is clear that the poor and the exempted groups still find it difficult to access services due to lack of informal fees, known as “*envelope*” payments, to doctors, nurses, midwives or other health staff. Indeed, a recent national survey shows that 65% of respondents experienced corruption at local health services and 70% of the medical staff interviewed admitted that they have asked patients to pay bribes. Due to this endemic corruption, the poor Vietnamese still have limited access to healthcare services.<sup>91</sup>
56. The HIFs come from different sources: premiums paid by the employees and employers-4.5% of salary (employer 3%, employee 1.5%)-premium paid from the Social Insurance Funds, premiums paid from the State budget, and premiums paid by the insured people themselves.<sup>92</sup>
57. Vietnam has progressively introduced a SHI for its population by gradually expanding the target population, the benefits package, and reducing the financial contribution from

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<sup>88</sup> Article 1. 6 : Law on Amending and Supplementing Some Articles of Law on Health Insurance, No. 46/2014/QH13, Parliament of Vietnam.

<sup>89</sup> Rousseau, T., *Vietnam: Social health Insurance*, Project Collaborator COOPAMI, 2010, p.13.

<sup>90</sup> Thuy Linh, *How can 20 Million People avoid the Poverty because of Medical Expenses?*, Lao Dong, 2017;

<https://laodong.vn/suc-khoe/lam-sao-de-20-trieu-nguoi-khong-bi-ngheo-hoa-vi-chi-phi-y-te-675145.bld>

<sup>91</sup> Marriot, A., *Vietnam's Health Care System Suffers on Failure Policy*, The Oxford Analytical Daily Brief, 2011;

<http://www.globalhealthcheck.org/?p=423>

<sup>92</sup> Rousseau, T., *Vietnam: Social Health Insurance*, Project Collaborator COOPAMI, 2010, p. 9.

the insured. The Vietnamese government has the intention to provide SHI to 100% of its population by 2030. However, it still has a long way to go.<sup>93</sup> There are a couple of reasons for this. Firstly, Vietnam's Social Security reimbursements do not entirely cover the SHI benefits package; instead, they pick up only a portion of the total costs of care, leaving providers to claim the remainder through user fees from patients. There is no cap on co-payment expenditures. SHI includes caps on benefits, but no cap on co-payment-related charges. Secondly, the quality of care is very different from level to level and from one region to another. As a result, patients go to seek care directly at private health facilities, which are not covered by SHI. Even if the government can provide SHI to 100% of the population, it should still make efforts to minimise health care costs that have not been covered by health insurance and increase the quality of healthcare services. This effort would encourage people to enrol in the state health insurance scheme voluntarily.

58. In Vietnam, private health insurance (PHS) has not developed much despite 60%<sup>94</sup> of the population spending out-of-pocket for health services-including people who are covered by SHI.<sup>95</sup>
59. The principal reason why the development of PHS is not active, it is a new subset of insurance products which includes personal accident insurance, medical expenses insurance, and healthcare insurance. The Ministry of Finance must ratify insurance regulations, clauses and premium scales of healthcare insurance products.<sup>96</sup> Before July 1<sup>st</sup>, 2011, HI was categorised in the package of non-life insurance. This regulation significantly restricted the population interest in PHS. As its premium was slightly high and the procedure was complicated.

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<sup>93</sup> Rousseau, T., *Vietnam: Social Health Insurance*, Project Collaborator COOPAMI, 2010, p. 9.

<sup>94</sup> *World Health Organization*, 2011.

<sup>95</sup> Pham, T., *Vietnam Health System & Health Infrastructure: Achievements, Challenges and Orientation*, Ministry of Health, p. 5;

[www.designandhealth.com/upl/files/122262/pam-le-tuan-2015.pdf](http://www.designandhealth.com/upl/files/122262/pam-le-tuan-2015.pdf)

<sup>96</sup> *Vietnam' Insurance Market 2013*, Hogan Lovells;

[www.hoganlovells.com/.../Vietnam%20newsflash\\_Jurisdiction%20Updf](http://www.hoganlovells.com/.../Vietnam%20newsflash_Jurisdiction%20Updf)

60. A significant portion of the Vietnamese population that is not covered by SHI includes mostly the poor migrant workers<sup>97</sup> who are unable to contribute to SHI. If these people are unable to afford SHI with the reason that SHI's premium is high, the more they cannot afford PHI whose premium is much higher than SHI's premium.
61. At this point, the author would like to demonstrate the reasons why there is a contrast in access to PHS between Vietnam and Belgium, France, and England. Populations' access to PHS in the three countries is different from Vietnam's because they have higher demands on health services, which cannot be met by the countries' public systems. The difference happens because the insurance allows payment of additional fees in order to access higher-quality providers. Ironically, in Vietnam, people who can afford PHS seek better health services despite being covered by SHI. Otherwise, they are not concerned about SHI.

## **6. Conclusion**

62. Generally, the three healthcare systems of Belgium, France, and England have some similar factors such as patients having freedom of choosing healthcare providers and being granted free medical treatment. Mostly, the relationships between doctors and patients are contractual and non-contractual (tortious) in exceptional cases. However, they follow different health model systems (Belgium and France: Bismarck and England: Beveridge) which direct them to different access to their healthcare systems.
63. Regarding Vietnam, it shows strong political commitment to developing a HC system aimed at equity, quality, and efficiency.<sup>98</sup> The continuous increase in HC spending, combined with the necessary modernisation of the Vietnamese HC system and ambitious national development plans, it should continue to drive strong growth in the

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<sup>97</sup> Up to 90 % of migrant workers in urban areas in Vietnam do not access to SHI due to their absence from So Ho Khau – House Hold registration system in which they register migration. This House Hold Registration document is given to who owns a private house. Under this household registration system, each household is given an household registration booklet (So Ho Khau) which records the names, sex, date of birth, marital status, occupation of all household members and their relationship with the household head (the owner of the house). In principle, no one can have his or her name listed in more than one house hold registration booklet. That is why the migrant workers cannot access health services funded by the government out of their registration.

<sup>98</sup> Tran. T., Hoang, P., Mathauer, I. and Nguyen, P., *A Health Financing Review of Vietnam with a Focus Social Health Insurance*, World Health Organization, 2011, p.38.

HC market over the coming years. Vietnam's HC system is at a crossroad. The country has managed to address its population's most basic needs but now faces a tremendous challenge of taking the country's healthcare system to the next level of development.<sup>99</sup>

64. Compared to the level and progress of the three countries, which are Belgium, France, and England in the national health insurance system, Vietnam is a country with many limitations though it has put efforts to achieve the targets. Despite having made efforts to develop SHI, the number of people who have remained uninsured is rather high (29% of the total population). Also, although the other portion of the population has been insured, they have not thoroughly enjoyed the benefits from SHI. Moreover, PHI has been stagnant and lacking State's attention in many aspects, including weaknesses in the promulgation and effective enforcement of health insurance law.

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<sup>99</sup> Gaskill, S. and Nguyen, H., *The Vietnamese Healthcare Industry: Moving to Next Level*, PWC, 2017, p.6.

# CHAPTER 3: MEDICAL MALPRACTICE LEGAL SYSTEMS

## 1. Introduction

1. In legal practice today, the majority of tort claims are for negligence.<sup>100</sup> Negligence is a cause of action in the offence, whereby a person who has suffered damage of his/her loved one, goods or financial wealth alone, may sue to recover damages from the person who caused the damage.<sup>101</sup>
2. The conceptual structure of negligence is highly flexible and capable of general application. These features have allowed courts to utilise the tort in the context of different claims for compensation. Duty, breach, causation, and damage are the elements which together make up any successful negligence claim. Their requirements may be rephrased as a series of questions, each of which must be answered affirmatively if the plaintiff is to win:
  - Does the law recognise a liability in this type of situation (duty)?
  - Was the defendant careless in the sense of failing to conform to the standard of care set by law (breach)?
  - Has the plaintiff suffered a loss (damage) for which the law regards the defendant as responsible either in whole or part (causation)?<sup>102</sup>

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<sup>100</sup> Harpwood, V., *Modern Tort Law*, Routledge Cavendish, Seventh Ed, 2009, p.19.

<sup>101</sup> Patten, B., *Professional Negligence in Construction*, Spon Press, 2003, p. 9.

<sup>102</sup> Markesinis, B. and Deakin, S., *Tort Law*, Clarendon Press - Oxford, Fourth Ed, 1999, p. 69;

Nathalie De Fabrique, *Encyclopedia of Clinical Neuropsychology*, Springer, New York, 2011, p. 1541-1542.

3. The functions of tort law are those purposes which people seek to achieve through tort law.<sup>103</sup> The primary functions of tort are compensation,<sup>104</sup> deterrence,<sup>105</sup> and justice.<sup>106</sup>
4. MM is a form of professional negligence, and such negligence forms part of the law of tort.<sup>107</sup> MM occurs when a negligent act, the omission by a doctor or other medical professional results in damage and harm to a patient. MM is behaviour which deviates from the generally accepted standard of care, that causes harm to the patient. Negligence by a medical professional can include an error in diagnosis, treatment or illness management. If such negligence results in injury to a patient, a legal case for MM can arise against the doctor, the hospital, local state or federal agencies that operate the medical facility.<sup>108</sup>
5. As MM is a sort of tort of negligence, the content of this Chapter has been constructed following the framework of the tort of negligence. The core duty of this Chapter is to analyse and compare MM laws in four countries namely Belgium, France, England, and Vietnam. Moreover, the content of the Chapter will include the parts of strict liability and criminal negligence to further describe the differences in MM laws in the four countries. Interestingly, a type of administrative MM liability in Vietnam establishes a point that is different from the laws of Belgium, France, and England.
6. The works above demonstrate the similarities and differences among the four countries which will create significant results for this research. These results can be applied to Vietnamese MM law.

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<sup>103</sup> Cane, P., *The Anatomy of Tort Law*, Hart Publishing, Oxford, 1997, p.206.

<sup>104</sup> Lunney, M. and Oliphant, K., *Tort Law: Text and Materials*, Oxford University Press, Third Ed, 2008, p. 23.

<sup>105</sup> Bermingham, V. and Brennan, C., *Tort Law Directions*, Oxford University Press, Fifth Ed, 2016, p.8.

<sup>106</sup> Owen, D., *Philosophical Foundations of Tort Law*, Oxford University Press, 1995, p. 93.

<sup>107</sup> Deakin, S., Johnston, A., & and Markesinis, B., *Tort Law*, Clarendon Press -Oxford, Fifth Ed, 2003, p.261.

<sup>108</sup> *Information Center: Medical Malpractice*;

<http://www.pereylaw.com/information-center-medical-malpractice/>

## 2. Medical malpractice law in Belgium

### 2.1. Background

7. In Belgium, MM liability is not regulated by specific legislation, and this results to a situation in which the general rules of civil liability govern civil liability of a physician for damage or injury caused by improper conduct.<sup>109</sup>
8. The current Civil Code in Belgium origins from the French Civil Code developed in 1804, known as Napoleonic Code. It bases on the principles of private property, the freedom of contract, and binding contract.<sup>110</sup> The bulk of the substance of this branch of law has been elaborated by the courts which over the last century have not felt obliged to adhere to the French interpretation of the same statutory context.<sup>111</sup> The core provisions of Belgian tort law have always been found in the present unmodified Article 1382 and 1383 of the Civil Code. The fault is the basis for malpractice in contract or tort that the claimant can choose either.<sup>112</sup>
9. The distinction which the Code makes between delicts (fault in intentional behavior, Art.1382, and fault in unintentional behavior, Art.1383) has no importance concerning the basis of liability. Different countless social situations in which a person may suffer injury through another's fault, all produce the same result in the area of tort liability.<sup>113</sup>
10. Non-contractual or tortious liability is only relevant in cases where there is damage to a third party, where services are rendered to patients or when they are not in a position to give consent to treatment. There is, however, little difference in practice, for possible consequences of a physician's breach of contractual duties in the field of medical law in the tort of negligence. A physician who causes personal injuries through malpractice breaches not only his contract with patient but also commits a tort. A decision of the

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<sup>109</sup> Genicot, G., *Droit Medical et Biomedical (Medical and Biomedical Law)*, Larcier, 2016, p. 339.

<sup>110</sup> *The Civil Code in Belgium*, 2015;

<http://www.lawyersbelgium.com/>

<sup>111</sup> Kruithof, M., and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, 2017, p.243.

<sup>112</sup> Widmer, P., *Unification of Tort Law: Fault*, Kluwer Law International, 2005, p. 30.

<sup>113</sup> Kruithof, M., and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, 2017, p.247.

*Cour de Cassation* of December 1973, excludes the so-called concurrent or alternative liability so that the patient has no option as to whether he should proceed in contracts or in torts. The law of delict as laid down in Articles 1382 et seq., civil is inapplicable to fault committed in the execution of a contractual obligation.<sup>114</sup>

11. The conjunction between tort and contract has been given much attention in the last decades. Until about 1970, the courts generally allowed parties aggrieved by an act which qualified both as a breach of a contract, to which they were a party as a tort, the choice<sup>115</sup> between a claim in tort or a claim in contract. The rules of tort were considered to be of a general nature and to remain applicable, even if the parties to the litigation had entered into a contract governing the matter. Most often, the victim would have an interest in having tort law applied. The action in tort allowed to avoid the application of contractual exemptions clauses; tort law contains more rules of strict liability than contract law; the period of limitation for a tort claim generally is longer than that for a claim based on some specific contracts.<sup>116</sup>
  
12. The Belgian courts, as well as the majority of legal writers, have acknowledged the possibility of a contract for medical services existing between a physician and his patient. Nevertheless, until 1936 a physician through inadequate, careless discharge of his medical duties, had caused damage. The Belgian courts required the patients seeking recovery to proceed under the general rule on tortious liability in Article 1382 of the Civil Code. In doing this, the courts seemed to endorse the view of some writers which still prevail up to date. The view upholds the services of a professional person and especially a physician by their very nature and repel a legally binding civil contract. The classical decision of the French *Cour de Cassation* of 20 May 1936 endorsed the view

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<sup>114</sup> *Cour de Cassation*, 7 December 1973, Arr. Cass., 1974, 395.

Nys, H., *Medical Law in Belgium*, Kluwer Law International, 2010, p.80.

<sup>115</sup> Cass, 13 January 1930, Pas., 1930, I, 115.

<sup>116</sup> Until recently, the limitation period for an action in tort, as a rule, was 30 years; it was five years when the tort constituted a criminal offence. The Act of 10 June 1998 adopted a limitation period of five years from the moment the victim is aware of the damage and of the identity of the liable party; in no event may it be longer than 20 years from the fact caused the damage. The period of limitation for contractual claims is presently ten years, from the moment conditions for liability are met.

Kruithof, M., and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, 2017, p.247

that the relationship between the physician and the patient is contractual.<sup>117</sup> Breach of physician's professional obligations entails liability of a contractual character. This interpretation is the most plausible one because an agreement regarding medical assistance has all the features of a normal contract and there is no reason to exclude it from contract law.<sup>118</sup>

13. Private medicine is also performed according to contracts. The relevant contract will often be between the patient and the doctor who provides the care. The insurers and private hospitals sometimes complicate the position. Therefore, a contract may exist between the insurer and a hospital rather than the patient and the doctor. In the simple situation of a contract for treatment between the patient and a doctor, the contract in practice, adds little or nothing to the law of tort. Belgium (and France) use contractual models for establishing the liability of a doctor, but the courts in all jurisdictions have been very reluctant to read the governing contracts. The courts regard the governing contracts as an agreement by the doctor to use the skilled care reasonably and to be expected to hold him/herself out as having the expertise of the defendant. The law of tort makes an identical demand. In particular, the courts are unhappy about construing an agreement for a specific medical or surgical result. For instance, a cure of the patients' cancer, or a pair of breasts that look like the ones in the surgeons' brochure. This is because they recognise the vagaries of biology. The clinician never has complete control, and so it is unfair for a contract to assume that s/he does.<sup>119</sup>
14. Moreover, the legal relationships between hospitals, doctors, and patients are possible contractual. Certainly this is an essential element to determine the responsibilities and their legal basis, in case of failure. To know who is responsible and based on which legal rule, it is not necessary to examine public or private hospital. Instead, it is essential to

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<sup>117</sup> Cour de Cassation (France), 20 May 1936, Dalloz Périodique 1936.1.88; see Memeteau, G., *Le Droit Médical* (Paris: Litec, 1985), 280 for discussion and references.

<sup>118</sup> Nys, H., *De overeenkomst in het kader van de uitoefening van de geneeskunde gisteren, vandaag en morgen* (*The Agreement in the Context of the Practice of Medicine yesterday, today and tomorrow* (in *De overeenkomst Vandaag en Morgen*, ed. M. Storme, Antwerpen: Kluwer Rechtswetenschappen), 1990, 495-542.

<sup>119</sup> Foster, C., *Medical Law: A Very Short Introduction*, Oxford University Press, First Ed, 2015, p.64.

check with whom the patient has concluded a contract: with the hospital or with the doctor.<sup>120</sup>

15. Contractual liability requires a valid contract, the non-performance of which has caused damage to one of the contracting parties. If one of these conditions of application of the contractual liability is missing, but the responsible party has committed a fault in a causal relation with the damage, he is a tort and liable. Therefore, a doctor or a hospital will incur extra-contractual liability when no medical / hospital contract has been concluded (§ 1), when this contract is null (§ 2), when the injured patient is not party to the contract (§ 3) finally, where the damage does not result from the non-performance of the medical contract (§ 4).<sup>121</sup>
  
16. The medical damage can be contractual as well as extra-contractual in nature. The question, in this case, concerns whether the patient who is bound by an agreement with the doctor can claim compensation for his suffered damage on an extra-contractual basis from the doctor. According to the confiscation ban, it is in principle not to claim extra contractually between parties that have an agreement. Unless the fault and the damage are alien to the execution of the contract.<sup>122</sup> An extra-contractual claim between contract parties is possible if the error is a shortcoming, not to a contractual obligation but to the general duty of care and if that error has caused damage other than the poor performance of the contract.<sup>123</sup> The victim who wants to claim extra-contractually must, therefore, prove that the error s/he is charged to the doctor does not constitute an infringement of the contractual obligations but on the general due care standard. He must also show that the damage does not result solely from the defective performance of the contract.<sup>124</sup>

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<sup>120</sup> Vansweevelt, T., *La Responsabilité des Professionnels de la Santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol. 1, 2015, p. 7.

<sup>121</sup> Vansweevelt, T., *La Responsabilité des Professionnels de la Santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol. 1, 2015, p. 9.

<sup>122</sup> Cass 4, 3 December 1975, Pass. 1976, I, 412.

<sup>123</sup> Case 14, October 1985, *Pas.* 1986, I, 155.

<sup>124</sup> Delphine, F., *De Medische Aansprakelijkheidsverzekering (The Medical Liability Insurance)*, 2013, Master's Thesis of the Master of Law Program, Faculty of Law of Gent University, p. 12.

17. It should be noted that, under Belgian law, there is no longer much difference between contractual liability and tort liability. A certain process of harmonization between the two regimes of responsibility has been noted in recent years. At the level of the gravity of the fault, the burden of proof and the extent of the compensation are almost two similar schemes. In the tort liability regime, the patient must prove that the physician's fault caused the damage. More precisely, it must also be shown that the physician did not have the diligence that could be expected from a normally diligent physician of the same category and placed under the same circumstances.<sup>125</sup>
18. A person injured by a defective product (in the medical sector) can base his claim either on the general provision of a contract, tort law or on the specific provisions of the Product Liability Act of 25 February 1991 without proving fault.<sup>126</sup>
19. A victim of a medical mistreatment also has the possibility to lodge a criminal complaint on the basis of Art. 418 of the Belgian Criminal Code (involuntary homicide and injuries).<sup>127</sup>

## 2.2. *Tort of negligence with fault*

### 2.2.1. *Fault*

20. Under Belgian law, the general liability rule relates to the fault concept is laid down in Article 1382 of the Civil Code.<sup>128</sup> The basic rule imposes liability on those who have been shown to have wrongfully caused the damage.<sup>129</sup> The fault is the basis for

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<sup>125</sup> Vansweevelt, T., *La responsabilité des professionnels de la santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.1, 2015, p.73.

<sup>126</sup> *Moniteur Belge of 22 March 1991 (Belgian Official Journal of 22 March 1991)*.

<sup>127</sup> Hennau-Hublet, C., *L'activité médicale et le droit penal (Medical Activity and the Criminal Law)*, Bruylant, 1987, p.144 ;

Naeyaert, Carsau and De Roeck, *Medical Errors and Compensation under Belgian Law*, p2;

[www.ncd-law.be/publications/Publicatie\\_Medical%20errors.pdf](http://www.ncd-law.be/publications/Publicatie_Medical%20errors.pdf)

<sup>128</sup> Article 1382 of the Civil Code: "Any act by which a person causes damage to another makes the person through whose fault the damage occurred liable to make reparation for such damage."

<sup>129</sup> Kruithof, M., and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, 2017, p. 249.

malpractice in contract or in tort that the claimant can chose either.<sup>130</sup> The principle is that a tortfeasor cannot be held liable if a fault is not imputable to him<sup>131</sup> if the claimant looks for compensation under the tort. The condition of blameworthiness relates to the free will and the capacity of discretion of the tortfeasor.<sup>132</sup> Each of the prerequisites to establish liability under Article 1382 of Civil Code is assessed on the basis of specific criteria. In principle, the actual findings regarding the existence of a fault neither depend nor affected by the findings concerning damage and causation.<sup>133</sup>

21. A fault is a violation of a written or unwritten rule of conduct in force to a certain society, at a certain moment. It is a flexible concept and the contents of which may vary according to time and place. Alternatively, it can be referred to as a socially unacceptable behavior. Two main subcategories of fault are distinguished. The fault can consist of negligence and departure from the general duty of care. Subject to an invincible mistake or other causes of justification rises fault from violation of statutory, regulatory provisions imposing a specific conduct and a duty to abstain.<sup>134</sup>
22. Under Belgian law, negligence as a breach of a duty of care requires that one take precautions in order not to cause harm to the person or property of others.<sup>135</sup> Negligence is not taking the amount of care a “normally prudent person” would have taken. Care is an effort aimed at protecting the interest of others. Such effort can consist of positive action, aimed at limiting the risks to others or abstaining from undertaking certain actions which increase the risk to others. Thus, both action and inaction can be negligent. However, there is no requirement to commit all efforts necessary to avoid harm to others. The cause of damage in itself does not constitute negligence.<sup>136</sup> The defendant’s

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<sup>130</sup> Widmer, P., *Unification of Tort Law: Fault*, Kluwer Law International, 2005, p. 30.

<sup>131</sup> H. van den Berghe/M. van Quickenborne/P. Hamelink, [1980] TPR, 1170-1171.

<sup>132</sup> Faure, M. and Bergh, R., *Negligence, Strict Liability and Regulation of Safety under Belgian Law: An Introductory Economic Analysis*, The Geneva paper on Risk and Insurance, 1987, p.98.

<sup>133</sup> Widmer, P., *Unification of Tort Law: Fault*, Kluwer Law International, 2005, p.32.

<sup>134</sup> Kruithof, M., and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, 2017, p. 250.

<sup>135</sup> Cass. 22 March 1957, *Pas.* 1957, I, 885.

<sup>136</sup> Court of Cassation 4 May November 2012 (C.10.0080.F), No. 276, 2012, *Pasicrisie belge* 1007.

conduct is compared to the behavior of a reasonable man (*bonus pater familias*),<sup>137</sup> a hypothetical normally prudent and careful person, who is placed in the same external circumstances.<sup>138</sup>

23. One of the most relevant circumstances is the foreseeability of the occurrence of harm.<sup>139</sup> The reason only requires one to take into account risk that the person is aware. Therefore, the same behavior can be negligent in one set of circumstances in which one should have realized certain third parties. This would be subject to the risks and not negligent on others who would not have expected other people to be affected.<sup>140</sup>
24. The casuistic character of the concept of negligence can distill from the case law a number of guiding principles for its application. One of the more important ones is that the prudent professional must conform to the normal standard of care required by state of the art in his profession. The use of un-adopted or outdated technology also constitutes negligence. Although case law does not allow a definition of a commonly accepted standard such as that of the best available technology. One is further under a duty to take reasonable measures to prevent damage if one exposes others to unusual risk.<sup>141</sup>
25. Establishing fault liability under Belgian law requires the joint presence of a fault, damage, and causal link between the fault and damage. In other words, a fault will only trigger liability if it lies at the basis of damage.<sup>142</sup>

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<sup>137</sup> Cornelis, L., *Principes du droit belge de la responsabilité extra-contractuelle*, (*Principles of the Belgian Law of Non-contractual Liability*), Bruylant 1991, p.39.

<sup>138</sup> Cass. 22 March 1957, *Pas.*1957, I, 885; Kruithof, M. and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, Second Ed, 2017, p. 250.

<sup>139</sup> Court of Cassation 12 November 1951, 1952 *Pasicrisie belge* 128;

Court of Cassation 24 October 1974, 1975 *Pasicrisie belge* 802.

<sup>140</sup> Kruithof, M. and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, Second Ed, 2017, p. 249.

<sup>141</sup> Kruithof, M. and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, Second Ed, 2017, p. 248-249.

<sup>142</sup> Widmer, P., *Unification of Tort Law: Fault*, Kluwer Law International, 2005, p.32.

### **2.2.2. Duty of care**

26. As presented, the duty of care originates either from a contract or tort. When does a physician meet his duties? What or how much care is owed in general and correspondingly to what degree of negligence is the physician liable? A general answer to these questions is to be found in the landmark decision of the French Cour de Cassation of 20 May 1936. The contract between the physician and his patient results in an obligation. It does not mean to cure the patient but to offer medical help conscientiously and diligently in conformity with the data and advances in medical science. As expressed in a more recent decision of the same court, such care must conform to the current data and advances of medical science, in the sense that the current level of scientific progress should be taken into consideration. The Belgian Cour de Cassation put an end to a discussion regarding the degree of care owed to a patient in general.<sup>143</sup>

### **2.2.3. Breach of a duty of care**

#### **2.2.3.1. In general**

27. Breach of his professional duty entails liability of a contractual character. This interpretation is the most plausible one since an agreement regarding medical assistance has all the features of a normal contract, and there is no reason to exclude it from the contract law. Non-contractual or tortious liability is also relevant in the case of damage to a third party or in a situation where the services are rendered to a patient when the patient is not in a position to give consent to treatment.<sup>144</sup>
28. A physician who causes personal injuries through malpractice breaches not only his contract with his patient but also commits a tort. A decision of the Court of Cassation of 7<sup>th</sup> December 1973 excludes the so-called concurrent proceed in contracts and torts. The law of delict as laid down in Article 1382 of the Civil Code is inapplicable to a fault

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<sup>143</sup> Nys, H., *Medical Law in Belgium*, Kluwer Law International, 2010, p.80.

<sup>144</sup> Vansweevelt, T., *La Responsabilité des professionnels de la santé (The Responsibility of Health Professionals)*, *Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.1, 2015, p. 73.

committed in the execution of a contractual obligation.<sup>145</sup> Nevertheless, if the breach of contract may be considered a criminal act at the same time (which in the case of MM may often be the case of the bodily infringement), an action for breach of duty in torts or delict remains possible.<sup>146</sup>

29. Similar to the common rule, breach of a duty of care is to prove that the physician failed to live up to the required standard of care.<sup>147</sup> Indeed, the standard of care should be defined as an establishment of the breach of duty.

#### 2.2.3.2. *Standard of care*

30. The Belgian Court of Cassation accepted the decision of the French Court of Cassation (*Mercier case*<sup>148</sup>). This is a contract between a physician and his patient resulting in an obligation 'not to cure' the patient but to offer him medical help conscientiously and attentively in conformity with the data and advances of medical science. The current level of scientific progress takes this into account. Consequently, a physician is under the obligation to use reasonable care and skills (effort) but is not required to cure the patient or to achieve a specific result (result obligation) since the outcome of a treatment is uncertain. On the other hand, the treatment not only depends on the skilled exercise of the medical practitioner but also on the physical state and reactions of the patient. As a result, a patient must show that he suffered harm because of the physician's fault which can consist of negligence, lack of skill, incorrect information, among others. However, exceptions are made by the courts in cases where a physician uses a known treatment, whose outcome is certain and which the physician is in full control of the healthcare provider. In such situations, the courts can hold a physician liable for not achieving a specific result, unless the physician can prove that the failure was not attributable to

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<sup>145</sup> Court of Cassation, 7 December 1973, *Arr. Cass.*, 1974, p. 395.

<sup>146</sup> Vansweevelt, T., *La responsabilité civile du médecin et de l'hôpital (The Civil Liability of the Physician and the Hospital)*, Maklu, 1996, p. 333;

Nys, H., *Medical Law: Supplement 44 Belgium, International Encyclopedia of Laws : Medical Law*, 2012, p.74.

<sup>147</sup> Deutsch, E. and Hans-Ludwig, S., *Medical Responsibility in Western Europe*, Springer, 1985, p.138.

<sup>148</sup> *Mercier*, Civ., 20 th May 1936, DP 1936.1.88.

him. Belgian judges have applied this reasoning in the case of failed abortion or sterilisations.<sup>149</sup>

31. A physician has no obligation to cure the patient but to exercise care that meets the normal professional standard. This means that the quality/standard of care should not fall below the care that would be shown in the same circumstances by a reasonable or careful physician. In defining this standard, the account taken is not based on individual qualities of a specific physician, but the typical qualities, skill, and learning commonly possessed by members of the medical profession in good standing.<sup>150</sup>
32. The physician's action in question should, therefore, be checked whether it complies with the stipulated medical standards. The Belgian jurisprudence is reasonably unanimous and generally speaks of a "normally competent and prudent physician",<sup>151</sup> sometimes a "good physician".<sup>152</sup>
33. In order to find the appropriate standard of conduct, a simple reference to "diligent" is not always sufficient. A more thorough concretisation is sometimes necessary on the particular professional knowledge or the specialisation of each physician. In reality, professional capacities should not be regarded as a personal quality of the debtor but rather as a requirement connected with the exercise of a certain activity. In other respects, the behaviour of the physician must be verified about the diligence required for a certain medical act and irrespective of the medical title of the physician being treated.<sup>153</sup>

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<sup>149</sup> Nys, H., *Medical Law in Belgium*, Kluwer Law International, p.82.

<sup>150</sup> Genicot, G., *Droit Medical et Biomedical (Medical and Biomedical Law)*, Larcier, 2016, p. 389.

<sup>151</sup> Liege, 17 avril 1972, *Jur. Liege*, 1972, 281; Gand, 5 dec. 1975, *R.W.*, 1976-1977, 1013.

<sup>152</sup> Trib. Courtrai, 23 juin 1960, *R.W.*, 1961-1962, 1812.

<sup>153</sup> Vansweevelt, T., *La responsabilité des professionnels de la santé (The Responsibility of Health Professionals)*, *Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.1, 2015, p. 27-28.

### 2.3. *Damage*

34. The actual Belgian law of damages is largely based on case law. The plaintiff-friendly scope of protection results from the broad interpretation that has always been given by the courts to the open and global terminology of the Articles 1382-1383 of the Civil Code concerning civil liability.<sup>154</sup> The Civil Code contains basic provisions governing the law of damages for personal injuries and requires any person who because of his conduct or negligence is responsible for causing harm to another person and compensates that person for the damage caused.<sup>155</sup>
35. The existence of the damage to the patient is an essential condition for concluding that the doctor is responsible. There is no civil liability without damage. In order to be compensated, the damage must, among other things, be certain. This means that the damage must exist and cannot be merely hypothetical because the damage is always the result of the comparison with a hypothetical element. However, the damage is never certain. In this regard, the judge will have to be satisfied with a "judicial certainty." This means a high degree of probability conforms to the ordinary course of things.<sup>156</sup>
36. Belgium classifies damage into two main heads: economic damage and non-economic damage.

#### 2.3.1. *Economic damage*

37. No statutory definition of recoverable pecuniary loss is given under Belgian law. To access the pecuniary damages following incapacity to work, the judge will use the capitalisation method based on the victim's earning unless there is insufficient data to establish the earning accurately enough. It is said that in those circumstances, damages

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<sup>154</sup> Cousy, H and Droshout, D., *Non-pecuniary Loss under Belgian Law* in Spier, J (ed.), *Unification of Tort Law: Liability for Damage Caused by Others*, Springer, Wien- New York, 2003, p.18.

<sup>155</sup> Quirke, J., *The Report of the Working Group on Medical Negligence and Periodic Payments*, Module 1, 2010, p. 16;

<http://courts.ie/>

<sup>156</sup> Vansweevelt, T., *La responsabilité des professionnels de la santé (The Responsibility of Health Professionals)*, *Responsabilités. Traité théorique et pratique*, Wolters Kluwer, 2015, p.67.

will be evaluated *ex aequo et bono*<sup>157</sup>. This method is also applied if the capitalisation method leading to under-estimation or over-valuation of the damages. The application of the *ex aequo et bono* method requires the judge to justify why the mathematical calculation proposed by the victim cannot be applied. The judge also concludes the impossibility to establish the recoverable damages because of lack of sufficient criteria. It also occurs that capitalisation is applied starting from an *ex aequo et bono* assessed calculation base, e.g., for the assessment of compensation for a young child for the loss of earning capacity if the child had not been injured.<sup>158</sup>

### 2.3.2. *Non-economic damage*

38. To establish a successful claim for damages, the plaintiff must prove that the damage satisfies three requirements. These requirements apply both to pecuniary and non-pecuniary loss. To be legally recognised as being recoverable, the damage has to be precise, personal and legitimate.<sup>159</sup> The Supreme Court of Belgium has consistently recognised the role of trial judges in determining the existence of loss and in calculating the quantum of damages. As such, the Belgian courts enjoy extensive discretionary powers about the assessment and award of damages for personal injuries. Damages for future loss may be awarded as a lump sum or by periodic payment. The court has the discretion to decide the method of compensation to be employed. If the way of periodic payment awards damages, the court may order that an index-linked annuity is purchased to provide for the payment in the future. Parties to a personal injuries claim are also entitled to compromise an action by periodic payments.<sup>160</sup>

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<sup>157</sup> The concept *ex aequo et bono* is supposed that an adjudicator, by deciding according to what which notwithstanding to that which is “fair” and “good”, acts “outside of the law”, or more pejoratively, acts notwithstanding the law”.

Black’s Law Dictionary 557 (West 6<sup>th</sup>ed 1990) ( defining *ex aequo et bono* as “in justice and fairness; according to what is just and good, according to equity and conscience”)

<sup>158</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p. 81-82.

<sup>159</sup> Cousy, H. and Droshout, D., *Non-pecuniary Loss under Belgian Law*, in J. Spier (ed.), *Unification of Tort Law: Liability for Damage Caused by Others*, Springer, Wien- New York, 2003, p.31.

<sup>160</sup> Quirke, J., *The Report of the Working Group on Medical Negligence and Periodic Payments*, Module 1, 2010, p. 15- 16;

## 2.4. Causation

### 2.4.1. In general

39. The plaintiff must prove not only that the defendant physician was negligent, but also the defendant's negligence was the cause of the damage that he or she has sustained. To determine when a fault can be considered as the cause of the damage, the theory of equivalence of conditions is appealed<sup>161</sup> under the Belgian law.
40. According to this theory, every fault, without which the damage would not have occurred as it happened *in concreto*<sup>162</sup> must be considered as the cause of the damage. This means that every fault which is a necessary condition for the damage entails responsibility. No selection is made between faults that have *a sine qua non*<sup>163</sup> relationship with the damage." These faults constitute the cause of the damage and are equivalent ".<sup>164</sup>
41. The application of the rigid rules of this theory, among other things, results in injury not being a direct consequence of fault only. The indirect cause of the damage is also sufficient to incur liability. It is only required that there is a necessary link between the

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<http://courts.ie>

<sup>161</sup> Vansweevelt, T., *La responsabilité des professionnels de la santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, 2015, p.71-72.

<sup>162</sup> Cousy, H and Droshout, D., *Non-pecuniary Loss under Belgian Law* in Spier, J (ed.), *Unification of Tort law: Liability for Damage Caused by Others*, Springer, Wien- New York, 2003, p.18.p.273;

*in concreto* means in the concrete.”(1) Concretely or palpably thinking or speaking. (2) With reference to actual, verifiable facts, rather than theoretically;

<http://www.oxfordreference.com/view/10.1093/acref/9780195369380.001.0001/acref-9780195369380-e-897>;

*in concreto* is considered as an ordinary negligence arising from one's failure to exercise such care in the interest of another as he exercises in his own affairs; <https://www.merriam-webster.com/dictionary/culpa%20levis%20in%20concreto>

<sup>163</sup> *Conditio sine qua non* means a necessary condition with the damage are in casual link with the damage, whatever their gravity and whatever the degree of distance with the damage. (I. Durant, “A propos de ce lien qui unit la faute au dommage” (About this link that blends fault with damage), in *Droit de la responsabilité*, CUP, N°68, Brussels, Larcier, 2004, p.16.)

<sup>164</sup> Vansweevelt, T., *La responsabilité des professionnels de la santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.1, 2015, p.71-72; H. Vandenberghe *et al.*, *o.c.* T.P.R 1980, p. 1348, n° 171.

fault and the damage. In other words, it is necessary that in the absence of fault, the damage would not have occurred as it has occurred in concrete. Some examples drawn from jurisprudence may clarify this rule:

1. A situation whereby a surgeon leaves/forgets a needle in a patient's body after a surgical procedure. This negligence forces a second operation to remove the international instrument. During this procedure, an operative risk develops, and the patient dies. The death of the patient becomes causally related to the physician's initial fault. Indeed, the operative risk and therefore the damage would not have occurred without its negligence';
  2. As a result of a doctor's fault during an operative procedure, it happens that the patient must be transferred immediately to a better-equipped hospital for treatment. During the transfer, the ambulance is involved in a traffic accident which results in the loss of valuable time. Subsequently, the patient dies. Without the doctor's initial fault, the damage would not have occurred as it was produced *in concreto*, so that doctor can be held responsible for the loss.<sup>165</sup>
42. The standard of proof is high because the causal relation must be established with near certainty. To alleviate the severe burden of proof of the patient, the judge may use the criterion of “the thing speaks for itself,” the “judicial presumption” or “*res ipsa loquitur*”<sup>166</sup> doctrine.

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<sup>165</sup> Vansweevelt, T., *La responsabilité des professionnels de la santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.1, 2015, p.71-72.

<sup>166</sup> *Res ipsa loquitur* (“the thing speaks for itself”) is a doctrine which enables to the plaintiff to prove duty and breach by circumstantial evidence. It was develop by common law courts to cover cases in which the plaintiff did not have access to the facts of an accident. According to *Sott v. Lodon and St. Katherine Docks Co.*, 159 Eng. Rep. 665 (Ex. 1865), the plaintiff must prove three elements in order to invoke the doctrine of *res ipsa loquitur*:(1) an absence of an explanation for how the accident happened; (2) that the cause of harm (the “thing”) was under the complete control of the defendant; and (3) that the accidents is od a kind that will not ordinarily occur without negligence. (Thomas Landmark, *Common Law Tort & Contract*, Lit Verlag, 1998, p.57.)

43. To invoke *res ipsa loquitur*,<sup>167</sup> the plaintiff has an initial burden to establish three conditions:

1. The general experience of mankind shows that the accident does not usually occur in the ordinary course of events without negligence on the part of those in control;
2. The person against whom the doctrine is sought to be invoked must have been in exclusive control of the instrumentality;
3. The person invoking the doctrine must not be in a position to know the cause of the accident;
4. The person against whom the doctrine is invoked must possess knowledge concerning the cause of the accident, or he must be in a better position to obtain that knowledge, so that the duty of explaining the accident should be in fairness, rest upon the person because of the greater means of knowledge.

<sup>168</sup>

44. Usually, this criterion will be used when the physician has left one of the instruments in the body of a patient or when the result of treatment is strange as compared with the normal result of treatment. In applying the theory of equivalence, the judge has to construct the events leading to the damage hypothetically and to imagine away the fault of the defendant. If the damage remains the same, the fault was not a necessary condition for the damage. It may be hard to apply this reasoning, in cases where it is uncertain what would have happened if a certain fault had not been committed. If the doctor had applied the correct treatment, the patient might still not have recovered. Here, the courts find a way out by compensating the victim for the loss of chance of recovery.<sup>169</sup>

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<sup>167</sup> Genicot, G., *Droit Medical et Biomedical (Medical and Biomedical Law)*, Larcier, 2016, p. 353.

<sup>168</sup> Leary, E., *Let Your Case Speak for Yourself*, 2014, p1;

[www.plaintiffmagazine.com](http://www.plaintiffmagazine.com)

<sup>169</sup> *Cf. infra* 2.2.5.3.

### 2.4.2. *Burden of proof*

45. The burden of proof mostly constitutes an important and very decisive issue. The patient who wants to sue a physician or a hospital has to prove the loss (the deterioration of the health status of the patient), the causation between the loss and fault. The patient always has to furnish the evidence (Article 1315, Civil Code).<sup>170</sup>
46. In civil procedures based on offences, e.g., a physician who carries out an intervention without informed consent and violates Article 392 of the Criminal Code, the physician is innocent as long as his/her guilt is not proven and (Article 6 European Convention on Human Rights) must be applied. In a judgment of 14<sup>th</sup> December 2001,<sup>171</sup> the Belgian Court of Cassation decided that the burden of proof concerning the issue of improper informed consent remain on the patient. The Court reasoned its decision by referring to the principle of presumption of innocence in criminal cases. A situation of a civil case like the one that was the object of the procedure before the Court of Cassation, a patient introduces a claim based on the transgression, and the patient must still prove that all factors constituting the transgression are present.<sup>172</sup>

### 2.4.3. *Loss of a chance*

47. The concept of loss of chance is well-known under Belgian tort law.<sup>173</sup> One can say it is used in two kinds of situations. In the first group of cases, to lose a chance is to lose the opportunity to see a situation improving. Most of the time, the application of the ‘but-for test’ leads to the conclusion that without the negligence of the defendant, the pursuer would not have lost the hope to obtain an advantage (patrimonial or physical). In these cases, the problem is not a causal one but is rather a problem concerning the evaluation of the lost opportunity which constitutes damages. In the second group of cases, to lose a chance is to lose the opportunity not to see a situation deteriorating. Mostly, the

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<sup>170</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, Vol.29, 2011, p.73

<sup>171</sup> Cass., 14 December 2001, *T. Gez./ Rev. Dr. Santé*, 2001-2002, 239.

<sup>172</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p.72.

<sup>173</sup> Vansweevelt, T. and Weyts, B., *Handboek Buitencontractueel Aansprakelijkheidsrecht (Extra-contractual Liability Handbook)*, Intersentia, 2009, p. 641-649.

application of the ‘but-for test’ cannot lead to the conclusion that without the negligence of the defendant, the damage would not have occurred. The problem is typically a causal one. For example, one cannot say that without the doctor’s negligence, the patient would not have died because the treatment is successful in only one case out of two. In such cases, one would expect the judges not to hold the doctor liable for the patients’ death. Indeed, one recalls that causation must be certain. Nevertheless, judges have imagined a subterfuge for helping victims by saying that the faulty conduct of the doctor caused certain damage consisting the loss of a chance to have avoided the death (or a worse state).<sup>174</sup>

48. In Belgium, the Court of Cassation applied the theory for the first time in MM in its judgment of 19<sup>th</sup> January 1984.<sup>175</sup> A patient who had many fractures in the legs had been hospitalised. Even though, during the weekend, one of the plaster casts showed a brown colour, his toes had swollen, and he had complained about pain in his legs. The doctor left the patient to fend for himself. The patient developed gangrene and consequently his right leg had to be amputated. The Court of Appeal of Brussels sentenced the doctor to compensate 80% of the damage because he was responsible for the fact that the patient had lost 80% chance of recovery. Although the physician argued that even if there had been appropriate medical care, there was a good chance that the leg would have had to have been amputated. However, the appeal to the Court of Cassation was scientific literature showing that gangrene is the consequence of wrong treatment or treatment that is delayed too long. According to the Court of Cassation, accepting a causal relation between the mistake and the fact that the patient had lost a chance of avoiding amputation was justified. Because his chances of recovery were estimated at 80%, the physician could be sentenced to pay compensation for 80% of the damage.<sup>176</sup>

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<sup>174</sup> Winiger, B., Koziol, H., Koch, B., and Zimmermann, R., *Digest of European Tort*, Springer, Wien - New York, Vol. 1, 2007, p. 557.

<sup>175</sup> Court of Cassation, 19 January 1998, *Arr. Cass.* 1984, 585;

Vanswevelt, T., and Dewallens, F., (eds.), *Handboek Gezondheidsrecht (Handbook of Health Law)*, volume I, 2014, 1387.

<sup>176</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p. 74.

## 2.5. *Tort of negligence without fault (strict liability)*

49. Strict liability is not a new issue in the tort of negligence in Belgium. Under the law, a person injured by a defective product can base his claim either on the general provisions of a contract, tort law or on the specific provisions of the Product Liability Act of 25<sup>th</sup> February 1991.<sup>177</sup> As from the date the Product Liability Act came into force, the recourse to Articles 1382 and 1383 of the Civil Code does not make much sense. Why should the plaintiff accept to bear the burden of proof of a fault of the seller or the manufacturer while he may obtain the indemnification of the damage by proving only the defect in the product as well as the damage and the causal link?<sup>178</sup>
50. Many cases of strict liability in the Civil Code are traditionally explained as a presumption of fault.<sup>179</sup> Article 1384 §1 Civil Code is a strict liability provision. According to it, one incurs liability for damages caused by objects that one has in his keeping. Unlike Article 1382 Civil Code which explicitly requires a fault and accordingly its demonstration, Article 1384 §1 Civil Code rests on a non-rebuttable presumption of fault. In support of his claim, the injured person must prove damage, the defectiveness of the object, and the existence of a causal relationship between the defect and the damage. A defect cannot be inferred from the mere fact, that the object has caused damage.<sup>180</sup> For decades, the Belgian Supreme Court defines the defect as “an abnormal characteristic of the thing which makes it liable, under certain circumstances to cause damage.”<sup>181</sup>

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<sup>177</sup> *Moniteur Belge* of 22 March 1991 (*Belgian Monitor* of 22 March 1991).

<sup>178</sup> Toussaint, B., “Belgium”, in *The International Comparative Legal Guide to: Product Liability*, Global Legal Group Ltd, London, 2013, p.99.

[http://www.liedekerke.com/images/wysiwyg/documentations/PL13\\_Chapter\\_13-Belgium.pdf](http://www.liedekerke.com/images/wysiwyg/documentations/PL13_Chapter_13-Belgium.pdf)

<sup>179</sup> Cf. the discussion in Vansweevelt, T. and Weyts, B., *Handboek Buitencontractueel Aansprakelijkheidsrecht (Manual Extra-contractual Liability Law)*, Intersentia, 2009, 496; cf.

Faure, M. and Bergh, R., *Negligence, Strict Liability and Regulation of Safety under Belgian law: An Introductory Economic Analysis*, The Geneva Papers on Risk and Insurance, Vol.12, 1987, p.102.

<sup>180</sup> Court of Cassation, 1<sup>st</sup> section, 6 March 1981, *RW* 1981-82, 31, comment Ludo Cornelis.

<sup>181</sup> Court of Cassation, 14<sup>th</sup> November 1986, *Pas.* 1987, I, 333;

Court of Cassation, 1<sup>st</sup> section, 1<sup>st</sup> March 1996, *Pas.* 1996, I, 228;

51. This liability is very strict, as defences available under Article 1384 §1 Civil Code are limited, namely the *force majeure*, (i.e., an event independent of the custodians) will be unpredictable and unavoidable), the victim's contributory fault, negligence, the act of a third party or an external cause. However, liability under article 1384 §1 Civil Code has limited relevance in matters of product liability. It rests on the custodian of the object, whom the Supreme Court defines as the person who exerts physical control over the object.<sup>182</sup> Thus, it is only in rare circumstances that the manufacturer or the professional supplier of the object will be considered as its custodian and will incur liability by article 1384 §1 Civil Code.<sup>183</sup>
52. Besides, the main text governing strict liability in Belgium is the Product Liability Act of 25<sup>th</sup> February 1991. A patient who is a victim of a defective object can also take another route, namely the Law of 25<sup>th</sup> February 1991 on liability for defective products. The Act of February 1991 implements the European directive on product liability.<sup>184</sup> This law imposes liability without fault on the producer. This means that the producer is liable for the damage caused by a defect in his product without proof of his fault being required.<sup>185</sup> It is important to note, certainly about the subject matter herein that the Product Liability Act does not distinguish between the lessee as a contractor or a third party. The victim of the damage may, by this law, render the producer liable for the damage caused by a defect in his product, regardless of the contractual or tort legal relationship with the producer. The Product Liability Act defines the term "product" as any tangible personal property. At first sight, there are few problems of interpretation about auxiliary medical matters: radiographic and narcosis equipment, prostheses,

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Kruithof, M. and Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, Second Ed, 2017, p.264;

Vansweevelt, T. and Weyts, B., *Handboek Buitencontractueel Aansprakelijkheidsrecht (Handbook on Extra-contractual Liability Law)*, Intersentia, 2009, 459.

<sup>182</sup> Court of Cassation, 25 March 1943, *Pas.* 1943, I, 110.

<sup>183</sup> Vansweevelt, T. and Weyts, B., *Handboek Buitencontractueel Aansprakelijkheidsrecht (Manual Extra-contractual Liability Law)*, Intersentia, 2009, p. 482.

<sup>184</sup> Directive du Conseil du 25 juill. 1985 (Council Directive of 25 July 1985), *J.O.C.E.*, 210/29; Wuyts, D., *The Product Liability Directive-More than Two Decades of Defective Products in Europe*, *JETL*, 2014, p. 1-34.

<sup>185</sup> Art. 1<sup>er</sup> Law of Product Liability.

needles, and other medical instruments. Means of assistance can be listed in the notion of "movable property." However, the parts of the body that man can donate (e.g., blood, tissue, organs, sperm) are also to be regarded as movable property and therefore fall under the broad concept of the law of "product." For whenever this "human material" is separated from the body, it exists in itself as a matter or independent movable thing upon which real rights are possible for damage caused by contaminated blood or a defective kidney.<sup>186</sup>

53. Under the Act, the producer is automatically liable for damage caused by a defect in his product. Thus liability without fault exists concerning any injured person (the buyer or another party). According to Article 7 of the Act, the burden of the proof of defect, the damage and causal link between the defect and the damages belong to the injured person. Art. 8 of this Act enumerates six defences for the producer. One of them is the state of the art which is the development risk defence that can be relevant for pharmaceuticals in particular.<sup>187</sup>
54. By way of example, the following cases are ways in which the Belgian case-law has accepted the responsibility of the producer for a defective product in the medical sector:<sup>188</sup>
- A bottle of limestone that explodes;<sup>189</sup>
  - A defective solution of perfusion to rinse an organ;<sup>190</sup>

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<sup>186</sup> Vansweevelt, T. and Weyts, B., *Handboek Buitencontractueel Aansprakelijkheidsrecht (Handbook on Extra-contractual Liability Law)*, Intersentia, 2009, p. 482.

<sup>187</sup> Vansweevelt, T., *La responsabilité des Professionnels de la Santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.2, 2015, p.36, p.76.

<sup>187</sup> Moniteur belge of 22 March 1991 ;

more in detail : Vansweevelt, T. and Dewallens, F., (eds.), *Handboek Gezondheidsrecht*, Vol.I, Intersentia, 2014, p. 516-1526.

<sup>188</sup> Vansweevelt, T., *La responsabilité des Professionnels de la Santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.2, 2015, p.38.

<sup>189</sup> Trib. Gand, 7 mai 2004, *T. Gez/Rev. dr. santé*, 2007208, 162.

<sup>190</sup> C.J., 10 mai 2001, C-203/99. Henning Veedfald;

- A defective vaccine;<sup>191</sup>
- Contaminated blood from the bacterium *Pseudomonas putida*.<sup>192</sup>

55. However, there were no any regulations to adjust MM based on strict liability. Later, till the appearance of the Law of May 15, 2007, and Law of March 31, 2010, on the Compensation for Damages Resulting from Medical Care have brought more effective rules to the law of MM in this country. The rules have especially created more opportunities for patients to seek for compensation which they have not satisfied in fault-liability compensation.
56. The author will discuss more the conditions of the new rules applied in the section of no-fault compensation.<sup>193</sup>

## 2.6. *Criminal negligence*

57. In many cases, a fault of a physician causes bodily harm to the patient and may be qualified as a criminal act in the sense of Article 418 Criminal Code (involuntary homicide and personal injury).<sup>194</sup> Since a professional medical offence generally coincides with the criminal offence of involuntary homicide (Article 418), the injured patient may opt for action in respect of criminal liability.<sup>195</sup>
58. These articles specify that a doctor's charge of unintentional blows, wounds or unintentional homicide rests on the conjunction of three elements: a) a fault which can be defined as any act which would not have been carried out by any other doctor of the same specialty who is normally cautious, competent and diligent, and placed in identical

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<sup>191</sup> Trib. Arlon, 23 févr.2006, *J.L.M.B.*, 2006, 1205; Delforge, C., *La Responsabilité du Fait des Produits (Product Liability)*, in *L'indemnisation des Victimes d'accidents Médicux en Europe (Compensation to Victims of Medical Accidents in Europe)*, Bruxelles, Bruylant, 2015, p.295.

<sup>192</sup> Trib. Liège, 26 mars 2002, *R.G.A.R.*, 2002, n° 13.572.

<sup>193</sup> *Infra Chapter 5.*

<sup>194</sup> Hennau-Hublet, C., *L'activité Médicale et le Droit Penal (Medical Activity and Criminal Law)*, Bruylant, 1987, p.144.

<sup>195</sup> Vansweevelt, T., *La responsabilité des Professionnels de la Santé (The Responsibility of Health Professionals)*, *Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.1, 2015, p.75-76.

circumstances; b) a harm: either the patient's death (homicide) or blows and wounds which can be caused by simple omission; and c) an obvious relationship of cause and effect between the fault and the harm. The absence of a practitioner's recording of his free and conscious patient's consent is considered similar to a fault by the doctrine.<sup>196</sup>

59. It must be accepted that the person who suffers the damage in the case mentioned above may bring an action by Articles 1382-1383 of the Civil Code before the criminal court.<sup>197</sup> Applied to medical liability, the patient who is a victim of professional misconduct can choose between contractual and extra-contractual responsibility, and this seems fair in most cases. Moreover, the jurisprudence is also established in this sense.<sup>198</sup> For MM, generally coincides with the offences of manslaughter or involuntary assault (Article 418 and s. C. pén).<sup>199</sup>
60. One of the most important legal obligations owed by a physician to a patient is the protection of confidences revealed by the patient to the physician. Article 458 of the Criminal Code lays upon a physician, a legal obligation not to disclose confidential information concerning a patient which s/he learns in the course of his professional practice.<sup>200</sup> The doctor's obligation of non-disclosure applies not only to information acquired directly from the patient but also to information concerning the patient which the doctor learns from other sources as the patient's doctor.<sup>201</sup>

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<sup>196</sup> Naeyaert, H., *Medical Errors and Compensation under Belgian Law*, p.2;

[www.ncd-law.be/publications/Publicatie\\_Medical%20errors.pdf](http://www.ncd-law.be/publications/Publicatie_Medical%20errors.pdf)

<sup>197</sup> Cass., 16 May 1974, *Pas.*, 1974, I, p. 1973;

Vansweevelt, T., *La Reponsabilité des Professionnels de la Santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, 2015, Vol.1, p.75-76.

<sup>198</sup> Bruxelles, 31 mars 196 1960, *Pas.*, 1961, II, p.154; Trib. Turnhout, 24 févr.1981, *R.G.A.R.*, 1982, 10.480;

Trib. Louvain, 17 déc.1983, *VI. T. Gez.*, 1989, 2892; comp. Bruxelles, 11 mai 1971, *J.T.*, 1972, 358.

<sup>199</sup> Vansweevelt, T., *La Responsabilité des Professionnels de la Santé (The Responsibility of Health Professionals), Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.1, 2015, p.76; See more detailed, to subject, by Vansweevelt, T., *Aids and the Law*, Maklu, 1987, no.34.

<sup>200</sup> Blockx, F., *Beroepsgeheim (Professional Secret)*, Intersentia, 2013, 507 p.

<sup>201</sup> *Right to Privacy - Medical Secrecy: Belgium*

61. Not all medical malpractices are criminal offences. An example can demonstrate this. A situation where a doctor agrees with his/her patient not to inform him/her of the HIV result of HIV tests. When the doctor fails to keep the promise, s/he violates the patient's right; it is a "right not to know." Such non-performance may cause harm to the patient even though it is not a criminal offence.<sup>202</sup>
62. This analogy between civil and criminal fault may partially explain the relatively high number of cases of criminal prosecution against physicians in Belgium.<sup>203</sup>

### 3. Medical malpractice law in France

#### 3.1. *Background*

63. France's Civil Code of 1804 promulgated by Napoleon shortly before he became Emperor put into the statutory form vast areas of French private law. The 2,283 articles of the original Code governed (what those trained in the common law) would call the law of torts, contracts, property, and the family (including the law of inheritance). Surprisingly, only five of those two-thousand-plus articles (articles 1382 to 1386) addressed what we could call tort law. Among them, Article 1382<sup>204</sup> proclaimed the fault principle: one must make reparation for injuries caused by one's fault. Article 1383<sup>205</sup> then defined to include negligence.<sup>206</sup>
64. Before the Patient's Rights Law of March 4, 2002, MM liability in the private sector was viewed as a matter of contract law. This was due to a famous ruling of the *Cour de*

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[http://europatientrights.eu/countries/not\\_ratified\\_not\\_signed/belgium/belgium\\_right\\_to\\_privacy\\_medical\\_secrecy.html](http://europatientrights.eu/countries/not_ratified_not_signed/belgium/belgium_right_to_privacy_medical_secrecy.html)

<sup>202</sup> Vansweevelt, T., *La Responsabilité des Professionnels de la Santé* (The Responsibility of Health Professionals), *Responsabilités. Traité théorique et pratique*, Wolters Kluwer, Vol.1, 2015, p.76.

<sup>203</sup> Nys, H., *Medical law in Belgium*, *International Encyclopedia of Laws: Medical Law*, Kluwer Law International, 2010, p.87.

<sup>204</sup> Article 1382: Any act of a person which causes injury to another obligates him by whose fault it occurred to make reparation.

<sup>205</sup> Article 1383: Everyone is liable for the injury he has caused not only by his act, but also by his negligence.

<sup>206</sup> Tomlinson, E., *Tort Liability in France for the Act of Things: A Study of Judicial Lawmaking*, *Louisiana Law Review*, Vol. 48, 1998, p.1299-1300.

*cassation* in the Mercier case.<sup>207</sup> Since 1936, a contract was deemed to be formed between a doctor and a patient, thereby excluding the application of tort principles. However, there was no deemed contract when the patient was unable to accept care (and his or her family, partner, or designated contacts could not be contacted). The liability regime was the one based on tort principles. The Law of March 4, 2002, modifies the legal basis for medical liability, which is now regarded as a “legal regime” that is neither contractual nor tortious. If a physician breaches his or her duty to inform, the applied provision is now Article 1382 of the Civil Code which means the physician’s responsibility is based on tort law.<sup>208</sup>

65. In another word, where the law does create medical liability, this may be under the heading of either tort or contract.<sup>209</sup> Contractual liability imposes sanctions for the non-observance of contractual obligations while tort law attaches sanctions to breaches of rules of conduct which are imposed by statute, regulation or case law.<sup>210</sup> In some jurisdictions, patients have a choice between contract and tort.<sup>211</sup>
66. MM was the subject of legislative reform in the Law of 4<sup>th</sup> March 2002. This law has created a liability of an undefined nature, contractual or tortious which applies to all members of the medical profession (physical persons or hospitals) including public hospitals. The law provides that, in principle, medical negligence is only incurred in case of fault (Art L 1142-1). The reason for a defect incurs it in a medical or healthcare

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<sup>207</sup> Civ., May 20, 1936, *DP*. I 1936, 1, 88.

<sup>208</sup> G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, *Chicago-Kent Law Review*, Vol.86, 2011, p.1096-1097.

<sup>209</sup> Hondius, E., *The Development of Medical Liability*, Cambridge, 2010, p.6.

<sup>210</sup> *Introduction to French Tort Law*;

[https://www.biicl.org/files/730\\_introduction\\_to\\_french\\_tort\\_law.pdf](https://www.biicl.org/files/730_introduction_to_french_tort_law.pdf)

<sup>211</sup> Hondius, E., *The Development of Medical Liability*, Cambridge, 2010, p.6.

product. However, it is also incurred in cases without fault with respect to liability for hospital-acquired infections although this is not a common case.<sup>212</sup>

67. As mentioned, the physician's responsibility is based on tort law when he/she breached the duty. Two general provisions govern the liability of the physician's own act, Article 1382-1383, which only require fault, damage, and causation. These requirements imply that negligent conduct which causes damage is sufficient for liability.<sup>213</sup>
68. Below, the author will analyse the elements to establish the liability of a physician who negligently causes harm to a patient. Just like in Belgium's MM law, it is important to demonstrate the standard of care and clarify the elements of tort liability: fault, damage, and causation in the context of MM under the law of France.

### 3.2. *Tort of negligence with fault*

#### 3.2.1. *Fault*

69. There is no definition of fault in the Civil Code.<sup>214</sup> In most cases, fault means that someone has not observed a certain standard of care. Hence, fault liability mainly implies negligence liability. The fault does not imply the notion of the duty of care. Basically, any relationship can give rise to liability. In principle, it is sufficient that negligent conduct caused damage. There are several ways to establish fault. First, a person commits fault if s/he violates a statutory rule. Each statutory rule is considered to have an entire scope in the sense that it protects each person who suffers damage which is caused by the violation of the statutory rule. Secondly, a fault can be established by the breach of a pre-existing unwritten duty. Unwritten duties can be derived from regulations, morals, and technical standards (in the case of MM, the court can use the standard of reference of the competent professional (*le bon professionnel*)).<sup>215</sup>

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<sup>212</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p.210-211.

<sup>213</sup> Dam, C., *European Tort Law*, Oxford University Press, 2006, p.42.

<sup>214</sup> P. Widmer, *Unification of Tort Law: Fault*, Kluwer Law International, 2005, p.92.

<sup>215</sup> Cees Van Dam, *European Tort Law*, Oxford University Press, 2006, p.302.

70. The Patients' Rights Law of March 4, 2002, concurs with the principle of fault-based liability in MM cases. However, it also admits the physicians' strict liability in specific circumstances.<sup>216</sup>
71. The duty to obtain the consent of the patient to a medical act is imposed by Article 16-3 of Civil Code and confirmed by the Law 2002. Failure to obtain this consent will constitute a fault, subject to exceptions based on the urgency of the act and the refusal of treatment by the patient.<sup>217</sup>

### **3.2.2. Duty of care**

72. There is a concept of a duty of care under the tort of negligence in France.<sup>218</sup> It is not different in Belgium, the duty of care is an obligation under a contract or legal duty under tort. It could be said that the obligation of care of a physician to a patient arises when they have a contract or the doctor has a legal duty to the patient.

### **3.2.3. Breach of a duty of care**

#### **3.2.3.1. In general**

73. As an exception to the rule, French law recognises a concurrent liability in the context of professional negligence. If a doctor acts in breach of his "*obligations professionnelles*", he will be liable to his client in both contractual and delict.<sup>219</sup>
74. It is a prevalent problem that a physician might easily breach a duty of consent. Normally, the physician must disclose to his or her patient the risks of a certain treatment or operation to obtain his or her well-informed consent. Case law defined this duty before being reaffirmed by the Patients' Rights Law of March 4, 2002, in article L. 1111-2 CSP. The *Cour de Cassation* states that such a duty of disclosure "*is rooted in the*

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<sup>216</sup> Florence G'Sell-Macrez, *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, Chicago-Kent Law Review, 2011, Vol. 86, p.1097.

<sup>217</sup> Hondius, E., *The Development of Medical Liability*, Cambridge, 2010, p.103.

<sup>218</sup> Youngs, R., *English, French & German, in Comparative Law*, Routledge, Third Ed, 1998, p. 395.

<sup>219</sup> Rossum, M., *Concurrency of Contractual and Delictual Liability in a European Perspective*, European Review of Private Law, Vol. 3, 1995, p. 539.

requirement to respect the constitutional principle of safeguarding the human person.”<sup>220</sup> The reference to the principle of human dignity explains that the decision condemning the practitioner who has failed to deliver complete information is based on Article 1382 of the Civil Code. The explanation means that such responsibility is now a matter of tort law.<sup>221</sup>

75. Just like the law of Belgium, France applies the decision of *Mercier* case to a standard of care and to prove the breach of a duty of care.

### 3.2.3.2. *Standard of care*

76. The *Mercier* case in 1936<sup>222</sup> held that a doctor must give patients “conscientious, attentive care in conformity with the current medical professional standards.” The law fixes the level of professional standards required (e.g., the duty to inform has been defined in legislation) by the code of ethical conduct (although this is controversial, case-law often refers to the provisions of this code to define a civil fault). Moreover, the law fixes the level of professional standards required by the medical profession itself (medical treaties, articles published in recognised journals, publications of medical congresses, conferences by consensus). Concerning this latter source, the significant difficulty lies in identifying a medical consensus or in the cases where no such consensus exists in verifying if the medical profession recognises a course of treatment used by the defendant.<sup>223</sup>

### 3.2.4. *Damage*

77. A patient can only recover damages concerning negligent medical treatment if he has suffered damage. All damage has to be compensated, including moral damages for pain

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<sup>220</sup> Cass. 1<sup>er</sup> civ., Oct. 9, 2001, *Bull. civ.*, No. 249.

<sup>221</sup> Cass. 1<sup>er</sup> civ., June 3, 2010, *Bull. civ.* I, No. 573;

G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, *Chicago-Kent Law Review*, Vol.86, 2011, p.1101.

<sup>222</sup> Case Civ, 20 May 1936, *D.* 1936, 88.

<sup>223</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p.209-210.

and suffering. Damages will be determined by comparing the current situation which the patient would be if the fault had not occurred. Similar to Belgium, France also categorises damages into two kinds: economic damage and non-economic damage.

#### **3.2.4.1. Economic damage**

78. Damages are awarded for the actual injury sustained by the victim and for all the consequential losses and expenses which emanate from the injury. In consequence of the injury, the injured person should be placed in the same financial position by an award of money. This should cover for the injuries which s/he could not have faced if the accident had not occurred.<sup>224</sup> Economic loss may include medical expenses, temporary loss of earning, and loss of future earnings.<sup>225</sup>

#### **3.2.4.2. Non-economic damage**

79. Different heads of non-economic damages can be distinguished. The main ones being a pain, physiological loss, sexual loss, loss of enjoyment, and loss of amenities etc. All persons who suffer a loss can make a claim: the primary victim, his family, heirs, even his professional partners in some instances.<sup>226</sup> There are no limits on the recoverability of non-pecuniary damages. Article 1382 of the civil code and following provisions do not contain any restrictions in this respect. Usually, courts award a general sum for the non-pecuniary loss but divide the award into specific categories of loss.<sup>227</sup>
80. Non-economic damage includes (1) pain and suffering and loss of physical/mental integrity. For example, according to *the Cour de Cassation*, loss of amenity from the “loss of quality of life”, which concerns not only the future impossibility of doing a particular activity sport. Moreover, pain and suffering and loss of physical/mental

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<sup>224</sup> Bell, B., *Governmental Liability: Some Comparative Reflections*, InDret, 2006, p. 14.

<sup>225</sup> Cass. soc. 28 March 1998, *Bull. civ.* V, n° 115, p. 89; Cass. 7 February 1979, *Bull. civ.* II, n° 41 (compensation shall be awarded even where the victim kept on working but suffered psychological problems).

<sup>226</sup> Koch, B., *Medical Liability in Europe, A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p. 216-217.

<sup>227</sup> Bell, J., *Governmental Liability: Some Comparative Reflections*, InDret, 2006, p. 16

integrity<sup>228</sup> and temporary and permanent impairment is considered as a non-economic loss.<sup>229</sup> For instance, aesthetic damage may lead to a loss of career, loss of sexual function,<sup>230</sup> and spoiled holidays.<sup>231</sup>

### 3.2.5. Causation

#### 3.2.5.1. In general

81. Under the French law, causation is one of the three general requirements of establishing liability; the other two are wrongful (“*fait juridique*”) act and damage. This is so in both areas of civil liability: tortious liability and contractual liability. As far as tortious liability is concerned, the causation requirement is expressed in Articles 1382 to 1386 of the Civil Code, which all state that the damage must have been “caused” by the defendant’s fault. Causation thus plays a prominent role in establishing liability.<sup>232</sup>
82. The proof of a causal link is required to compensate for the consequences of any breach of contract or any tort. However, the causation criterion is difficult to determine. The theory of equivalence of conditions has commonly been applied in French civil law so a factor must be a ‘*but-for*’ condition of damage to qualify as a cause. It means that causation is not established unless it is proven that the damage would not have occurred in the absence of the factor in question. In principle, the burden of proof is upon the claimant to prove that the defendant’s wrongful act resulted in his or her damage. In this context, causation is considered as a legal fact (“*fait juridique*”) that can be proved by all means (“*par tous moyens*”).<sup>233</sup> In one recent decision of the civil law courts, the *sine*

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<sup>228</sup> Ripert, G., *Le Prix de la Douleur (The Price of Pain)*, D. 1948, chr. 1.

<sup>229</sup> Melennec, L., *L’indemnisation du Préjudice Esthétique (Compensation for Aesthetic Damage)*, *Gaz. Pal.*, 5 nov. 1976, p.2.

<sup>230</sup> Melennec, L., *Le Préjudice Sexuel (Sexual Prejudice)*, *Gaz. Pal.*, 1997, p. 1;

Bourrié-Quenillet, M., *Le Préjudice Sexuel: Prevue, Nature Juridique et Indemnisation (Prejudice Sexual: Prevue, Legal Nature and Compensation)*, *J.C.P.* 1996, I, p. 3986.

<sup>231</sup> Nîmes, 19 May 1978, *Gaz. Pal.* 1980, I, somm. 186.

<sup>232</sup> Galand-Carval, S., *Causation under French Law*, Kluwer Law International, 2000, p. 53.

<sup>233</sup> Ferreira, C., *The Loss of Chance in Civil Law Countries: A comparative and Critical Analysis*, *Maastricht Journal of European and Comparative Law*, 2013, p. 60.

*qua non-condition* has even been referred to as a principle.<sup>234</sup> However, the principle of equivalence is not always applied by the courts. The notion of the direct link<sup>235</sup> or adequate causation is also invoked as well.<sup>236</sup>

### **3.2.5.2. Burden of proof**

83. The victim has the burden of proving the elements of liability: the fault, the damage, and the chain of causation in the case of fault-liability.
84. In case of strict liability, the victim has to prove the conditions of application of this kind of liability regime. For instance, for damage resulting from a hospital infection, the victim has to prove the infection and the fact that it was acquired at the hospital. The hospital can only exonerate himself of responsibility by adducing evidence of a case of *force majeure* (an insufficient defence)<sup>237</sup>

### **3.2.5.3. Loss of a chance**

85. Stretching back to the 1960s, the concept debated here has been particularly developed in French case law regarding the loss of chance of recovery or survival in civil liability for MM. Resorting to the loss of chance as an instrument, it was consciously applied in overcoming the difficulties created in such an area. The demands of proof of a causal connection emerged from a decision of the *Cour d'appel* of Grenoble on 24<sup>th</sup> October 1961. This was about a case concerning the lack of timely diagnosis of a fracture already confirmed by radiography with subsequent deterioration of the patient's health. A few years later, it was the *Cour de Cassation* itself that confirmed this doctrine through a

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<sup>234</sup> *Le principe de l'équivalence des causes dans la production du dommage en matière de responsabilité délictuelle (The Principle of Equivalence of Causes in the Production of Tort Damage)*: Cass civ (2) 27 March 2003, *Bull civ* II, n°76 ; *JCP G* 2004, I, 101, n° 13, obs G Viney.

<sup>235</sup> Cass. Civ. (3) 19 February 2003, no00-13253, *RCA* 2003, common n°125, *RTD civ* 2003, 508.

<sup>236</sup> Goldberg, R., *Perspectives on Causation*, Hart Publishing, 2011, p.210.

<sup>237</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, 2011, De Gruyter, p. 233.

judgment dated 14<sup>th</sup> December 1965. It was followed by several decisions in similar cases of MM.<sup>238</sup>

86. It should be emphasised that French courts tend to compensate for the uncertainty of causal judgments by widely using the concept of loss of chance. In a seminal case, a doctor had committed an error of diagnosis on a child who remained crippled: the judges condemned the doctor to pay damages for the “loss of a chance to cure”.<sup>239</sup> Since this decision was made, French courts often use the “loss of a chance” concept to compensate the victims even though the causal link is uncertain. It is often decided that if the patient was not thoroughly informed, he or she should be compensated only for the loss of a chance to escape the risk. Moreover, compensation is granted for loss of chance when the patient would have benefited from an earlier or better treatment, but it is impossible to determine when the patient would have recovered if such treatment had been provided. Thus, the victim must establish that his/her chance of survival, recovery, or even fewer sequelae would have been greater if the doctor had given a correct diagnosis or appreciate the care.<sup>240</sup>
87. There are situations in which following mistakes in the diagnosis or malpractice in treatment, the patient dies or his/ her health becomes deteriorated. In other words, if it were not for the mistake, the death or the deterioration of the patient’s condition could have been prevented. The situations of breach of duty in informing the patient of the risks of the treatment have been considered as equivalent to a situation of misdiagnosis or fault in medical treatment.<sup>241</sup> In these cases, it is deemed that the fault has deprived the patient, either of chance not to take the risk that was involved or of a chance of being cured by earlier treatment. The quantification of damages is effectuated on a

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<sup>238</sup> Ferreira, C., *The Loss of Chance in Civil Law Countries: A comparative and Critical Analysis*, Maastricht Journal of European and Comparative Law, 2013, p. 60.

<sup>239</sup> Cass. 1e civ., Dec. 14, 1965, *Bull. civ.* I, No. 707; *JCP* 1966, ii, 14753, note R. Savatier; see also Cass. 1e civ., Jan. 27, 1970, *Bull. Civ.* I, No. 37; *JCP* G 1970, II, 16422, note Rabut.

<sup>240</sup> G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, *Chicago-Kent Law Review*, Vol. 86,2011, p.1114.

<sup>241</sup> Ferreira, C., *The Loss of Chance in Civil Law Countries: A comparative and Critical Analysis*, Maastricht Journal of European and Comparative Law, 2013, p. 60.

“mathematical’ basis”. The judge quantifies the lost chance using a percentage (e.g. 60%), calculates the victim’s total personal injury (e.g., €100,000 and then applies a percentage to the set figure (60% of 100,000= € 60,000).<sup>242</sup>

### 3.3. *Tort of negligence without fault (strict liability)*

88. The cornerstone of French tort law is Article 1832 of French Civil Code which provides: “Any act whatsoever of man, which causes damage to another, obliges the one by whose fault it occurred, to compensate it.” Under Article 1382 CC, proof of fault on the part of the defendant is a prerequisite of liability.<sup>243</sup> The claimant has been exempted from having to prove fault so long as the person can demonstrate the products were defective and that such defective products were the cause of his damage or injury. So, the mere marketing of defective products constitutes proof of the manufacturer’s fault. This is an important development of the law in favour of the victims of product defects. A strict liability “*obligation de sécurité*” thus applies under both the law of contract and tort.<sup>244</sup>
89. For strict liability in MM cases, there are two important Acts. Firstly, Act 1991-1406 of 31<sup>st</sup> December 1991 created a fund for persons infected with HIV as a result of blood transfusions. Secondly, Act 2002-303 of 4<sup>th</sup> March 2002 regarding the law on the rights of sick people and the quality of health care system, the so-called *Loi Kouchner*.<sup>245</sup>
90. Before the Law of March 4, 2002, physicians or clinics were sometimes deemed to owe an “*obligation de résultat*” (requirement of results) to their patient in particular circumstances. In such cases, they were liable because the expected result (safety in conducting analyses, for example) was not reached even though no negligence was established. Today, strict liability is provided for in various texts, especially in cases where the physician provides health products and when the patient gets infected in a

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<sup>242</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p. 211-212.

<sup>243</sup> Bell, J., Boyron, B., and Whittaker, S., *Principles of French Law*, Oxford: University Press, 2008, p. 357.

<sup>244</sup> Fairgrieve, D., *Product Liability in Comparative Perspective*, Cambridge, 2005, p.89-90.

<sup>245</sup> Dam, C., *European Tort Law*, Oxford: University Press, 2006, p.305.

hospital (nosocomial infection).<sup>246</sup> The following are the two types of strict liability: strict liability for products provided by health professionals and strict liability for hospital-acquired infections (“Nosocomial infections”).

***Strict liability for products provided by health professionals***

91. The *Code de la Santé Publique* states that health professionals are strictly liable for any damage caused by the health products (*produits de santé*) provided to patients.<sup>247</sup> This regulation seems similar to Belgium although the lists of products between Belgium and France may not be the same. Evidently, the law requires the provided product to be defective; such products may be pharmaceuticals,<sup>248</sup> cosmetics, poisonous substances, preparations, vaccines,<sup>249</sup> contraceptives, insecticides, dietary foods for particular medical purposes or medical devices.<sup>250</sup> In doing so, the law reaffirms previous solutions developed by the courts. Moreover, the *Cour de Cassation* ruled that transfusion agency to be strictly liable for harm caused by the poor quality of the blood products that they provide. Such a strict obligation of safety (“*obligation de sécurité de résultat*”) was extended to clinics in the case where they provide blood products. It should be noted that compensation was made easier when the courts relaxed the causation requirement. When the victim proves that his/her viral contamination followed a blood transfusion and no other mode of contamination existed, the burden of proof is shifted to the defendant. The defendant has to prove that the provided blood products were not defective. Such presumption is now provided for by various

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<sup>246</sup> G'Sell-Macre, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, *Chicago-Kent Law Review*, Vol. 86, 2011, p. 1105.

<sup>247</sup> CPS art. L. 1142-1.

<sup>248</sup> In particular, CPS art. L. 5111-1 gives a definition of the notion of drug, which reflects the definition of the Directive No. 2004/7 of March 31, 2004.

<sup>249</sup> Cass. 1e civ., Oct. 29, 1985, *Bull. Civ. I*, No. 273; *RTD civ.* 1986, 762.

<sup>250</sup> CPS art. L. 5111-1.

provisions of the Code<sup>251</sup> which have even abandoned the requirement of the absence of another possible factor.<sup>252</sup>

92. The *Cour de cassation* has also decided that health professionals owe an obligation of safety for the objects they use in the course of any therapeutic act. However, the physician may be held liable only when the equipment they use is defective; for example, a physician's liability was excluded in a case where the patient had an allergic reaction to the physician's gloves.<sup>253</sup> Also, the *Conseil d'État* has also decided that public health institutions are strictly liable for the defective products that they supply or materials they use. In cases of contaminated transfusions (e.g. HIV, hepatitis), administrative courts have also granted compensation to victims without requiring proof of negligence.<sup>254</sup>

***Strict liability for hospital-acquired infections (“Nosocomial infections”):***

93. With regard to nosocomial (hospital-acquired) infections, the *Cour de Cassation* has ruled that physicians in both private and public health institutions were under a “safety obligation of result.” In other words, any time the infection may be attributed to medical care, clinics, and physicians are strictly liable unless they establish that victim's harm resulted from an external cause (*cause étrangère*). There is no presumption of a causal link between care and infection, so it is for the patient to demonstrate that his or her infection was contracted in the hospital. Whereas this ruling concerned both private practitioners and health institutions, the Patients' Rights Law of March 4, 2002,

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<sup>251</sup> CPS art. L. 3122-2 (HIV).

<sup>252</sup> G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, Chicago-Kent Law Review, 2011, p. 1105 -1106.

<sup>253</sup> G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, Chicago-Kent Law Review, Vol. 86, 2011, p. 1106.

<sup>254</sup> CE ass.; May 26, 1995, Cts N'Guyen, Jouan, Cts Pavan *Rec. lebon*, 221; RFDA 1995, 748, concl. Dael; *AJDA* 1995, 508, chron. Stahl, J. and Chauvaux, D.; *JCP* 1995, II, 22468, note J. Moreau.

G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, Chicago-Kent Law Review, Vol. 86, 2011, p. 1106.

confirmed it only for healthcare institutions. Private practitioners are no longer under this rule. Thus, while clinics and health institutions are still strictly liable for hospital-acquired infections, physicians are liable for negligence for all interventions that occurred after September 5, 2001.<sup>255</sup> In the public sector, hospitals are strictly liable, and Article L. 1142 para. 2 CPS provides that health institutions be responsible for damages resulting from hospital-acquired infections, except in a case where they establish an external cause for the victim's harm.<sup>256</sup>

### 3.4. *Criminal negligence*

94. Over time, there was less deterrence to professional expertise and fewer acceptances of professional “mistakes” when things went wrong. While in the later part of the twentieth century, the concern with professional responsibility manifested itself predominantly in civil liability, there has been an increasing willingness to engage with criminal liability of health professions. So, for example, in the case of *Vo v. France*,<sup>257</sup> the issues of criminal liability arose where there was a negligent performance of a clinical procedure due to a mistake over the identity of the patient which resulted in the miscarriage. On the other hand, contamination of blood has led to criminal litigation in France.<sup>258</sup>
95. In France, negligence is stated in Article 121-3 of the Penal Code (*Code Pénal*) as being a criminal offence: “a *délit* (offense)<sup>259</sup> also exists, where the law so provides, in cases of recklessness, negligence, or failure to observe an obligation of due care or precaution imposed by any statute or regulation, where it is established that the offender has failed to show due diligence, taking into consideration where appropriate, the nature of his role

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<sup>255</sup> Cass. 1e civ., June 21, 2005, *Bull. civ. I.*, No. 276.

<sup>256</sup> G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, *Chicago-Kent Law Review*, Vol. 86, 2011, p.1107.

<sup>257</sup> *V v France*, no. 53924/00, ECHR 2004-VIII.

<sup>258</sup> Farrell, A. and Kazarian, M., *The Role of the Criminal Law in Healthcare Malpractice in France: Examining the HIV Blood Contamination Scandal*, *Medicine, Crime and Society*, 2013, p. 65;

Tamara, K and Jean, V., *European Union Health Law: Themes and Implications*, Cambridge University Press, 2015, p. 25.

<sup>259</sup> *Délit* is the second category of criminal offences in French criminal law.

or functions, of his capacities, powers and of the means available to him”.<sup>260</sup> This rule is very similar to the criminal law of Belgium.

96. In France, involuntary and negligent conduct resulting in injury is criminalised. In the hierarchy of crimes, the most severe involuntary offence against the bodily integrity of a person in French criminal law is manslaughter (*homicide involontary*). However, *homicide involontaire* admits a broader scope for the criminalisation of negligence as it includes “causing the death of another person by clumsiness, negligence, carelessness, recklessness or breach of an obligation of safety or prudence imposed by statute or regulations”.<sup>261</sup>
97. French criminal procedures reflect a victim-oriented approach. This is evidenced by the fact that, victims of criminal offences in France have the right to join “civil parties” (*de parties civiles*).<sup>262</sup> As a consequence, they launch Public Prosecution (*Action Publique*) and are parties to the civil action in the proceedings.<sup>263</sup>

#### **4. Medical malpractice law in England**

##### **4.1. Background**

98. England does not have a civil code. The courts have mainly developed civil law in their case. Common law was meant to bring a unitary, national legal system under the auspices and control of centralized power in the form of a sovereign king.<sup>264</sup> Thus, the medieval origin of the current English legal system implies that even today centuries-old cases may still be relevant for legal practice. The common law system is not run by

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<sup>260</sup> Article 123-3 al 3 Code Pénal.

<sup>261</sup> Article 221-6 Code Pénal ;

Kazarian, M., Griffiths, D., and Brazier, M., *Criminal Responsibility for Medical Malpractice in France*, Westlaw.UK, 2011, p.3.

<sup>262</sup> Constitutions *de parties' civile* are civil claims for compensation brought in criminal courts in French criminal proceedings. Victim who join constitutions *de parties civile* are called *parties civiles* because they are parties to the civil action in the criminal proceedings.

<sup>263</sup> Farrell, A. and Kazarian, M., *The Role of the Criminal Law in Healthcare Malpractice in France: Examining the HIV Blood Contamination Scandal*, *Medicine, Crime and Society*, 2013, p. 65.

<sup>264</sup> Slapper, G. and Kelly, D., *English Legal System*, London: Cavendish, Fifth Ed, 2001, p.3.

rules but by cases and precedents. When a common law judge is called to decide a case, he will look for a comparable case rather than an applicable law. Subsequently, he will try to find guidance in the decision given in the comparable case. In finding the rule in common law, the emphasis is on the comparison of the facts of the case and not, as is the case in most continental systems, on the application of an abstract standard. However, these differences between the common law and the continental approach should not be exaggerated. The differences between common and civil law seem to be in policy rather than on a systematic level.<sup>265</sup>

99. The three main sources of liability in English law are contracts, unjust enrichment, and torts. Tort is classically described as, “...*a species of civil injury or wrong. A civil wrong is one which gives rise to civil proceedings- proceedings, that is to say, which have as their purpose of enforcement some right claimed by the plaintiff against the defendant. Most torts require either intention or negligence.*” Strict liability is rare in English law.<sup>266</sup>
100. MM is a type of tort of negligence. MM is concerned with claims for damages for injuries suffered by patients at the hands of doctors and other healthcare professionals. Unlike in other professional contexts, the law of contract plays little or no part in medical law. Other than situations where patients seek treatment privately, patients do not enter into contracts with their doctors. Even where they do, the courts have been reluctant to impose more obligations on the doctor than those imposed in tort. Hence, exceptional circumstances notwithstanding, a doctor will be held only to exercise reasonable care and skill (the tortious duty) rather than warranting a particular outcome from the treatment.<sup>267</sup>
101. Issues arising between the doctor and patient are seen mostly as being matters related to the doctor’s duty of care to the patient. The emphasis on the duty of care means that we

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<sup>265</sup> Dam, C., *European Tort Law*, Oxford: University Press, 2006, p.500.

<sup>266</sup> Clerk, J and Lindsell, W., *On Torts*, Sweet & Maxwell, 2014, p.2.

<sup>267</sup> Walton, C. and Kramer, P., *Charlesworth & Percy, On negligence*, Thomson Reuters, 2014, p. 657; Clerk, J. and Lindsell, W., *On Torts*, Sweet & Maxwell, 2014, p.689.

are concerned primarily with the tort of negligence rather than the tort of trespass to the person. There is one significant exception in the field of capacity to consent and the reality of consent. Medicine in the United Kingdom is mainly practised within the National Health Service (NHS).<sup>268</sup> The rule is a publicly provided and funded service, and the patient has no contractual relationship with the healthcare provider. This aspect seems slightly different from Belgium and France where the obligation of the doctor is more in a contract. However, where the medicine is practised privately and therefore in pursuance of a contract, the same duty of care arises. In other words, the different legal framework does not affect the standard required.<sup>269</sup>

102. England is a universal law jurisdiction. The courts have traditionally fashioned legal rules through decisions reached in particular cases.<sup>270</sup> Under tort of negligence in England, to succeed in the act of negligence, the claimant must establish:

1. That the defendant owes the claimant a duty of care;
2. That the defendant breached that duty by failing to exercise reasonable care;
3. The breach of duty caused the claimant's injuries.<sup>271</sup>

#### 4.2. *Tort of negligence with fault*

##### 4.2.1. *Fault*

103. The proposition that “the English law of torts is generally based upon the fault of the defendant” or that “fault is generally required for liability in tort” is in practical terms correct. Some would go so far as to say that fault is always necessary.<sup>272</sup>

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<sup>268</sup>Jackson, R. and Powell, J., *On Professional Liability*, Sweet & Maxwell, 2012, p. 976.

<sup>269</sup> Hodgson, J., *Medical Malpractice: An Overview of the English Position*, Annals of Health Law, Vol. 3, 1994, p. 225.

<sup>270</sup> Stauch, M., *The Law of Medical Negligence in England and Germany: A Comparative Analysis*, Hart Publishing, 2008, p.7.

<sup>271</sup> Jackson, E., *Medical Law: Text, Cases, and Materials*, Oxford University Press, 2006, p.108.

<sup>272</sup> Widmer, B. and Rogers, H., (eds.), *Unification of Tort Law: Fault*, Kluwer Law International, 2005, p. 65.

104. Most patients in England (those receiving treatment under the NHS) will be required to bring a claim for medical injury in negligence. Here the need for faulty conduct by the doctor may be regarded as axiomatic as it is woven into the fabric of the tort, with its requirement - to be discussed shortly - that, to be liable, the defendant must fail to take the care expected of a reasonable professional in the circumstances. In this context, the courts have been mindful of the inherent uncertainty of medicine - the inability of the doctor to control all variables. As Lord Diplock<sup>273</sup> remarked in *Sidaway v Bethlem Royal Hospital*<sup>274</sup>, “*inevitably all treatment, medical or surgical, involves some degree of risk that the patient’s condition will be worse rather than better for undergoing it.*” Statistically, the chances of any risk of the proposed treatment going away at all may be small - but it is never totally absent, and the degree of possible worsening involved may cover a whole spectrum of disabilities from occasional mild discomfort to what might justify the epithet catastrophically.<sup>275</sup>

#### **4.2.2. Duty of care**

105. Where a patient has injured allegedly as a result of a doctor’s negligence, by far the most common basis for a claim will be in the tort of negligence.<sup>276</sup>
106. The doctor’s duty of care is the first requirement for the liability to be established in the tort of negligence: this is the duty to be careful in whatever it is, a person - the doctor- is doing or in some cases even not doing, that it does not cause harm to another. If the law prescribes that there is to be found such a duty in the circumstances of the individual case, the first stage of liability in the tort of negligence is satisfied. However, if it is held

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<sup>273</sup> Diplock, L., the British judge, had been the most senior judge in the House of Lords, Britain's highest court of appeal. He relinquished that post in 1984 but continued as an ordinary Lord of Appeal.

<http://www.nytimes.com/>

<sup>274</sup> *Sidaway v Bethlehem Royal Hospital* [1985] AC 871.

<sup>275</sup> Stauch, M., *The Law of Medical Negligence in England and Germany: A Comparative Analysis*, Hart Publishing, 2008, p. 27-28.

<sup>276</sup> Walton, C. and Kramer, P., *Charlesworth & Percy, On negligence*, Thomson Reuters, 2014, 653;

Ian Kennedy & Andrew Grubb, *Principles of Medical Law*, 1998, p. 285 -293.

that, ‘no such duty exists in the light of the facts, the tort of negligence cannot be established.’<sup>277</sup>

107. In apportioning the doctor’s duties to their patients in tort law, the English courts have insisted upon his assumption of responsibility for the latter’s welfare, coupled with the representation of specialist knowledge and skill. As Lord Hewart CJ stated in *R v, Bateman*:<sup>278</sup>

*“If a person holds himself out as possessing special skill and knowledge, and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient to his discretion and treatment accordingly, he owes a duty to the patient...No contractual relation is necessary, nor is it necessary that the service is rendered for reward.”*

108. Hence, it can be said that a duty of care is imposed upon the doctor once s/he has *assumed responsibility* for the patient’s care. For general practitioners, it might be said that an individual becomes their patient under the NHS (choice of a medical practitioner) regulation 1998 as soon as s/he registered on their patient’s need for medical service. In the hospitals, a doctor-patient relationship exists once the doctor has undertaken to provide medical services to the patient; the duty may arise as soon as the patient presents him/herself for treatment before a doctor actually sees him.<sup>279</sup> There was a judgment of this type of a case, *Nield J*<sup>280</sup> *“there was here such a close and direct relationship between the hospital and the watchmen that there was imposed on the hospital duty of care which they owed to the watchmen. Thus, I have no doubt that Nurse Corbert and Dr Banerjee were under a duty to the deceased to exercise that skill and care which is*

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<sup>277</sup> Kaye, P., *An Explanatory to the English Law of Torts*, Barry Rose Law Publishers, 1996, p. 22.

<sup>278</sup> Stauch, M., *The Law of Medical Negligence in England and Germany: A Comparative Analysis*, Hart Publishing, 2008, p.7.

<sup>279</sup> Walton, C. and Kramer, P., *Clerk & Lindsell, On Torts*, Sweet & Maxwell, 2014, p.56.

<sup>280</sup> The judge of the case *Barnett v Chelsea and Kensington Hospital Management Committee*, [1969] 1 QB 428.

*expected of persons in such positions acting reasonably...*”<sup>281</sup> In addition, the health authority or NHS trust might owe a primary duty of care to patients to ensure that they receive adequate treatment. The Court of Appeal in *Wisher vs Essex AHA*<sup>282</sup> clearly thought it was possible for a health authority to owe patients a primary, non-delegable duty of care to provide properly skilled medical staff and an adequately equipped hospital.<sup>283</sup>

### **4.2.3. Breach of a duty of care**

#### **4.2.3.1. In general**

109. The breach of the duty of care is the act or omission, giving rise to the claim. Once again, in most common situations where the injury is suffered, it is easy to identify the act of negligence.<sup>284</sup>
110. If a health professional fails to attain the standard of care prescribed by law, thereby he commits a breach of duty.<sup>285</sup> The standard of care must be assessed regarding the individual patient, so if the doctor knows that her patient is usually susceptible to a particular risk, then a reasonable doctor would take that into account.<sup>286</sup>

#### **4.2.3.2. Standard of care**

111. The standard of care is the care which should be exercised by a reasonable, ordinarily careful person. The fictional “reasonable man” is careful to inquire into the existence of possible dangers and acts with prudence to avoid exposing others to the risk of harm. In order to take precautions that are proportionate to the risk, the reasonable man will have

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<sup>281</sup> *Barnett v Chelsea and Kensington Hospital Management Committee*, [1969] 1 QB 428.

<sup>282</sup> *Wisher v Essex AHA* [1986] 3ALL ER 801.

<sup>283</sup> Jackson, E., *Medical Law: Text, Cases and Materials*, Oxford University Press, 2013, p.108-109.

<sup>284</sup> Barrie, P., *Compensations for Personal Injuries*, Oxford: University Press, First Ed, 2002, p.18.

<sup>285</sup> Walton, C. and Kramer, P., *Charlesworth & Percy, On Negligence*, Thomson Reuters, 2014, 659; Jackson & Powell, *On Professional Liability*, Sweet & Maxwell, 2012, p. 992.

<sup>286</sup> Jackson, E., *Medical Law: Text, Cases and Materials*, Oxford University Press, 2013, p.121.

to foresee the risk. If the risk is too small that injury cannot reasonably be foreseen, the failure to take precautions will not be a breach of a duty of care.<sup>287</sup>

112. The truth is that the standard of care -reasonable care - is merely what the courts decide it based on the facts of a particular case, in light of certain established principles held to apply. Those decisions will be carried out by the courts mindful of the serious economic effects of requiring various measures to be adopted as part of the standard of care and of the need to balance safety in the community with the flexible and tolerant conduct of ordinary life.<sup>288</sup> As always, in the law of tort, policy - social, judicial and economic - has played a large part in shaping court's decisions in the area of standard of care in negligence.<sup>289</sup>
113. The English laws of MM and the standard of care have traditionally been grounded in the case of *Bolam vs Frien Hospital Management Company*.<sup>290</sup> In this case, Mc Nair J stated that:

*“The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill; it is a well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.”*<sup>291</sup>

*“A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that*

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<sup>287</sup> Barrie, P., *Compensations for Personal Injuries*, Oxford: University Press, First Ed, 2002, p.18;

Walton, C. and Kramer, P., *Clerk & Lindsell on Torts*, Sweet & Maxwell, 2014, p.704.

<sup>288</sup> *Thompson v. Smith Ship Repairers Ltd* [1984] QB 405.

<sup>289</sup> Kaye, P., *An Explanatory to the English Law of Torts*, Barry Rose Law Publishers, 1996, p. 240.

<sup>290</sup> *Bolam v Frien Hospital Management Company* [1957] 2 All ER 118, 121.

<sup>291</sup> Goldberg, R., *Medical Malpractice and Compensation in the UK*, Chicago-Kent Law Review, Vol. 87, 2011, p. 144.

*particular art....merely because there is a body of opinion which would take a contrary view.*”<sup>292</sup>

114. Therefore, where medical opinion is divided, *Bolam* establishes that a doctor is not negligent merely because he adheres to one body of opinion rather than another.<sup>293</sup> The House of Lords confirmed this in *Maynard v. West Midlands Area Health Authority*.<sup>294</sup> The House of Lords in *Maynard* and also in *Sidaway v. Board of Governors of the Bethlem Royal Hospital* were subject to relentless criticism by academics in the 1980s and early 1990s for elevating “to the status of the unquestionable proposition of law derived from *Bolam*. The courts can not review that “professional practice”.”<sup>295</sup>

### 4.3. *Damage*

115. The general principle of tort law is that the patient should be adequately compensated for all the losses s/he suffered. The patient can bring one action in respect of a tort. It is not possible to bring a second action based on the same facts. In the first place, the patient is entitled to be restored to the position that he would have been in had the tort not been committed. When this is not possible, damages will be paid. Similarly, in Belgium and France, they can consist of economic and non-economic damage.

#### 4.3.1. *Economic damage*

116. The pecuniary loss will generally embrace a loss of earning and expenses consequent to the injury (nursing care, equipment, special accommodation etc.). In cases of catastrophic injury, the latter often exceeds the former many times over, especially bearing in mind that the claimant is entitled to claim the cost of private care and treatment even if they are available from public funds. The basic principle is that the

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<sup>292</sup>McHale, J., *Medical Malpractice in England - Current Trends*, European Journal of Health Law, 2003, p.136.

<sup>293</sup> Walton, C. and Kramer, P., *Charlesworth & Percy, On negligence*, Thomson Reuters, 2014, 659;  
Clerk & Lindsell, *On Torts*, Sweet & Maxwell, 2014, p.704;

Jackson & Powell, *On professional liability*, Sweet & Maxwell, 2012, p. 981.

<sup>294</sup> *Maynard v. West Midlands Area Health Authority* [1985] 1 *All E.R.* 635 at 638-639 (Lord Scarman).

<sup>295</sup> Goldberg, R, *Medical Malpractice and Compensation in the UK*, Chicago-Kent Law Review, Vol. 18, 2011, p.144.

claimant is entitled (subject to any reduction for contributory negligence - unusual in a clinical negligence situation - to be put in the position he would have been in if the tort had not been committed, in so far as payment of damages can do that.<sup>296</sup>

117. When a patient is injured as a result of MM, he is typically faced with two types of loss: the positive expenses to which he incurred such as medical and nursing expenses and the negative loss of gains he would have made but for the injury.<sup>297</sup> Concerning medical, nursing and other expenses, the plaintiff's claim for nursing expenses is unaffected by the fact that they may be rendered gratuitously, for example, by a spouse or a parent. The proper basis for recovery is the proper and reasonable cost of supplying his needs.<sup>298</sup> Thus, quite similar to Belgian law, a spouse or the children may recover damages for the value of services rendered by the wife or mother who was not in paid work at the time of the accident. According to the English Court of Appeal, damages in respect of the care and attention of a loving relative should and enable the plaintiff to make "reasonable recompense" but not at the commercial rate.<sup>299</sup>

#### ***4.3.2. Non-economic damage***

118. The claimant is entitled to damages for pain, suffering, and loss of amenity, which are normally awarded as one lump sum payment and are in effect based on a flexible judicial tariff system. In the case of non-fatal injuries, only the victim may claim damages for non-pecuniary loss. Similarly, in France, where a person with a close relationship of love and affection suffers psychiatric trauma by witnessing the injury of the victim or

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<sup>296</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p. 191.

<sup>297</sup> Giesen, D., *International Medical Malpractice Law: A Comparative Study of Civil Liability Arising from Medical Care*, Kluwer Academic Publishers Group, 1998, p.223.

<sup>298</sup> *Donnelly v Joyce* [2973] 3 *ALL ER* 475, CA;

*Daly v General Steam Navigation Co* [1980] 3 *ALL ER* 696, CA.

<sup>299</sup> *Housecroft v Burnett* [1986] 1 *ALL ER* 332, C1; *Hodges v Frost* [1984] 53 *ALL ER* 373.

its immediate aftermath, he may have a claim but this is his own claim, based on a duty of care to him, not one who is “parasitic” on that of the victim.<sup>300</sup>

119. The categories of non-pecuniary loss usually are (1) Loss involving physical injury to the body. Damages will be awarded for this no matter what the course of action, provided the principles of factual and legal causation are satisfied. (2) The psychic injury which is analogous to bodily injury in that it amounts to a medically recognized illness. (3) The non-physical injury which causes “worry,” “anxiety,” “distress” or “injury to feelings.”<sup>301</sup>

### **4.3.3. Causation**

#### **4.3.3.1. In general**

120. Even if a claimant can satisfactorily establish a breach of duty, there is still the question as to whether the defendant’s alleged negligence actually “caused” the harm which was suffered which needs to be resolved in the majority of torts.<sup>302</sup> In these torts, and indeed in torts actionable per se, if substantial damages are sought, the claimant must establish that:

1. The defendant’s conduct did, in fact, result in the damage about which he complains, and
2. The damage is not in law too remote a consequence of the defendant’ wrongdoing.<sup>303</sup>

Many medical negligence actions have failed at this final hurdle.<sup>304</sup>

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<sup>300</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p. 192-193.

<sup>301</sup> Rogers, H., *Damages for Non-Pecuniary Loss in a Comparative Perspective (Non-Pecuniary Loss under English Law*, Springer, Wien -New York, 2011, p.54.

<sup>302</sup> McHale, J., *Medical Malpractice in England - Current Trends*, European Journal of Health Law, 2003, p.145.

<sup>303</sup> Clerk, J. and Lindsell, W., *On Torts*, Sweet & Maxwell, 2014, p.56.

<sup>304</sup> McHale, J., *Medical Malpractice in England - Current Trends*, European Journal of Health Law, 2003, p.145.

121. In English law, normally the “*but for*” test is applied to determine the causation. “*But for*” is to test the damage suffered by the claimant would not have been suffered *but for* the defendant’s breach of duty. The law assumes that it is possible to show (and, therefore, that the law should demand demonstration) that X would not have happened but for Y. The corollary is that, if this cannot be demonstrated, causation is not proved and the defendant, regardless of any breach of duty, is not liable.<sup>305</sup>
122. The term “causation” should be approached with caution. Judges tend to shy away from both scientific and philosophical formulae of causation.<sup>306</sup> Although in many cases, scientific evidence may be absolutely essential in deciding the causation question; the legal method is very different from the scientific method since the lawyer wants to know more than what events or occurrences contributed to a particular outcome. In the law of tort, causes assume significance to the extent that they exist. The court in deciding how to attribute responsibility for the claimant’s damage. “The decision of the case must turn not simply focus on causation but on responsibility too.”<sup>307</sup>
123. The “*but for*” test will be applied in circumstances where the plaintiff alleges that the defendant’s tortious act was both necessary and sufficient to cause his or her injuries. The “*but for*” test requires the plaintiff to establish this causal link to a balance of probabilities. The “*but for*” test is used in the majority of medical negligence cases in assessing whether there is a causal link between an alleged breach in the standard of care owed to a plaintiff and the damages suffered by the plaintiff.<sup>308</sup> It has been

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<sup>305</sup> Grubb, A., Laing, J., and McHale, J., *Principles of Medical Law*, Oxford University Press, 2010, p.330.

<sup>306</sup> *Stapley v Gypsum Mines Ltd* [1953] A.C.663 at 681 and 687;

*The Wagon Mound (No.1)* [1961] A.C.388 at 491.

<sup>307</sup> *M’Leans v Bell* (1932) 48 *T.L.R.* 467 at 469;

*Weld –Blundell v Stephens* [1920] A.C. 956 at 986;

Clerk, J. and Lindsell, W., *Tort*, Sweet & Maxwell, Twenty-first Ed, 2014, p.56.

<sup>308</sup> Hinkson, E. and Thomas, G., *Causation in Medical Negligence Cases*, 2007, p2;

<http://blog.harpergrey.com.nmsrv.com>

traditionally applicable even in cases where the hypothetical question requires prediction of human reaction.<sup>309</sup>

#### **4.3.3.2. Burden of proof**

124. In the area of clinical negligence, as in all other aspects of civil litigation, is on the claimant who must prove causation, and it must be established on a balance of probabilities.<sup>310</sup>

#### **4.3.3.3. Loss of a chance**

125. A school of authority has developed around the notion of “loss of a chance,” i.e. where it is alleged that, by the defendant’s failure to diagnose or treat, or both, the patient has lost the opportunity to avoid an adverse outcome. Where it is more likely than not that the injury would have been avoided without the failure, no difficulty arises, and the claimant will succeed in his suit and be compensated in full, but where it cannot be established as being more likely than not, the claimant on a conventional approach fails.<sup>311</sup>
126. In the leading case of *Hotson v. East Berkshire Health Authority*<sup>312</sup> the House of Lords rejected the notion that a loss of a chance of avoiding harm could constitute an injury itself (which the Court of Appeal had endorsed) and held that where the evidence established that on a balance of probabilities the failure to diagnose/treat was not the cause of the injuries, the claim must fail. In the case of *Tahir v. Haringey HA*, Otton LS stated that *Hotson* was a case precluding the recovery of “damages for the loss of a

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<sup>309</sup> Hillel, D., McCague, P., Yaniszewski, P., *Proving Causation where the But for Test is Unworkable*, Vol. 30, 2005, p. 218.

<sup>310</sup> *Pickford v. Imperial Chem. Indus. Plc.*, [1998] 3 *All E.R.* 362, [1998] 1 *W.L.R.* 1189 (H.L.);

Goldberg, R., *Medical Malpractice and Compensation in the UK*, *Chicago-Kent Law Review*, Vol.87, 2011, p.146.

<sup>311</sup> Price, D., *Medical Law in United Kingdom*, Kluwer Law International, 2002, p. 101.

<sup>312</sup> *Hotson v. East Berkshire Health Authority* [1987] *AC* 750 House Lords.

chance of a complete or better recovery.”<sup>313</sup> However, in *Hotson*, Lord Mackay *stated* “*I considered it would be unwise in the present case to lay it down as a rule that a plaintiff could never succeed by proving loss of a chance in a medical negligence case*”, and in the case of *Smith v. NHS Litigation Authority Andrew*<sup>314</sup> Smith J, *obiter* distinguished *Hotson* (which was arguably on a “true” loss of a chance case anyway) and made positive noises regarding potential recovery for loss of chance. The Court of Appeal in *Hotson* had been especially concerned that a private patient in the same situation would, by contrast, be able to recover damages in contract based on the loss of a chance by virtue of the absence of need to establish damage in order to prove a breach of contract (this is merely a matter of quantification in this context).<sup>315</sup> However, in the case *Gregg v. Scott*, the House of Lords concluded that the claim based on loss of a chance should fail. A majority was not prepared to abandon the traditional balance of probability test applied in cases of medical negligence.<sup>316</sup> The reasoning was interesting: “*A wholesale adoption of possible rather than probable causation as the criterion of liability would be so radical a change in our law as to amount to a legislative act. It would have enormous consequences for insurance companies and The National Health Service...I think that any such change should be left to Parliament*”.<sup>317</sup>

127. Hence, to institute causation, the claimant must prove, on the balance of probabilities (51% or more), that negligence was the cause of injury. This entitles the patient to full compensation. If the balance of probabilities is 49% or less, then the patient is not entitled to any compensation.<sup>318</sup>

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<sup>313</sup> *Tahir v. Haringey HA* [1998] *Lloyd's Rep Med* 104 at 104 at 108 (CA). Further, in *Pearman v. North Essex Health Authority* [2000] *Lloy's Rep Med* 174 Butterfield J asserted that “Damages are not recoverable simply for the loss of a chance of a complete or better recovery.”

<sup>314</sup> *Smith v. NHS Litigation Authority Andrew* [2001] *Lloy's Rep Med* 90 at 100-102 (QBD).

<sup>315</sup> Price, D., *Medical Law in United Kingdom*, Kluwer Law International, 2002, p. 101-102.

<sup>316</sup> Walton, C. and Kramer, P., *Charlesworth & Percy on Negligence*, Thomson Reuters, 2014, 673.

<sup>317</sup> *Gregg v. Scott* [2005] 2 A.C. 176.

<sup>318</sup> Walton, C. and Kramer, P., *Clerk & Lindsell, On Torts*, Sweet & Maxwell, 2014, p.727;

Jackson, R. and Powell, J., *On Professional Liability*, Sweet & Maxwell, 2012, p. 1003-1004.

#### 4.4. *Tort of negligence without fault (strict liability)*

128. Where a defective product causes an injury, there are three potential grounds for establishing a right to compensation. First, a defect will probably have been a breach of contract, and the purchaser can claim against the seller for this breach. Damages for an injury caused by a breach of a contract would be assessed in the same way as a claim in tort. Secondly, there may be a remedy in tort. The classic case of *Donoghue v Stevenson*<sup>319</sup> was a claim in the tort of negligence brought by the person who drunk but did not buy, the ginger beer against the company which made and bottled it and delivered it in an opaque bottle which prevented inspection of the contents. Thirdly, the Consumer Protection Act 1987 may create strict liability where personal injury or property damage has been caused as a result of a defect in a product. This Act was introduced to comply with a 1985 European Directive on Product Liability.<sup>320</sup>
129. The application of the Directive in medical context is illustrated by *A v National Blood Authority*<sup>321</sup> where the Directive was held to have been infringed by the supply of blood products infected with hepatitis C even though at that time there was no reasonably effective method of screening for the virus - and in some cases, the supply had been taken before the risk was even known. The Directive could also, of course, apply to drugs, subject to the availability of the so-called “development risks” defence. Note, however, that in a typical case, a hospital would not be a “producer” of the blood or drug and would not incur liability except via the “failure to disclose source” route.<sup>322</sup>
130. Another issue, in the case of absence of consent to the treatment, is also put into a strict liability because the course of action is trespass, not negligence. Trespass to a person is strict liability. The patient does not need to establish any fault on the part of the healthcare provider to make him liable for compensatory damages. Since motive has no role in strict liability, a healthcare worker who aims to relieve pain which the patient has

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<sup>319</sup> *Donoghue v Stevenson* [1932] AC 562.

<sup>320</sup> Barrie, P., *Compensation for Personal Injuries*, Oxford: University Press, First Ed, 2002, p.128.

<sup>321</sup> *A v National Blood Authority* [2001] 3 *All England Law Reports* (All ER) 289.

<sup>322</sup> Koch, B., *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p. 186.

not consented to, whether expressly or impliedly, can be faced with legal action in trespass to the person.<sup>323</sup>

131. Consent to treatment is a controversial topic with divergent views on what amounts to patient consent. It has been stated that:

*“For medical interventions, it is widely accepted that consent means a voluntary, un-coerced, decision, made by a sufficiently competent or autonomous person on the basis of adequate information and deliberation, to accept rather than reject some proposed course of that action that will affect him or her.”*<sup>324</sup>

#### 4.5. *Criminal negligence*

132. The beginning with, English criminal law states that a criminal offence normally requires a guilty mind. In England, negligently causing bodily injury, short of death is a criminal offence only in specific contexts. For example, in healthcare, willful neglect of mentally ill or incapacitated patients,<sup>325</sup> (arguably) grievous bodily harm<sup>326</sup> or child neglect.<sup>327</sup> There has never been a general principle for criminalising negligence.<sup>328</sup>
133. When a negligent action results in the death of a patient, the doctor can face criminal charges under the offence of gross negligent manslaughter. For these charges to be successful, the House of Lords has outlined four criteria which must be satisfied: (1) there must be a duty of care to the patient, (2) there must be a breach of duty of care, (3) this breach must cause or significantly contribute to the death of the victim, and (4) this

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<sup>323</sup> Thomas, G., *Consent in Health Care Practice*, 1998, p. 1.

<http://www.nadr.co.uk/>

<sup>324</sup> Gillon, R., *Philosophical Medical Ethics*, Chichester: Wiley & Sons, 1987, p.1.

<sup>325</sup> Mental Health Act 1983 s 127; Mental Capacity Act 2005 s 44.

<sup>326</sup> Offences against the Person Act 1861 s 20.

<sup>327</sup> Children and Young Persons Act 1933 s 1.

<sup>328</sup> Kazarian, M., Griffiths, D., and Brazier, M., *Criminal Responsibility for Medical Malpractice in France*, Westlaw.UK, 2011, p.36;

Asworth, A., *Principles of Criminal Law*, Oxford University Press, Sixth Ed, 2009, p.276-277.

breach must be sufficiently great to merit criminal punishment.<sup>329</sup> This test is objective, and therefore, no evidence of recklessness or disregard is required for an act or omission to fall within the criminal law.<sup>330</sup> A monetary error made in their absence can lead to the conviction if the consequences of such an error are sufficiently grievous regardless of the defendant's intention. Yet, someone performing the same error and is less emphatic about the patient's outcome, and shows evidence of malicious intent would not face criminal charges if fortunate enough to have a better patient outcome. As such, chance can dictate their fate.<sup>331</sup>

134. As mentioned earlier, a physician would be liable for the offence of gross negligent manslaughter if an act or omission on his/her part leads to the death of a patient and if that act or omission is deemed sufficiently gross. In the case of *R. v Bateman*<sup>332</sup> where the doctor's patient died during childbirth, the judge advises the jury to convict if they felt:

*"...the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the state and conduct deserving punishment."*

135. The case of *R. Adomako*<sup>333</sup> provides the current test for gross negligent manslaughter. The defendant, who was an anaesthetist who had negligently failed to notice that a ventilation tube had become disconnected, was based on whether the conduct is leading to the patient's death, was so far departed from acceptable standards that it should be judged under criminal proceeding.<sup>334</sup> In essence, jurists should decide whether the act

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<sup>329</sup> *Homicide: Murder and Manslaughter. The Crown Prosecution Service;*

<http://www.cps.gov.uk/>

<sup>330</sup> Griffiths, D., Sanders, A., *Bioethics, Medicine and the Criminal Law*, Cambridge University Press, 2013, p.123.

<sup>331</sup> McGowan-Smyth, S., *Criminal Liability for Gross Negligence in Medical Contexts: Should It Depend on Consequence?*, Human Welfare, Vol. 2, 2013, p 56.

<sup>332</sup> *R. v Bateman* [1925] *All ER* rep 45.

<sup>333</sup> *R. Adomako*, [1995] 1 AC 191.

<sup>334</sup> Levy, S., *Criminal Liability for Negligence*, Medicine and Law, 2006, p. 603.

was criminal or whether they think a crime has been committed. This reasoning, unsurprisingly has circularity as a frequent criticism. In both cases, it would seem that an act is only worthy of punishment if it leads to the death of a patient.<sup>335</sup>

## **5. Medical malpractice law in Vietnam**

### **5.1. Background**

136. The Civil Code 2015 and Law on Medical Examination and Treatment 2009 (LMET) are the main bases for adjusting MM. In addition, criminal and administrative liabilities can be applied in case of such an occurrence. Unlike the situation in Belgium, France, and England, in Vietnam, there is neither legal literature about MM nor any jurisprudence that have been published.
137. In Vietnam, the Civil Code regulates local transactions under contract and tort. The Civil Code enacted in 2005 was in use in Vietnam. However, the Civil Code of 2005 was replaced by a new reformed Civil Code enacted on 24<sup>th</sup> November 2015 and was put into practice on 1<sup>st</sup> January 2017.
138. According to the Civil Code, tort liability is the responsibility to commit unlawful acts which cause damage to others regarding property, health, personality and personal rights that previously occurred between the person causing the damage and the person being caused the damage. The unlawful acts are not described in the contract, and they are not scoped in the contract breaches. The acts of causing damage outside the contract are the acts of infringement upon the group of persons entitled to be protected by law.<sup>336</sup>
139. Similarly. In Belgium, France, and England, the law of tort is applied when a physician negligently causes damage. To establish MM case, the patient must prove fault and other elements: a duty of care, breach of a duty of care and causation.
140. Recently, Vietnam has legalised to the law on compensation without fault but in a strict scope.

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<sup>335</sup> McGowan-Smyth, S., *Criminal Liability for Gross Negligence in Medical Contexts: Should it Depends on Consequence?*, Human Welfare, Vol. 2, 2013, p. 56.

<sup>336</sup> Article 548 - Civil Code.

## 5.2. *Tort of with fault*

### 5.2.1. *Fault*

141. There is no definition of fault in the Civil Code, but it classifies fault into two kinds: intentional fault and unintentional fault (negligence). To have a complete overview of medical fault in Vietnamese law, it requires the combination of various legal sources such as the Civil Code, LMET, and legal guiding documents.
142. The definition of fault in Vietnam seems slightly different as compared to Belgium, France, and England. The three countries have common aspect fault definition. Generally, a fault is defined as “that is a person fails to obtain an acceptable standard/behaviour when carrying out a duty.” Evidently, Belgium says that a fault is a violation of a written or unwritten rule of conduct in force in a specific society at a precise moment. It is a flexible concept, whose contents may vary according to time and place. Alternatively, it can be referred to as socially unacceptable behaviour. In this case, two main subcategories of fault are distinguished. The fault can consist of negligence, that is, departure from the general duty of care. Subject to an invisible mistake or other causes of justification, fault also arises from a violation of statutory or regulatory provisions imposing specific conduct or a duty to abstain.<sup>337</sup> Elsewhere, in France, the fault is described in ways: First, a person commits fault if he violates a statutory rule. Each statutory rule is considered to have an entire scope in the sense that it protects each person who suffers damage which is caused by the violation of the statutory rule. Secondly, the fault can be established by the breach of a pre-existing vocal duty.<sup>338</sup> In England, the fault is similar to Belgium and France in that the fault means that the defendant must fail to take the care expected of a reasonable person in the circumstances.<sup>339</sup>

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<sup>337</sup> Kruithof, M., and De Bondt, W., *Introduction to Belgian Law*, Wolters Kluwer, 2017, p. 250.

<sup>338</sup> Cees Van Dam, *European Tort Law*, Oxford University Press, 2006, p.302.

<sup>339</sup> Stauch, M., *The Law of Medical Negligence in England and Germany: A Comparative Analysis*, Hart Publishing, 2008, p. 27-28.

143. While Vietnam only specifies that a fault is an act that causes unintended damage. The following is evidence to explain the fault in Vietnam as well as its differences with other countries.

144. Under the tort of negligence, the author will follow the route of unintentional fault as it has the meaning of negligence.

*“Unintentional fault is in a case that a person does not foresee his act likely causes damage although he must know that the damage will occur or might be prevented.”<sup>340</sup> The act, in this case, will be called an illegal act.*

145. The definition of unintentional fault implies that to establish the liability, the person who causes damage does so without realising that the error might cause damage. In other words, the person recognises that the act is wrong, but s/he performs the act without expecting damage; instead, the person believes that damage is preventable, then that damage occurs as a result of an illegal act.<sup>341</sup>

146. As for the meaning of an illegal act, the law does not regulate it, but it is explained by the researcher as:

*“An illegal act is a behaviour. It can exist in the forms of action or no action. Every human thought is never considered a violation of the law;*

*An illegal act is an act that must be contrary to the specific requirements of the law such as doing what the law prohibits or failure to do what the law requires.”<sup>342</sup>*

147. Under this definition, there is a considerable difference compared to definitions of fault in Belgium, France, and England. While infringing of a standard is a prerequisite in

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<sup>340</sup>Article 364 - Civil Code 2015.

<sup>341</sup> Article 5.276 - Civil Code.

<sup>342</sup>Le, V.S., *Discuss the Events of Force Majeure and the Principles of Speculation of Fault in Article 584 of the Civil Code 2015*, Ministry of Justice, 2017;

<http://www.moj.gov.vn/qt/tintuc/Pages/nghien-cuu-trao-doi.aspx?ItemID=2103>

determining a fault in the three countries, causing damage is a core element in determining according to the Civil Code in Vietnam.

148. Combined with the LMET, a fault is determined when a physician infringes the responsibilities for care and treatment of patients; infringes the professional and technical criteria and professional ethics (infringement the so-called standard of care which the author will discuss below) and infringes upon the rights of patients.

Based on the LMET there are three instances in which that fault may occur.

149. First, there are some Articles (from Article 54 to 68) which must be followed when health professionals are offering health services. However, to the best of the researcher's knowledge, it seems like a very general guideline. Failure to follow this guideline leads to a situation where fault will be established.
150. Secondly, the fault is also established in another case. If a health professional applies medical professional methods and technology which are not admitted cause damage,<sup>343</sup> he commits a fault. Therefore, according to Vietnamese law, a fault is determined when someone fails to obligate the provisions approved by the Government.
151. Thirdly, a fault in MM law in Vietnam may also include:

*“...infringing upon patients’ rights; failing to observe professional and technical regulations in medical examination and treatment; taking advantage of positions and powers in medical examination and treatment, abusing the profession to harm the honor, dignity and body of a patient, erasing and modifying case history dossiers to falsify information on medical examination and treatment.”<sup>344</sup>*

The researcher will discuss the standard of care under Vietnamese law in the following part (breach of a duty of care).

152. The researcher will discuss more the second point of fault. It seems a fault in MM even if a doctor uses medical professional methods and techniques in the right way according

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<sup>343</sup> Article 6.6 - Law on Medical Examination and Treatment, No. 40:2009/QH12.

<sup>344</sup> Article 6. 10- Law on Medical Examination and Treatment.

to international standards but those that are not yet recognised in Vietnam and damage occurs (damage may be caused by a fault or not). For example, a Vietnamese doctor trained in France may be knowledgeable on some advanced therapies in cancer treatment that are internationally accepted in cancer treatment. Suppose he applied the same therapies in Vietnam, where they are not recognised. Then, unfortunately, the patient dies. Consequently, it is challenging for the doctor to avoid liability in this case as it is not easy to prove that whether there is a causation between fault and damage. In practice, Vietnam has been lagging behind in learning and adapting new international standards in health care.

153. The MM laws of Belgium, France, and England may not have enacted the so-called “fault” as written in Vietnamese medical law. That fault is: *“taking advantage of positions and powers in medical examination and treatment, abusing the profession to harm the honour, dignity, and body of a patient, erasing and modifying case history dossiers to falsify information on medical examination and treatment.”*<sup>345</sup> It is not difficult to answer the question of why this regulation exists in Vietnamese MM law. The reason is that corruption is prevalent in the system as indicated earlier.
154. Moreover, in cases of emergency, the physician will be exempted from the liability if technical means, equipment, and/or practitioners are not available. There is also no liability if there are no professional regulations on a disease. Other forces majeure cases result in such incidents. This regulation aims to exempt the physicians from liability. However, it is clear that this is the fault of the government for failing to provide adequate resources in health care services. In practice, numerous patients have to suffer damage when this regulation is referenced. Physicians like to blame the lack of equipment, human resources, as well as an incident being out of their professional knowledge to escape the liability. This point, indeed, should be considered as a no-fault compensation.
155. For example, a case occurred in September 2016. Truc - a woman who was expectant with twins, was taken to a general hospital in Hau Giang: a province in the South of Vietnam. The doctor said that she was fine and all she had to do was wait to deliver. Suddenly, she began bleeding, and after an ultrasound, the doctor stated that the twins

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<sup>345</sup>Article 6. 10 - Law on Medical Examination and Treatment.

died. Truc was transferred to Can Tho Maternity Hospital in a critical condition. What ensued was: stillbirth, liver failure, kidney failure, and coagulopathy. The physician did dialysis and plasmapheresis, but she died later. Explaining her death, the manager of the hospital in Hau Giang said,

*“As that day was a Sunday, no obstetrician was present. There was only a general physician. When her health deteriorated, the obstetrician was called immediately to treat her, but his house is very far from the hospital, so it took time for him to come to save her and her children.”*

156. This case is still being investigated. Investigators are trying to find out the cause of the deaths of the twins and the woman. While waiting for the conclusion, a representative of the hospital in Hau Giang visited and gave some money to her family.<sup>346</sup>
157. Clearly, in this case, to avoid or reduce liability, lack of human resource was referenced. However, it sounds incredibly unreasonable that a hospital could run with obstetric functions but without enough obstetric professionals.
158. As such, Vietnam does not have a complete fault definition, and it is understood differently from other countries. Having an acceptable rule on a fault in the medical sector, it is necessary to combine different legal sources. The main difference is that the fault of law in Vietnam does not mention acceptable standard/ behaviour. This difference makes the application of the law misleading since the fault only focuses on the damage caused by an unintentional act. It ignores an essential factor in determining the fault. The fault is a failure to obtain the acceptable standard/ behaviour which causes the damage.

### **5.2.2. Duty of care**

159. Article 274 of the Civil Code defines duty as:

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<sup>346</sup> T., Luy, *The Hospital Negligently Caused Deaths of the Mother and Child was Sued*, Tuoi Tre, 2016;

<http://tuoitre.vn/tin/chinh-tri-xa-hoi/20160912/gia-dinh-to-benh-vien-tac-trach-lam-chet-ca-me-lan-con/1170258.html>.

*“Duty is a task under which a person or more than one person (hereinafter referred collectively to as the obligator) must transfer an object, transfer rights, pay money or return valuable papers, perform tasks or refrain from doing tasks in the interests of one person or a number of persons (hereinafter referred collectively to as the obligee).”*

160. Besides, Article 275 of the Civil Code states that several bases arise from liability to a duty of care. Among these bases, exists one related to MM, which is referred to as *“illegal act of causing damage.”* The concept of an illegal act in the context of MM is discussed below.

161. Also, Article 276 of the Civil Code outlines the objects of the duty:

*“Objects of duty may be a property or a task which must be performed or not be performed; an object of duty must be determined”;*

162. Synthesizing the Articles 274, 275, and 276, duty in the context of MM is a task that must be or not is performed by a medical practitioner in the interests of a patient. A medical practitioner must perform or not perform the duty of care by the statutory medical regulations. That duty must be regulated by law (determined duty).

163. Also, the LMET requires the definitions of examination, treatment, and patients to explain the duties of medical practitioners. It is a way to establish the relationship between medical practitioners and patients via duty of care:

*“Medical examination means the inquiry into diseases and medical history, physical examination, and instruction for paraclinical testing or functional probe, when necessary, diagnosis and instruction of recognised appreciate treatment methods;*

*Medical treatment means the use of recognised professional and technical methods and drugs licensed for circulation for first aid, cure, care and functional rehabilitation of patients;*

*Patients are the users of medical examination and treatment services.*<sup>347</sup>

164. Under the definitions, a patient can contact a medical practitioner (in private or through public agencies) to use the described health services, and the practitioner provides certain health care services. The context means that the duty of care of a medical practitioner is established. Linking to the Civil Code, a health practitioner must perform or not to perform in the interest of a patient. For example, diagnosing and treating the patient or not applying new treatment methods that are not yet recognised to treat the patient.
165. Similarly, in Belgium and France, in Vietnam, a duty of care originates from the Civil Code, a contract or from tort. Nevertheless, the patients claim only for compensation under the tort of negligence although they establish a contract when using health services.<sup>348</sup> It seems that the private physicians do not assure the outcome but carry the duty most reasonably.

### **5.2.3. Breach of a duty of care**

#### **5.2.3.1. In general**

166. In the Civil Code of Vietnam, the breach of duty means the obligator fails to follow the regulations stated below:<sup>349</sup>

*“Perform a duty under which a person owing a duty is obliged to perform that exact duty;*

*Or not to perform a duty under which a person owing a duty is obliged to, or not to perform that specific duty.”*

167. However, a breach of a duty of care is not defined in the LMET. The Civil Code seems concerned with establishing a breach of a duty of care in the case of MM.

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<sup>347</sup> Article 2 - Law on Medical Examination and Treatment, No.40/2009/QH12.

<sup>348</sup> Article 584 - Civil Code.

<sup>349</sup> Article 281 - Civil Code.

168. One of the most difficult challenges in Vietnam is to answer the question: what are the criteria to determine a breach of duty? In Belgium, France, and England, *the standard of care* is taken into consideration when determining whether an act is a breach of a duty of care.
169. The Belgian and French laws state that a doctor must give patients “*conscientious, attentive care in conformity with the current medical professional care.*” England also has a similar notion of a standard of care. It is described that “*A doctor is not guilty of negligence if he has acted by a practice accepted as proper by a responsible body of medical men skilled in that particular art....merely because there is a body of opinion which would take a contrary view.*”<sup>350</sup> The notion of a standard of care in the three countries shows a common idea that a doctor is under a duty to use reasonable care and skills to offer a patient medical help conscientiously and attentively. In another word, it should conform to the data and advances in medical science, in the sense that the current level of scientific progress should be taken into account.<sup>351</sup>

Below, the author will present the standard of care in Vietnam.

#### **5.2.3.2. Standard of Care**

170. The standard of care in Vietnam does not have the same features as the standard of care in Belgium, France, and England. To determine the so-called standard of care in Vietnam must contain two elements:
1. Instead of being considered a skilled person, a physician must be licensed to practice. It means having a physician license is a one of the condition to meet a standard of care.
  2. Then, the licensed practitioner has to obligate these regulations in medical examination and treatment. These regulations can be seen in

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<sup>350</sup>McHale, J., *Medical Malpractice in England - Current Trends*, *European Journal of Health Law*, 2003, p.136.

<sup>351</sup>Nys, H., *Report on Medical Liability in Council of Europe Member States*, Council of Europe, 2005, p. 2.

Vietnam as the obligation to use reasonable care and skills as other countries.  
It is presented as the following:

- (a) *A medical examination is an inquiry into diseases and medical history, physical examination, and instruction for paraclinical testing or functional probe, when necessary, for diagnosis and instruction of recognised appreciate treatment methods;*
- (b) *Medical treatment means the use of recognised professional and technical methods and drugs licensed for circulation for first aid, cure, care and functional rehabilitation of patients;”*

171. Based on the above regulations, Vietnam does not use the notion of “reasonable person” or “skilled doctor” to indicate a person who is qualified to carry a duty of care under the evaluation of his peer(s). Instead of calling the physician is “a skilled person,” Vietnam names that one is a “licensed person.”<sup>352</sup> Understanding, the licensed person may be skilled or not according to the LMET when s/he is never evaluated by peer(s).<sup>353</sup>

172. If a medical practitioner would like to get the license, he/she has to satisfy the following conditions:

1. *Professional diplomas in health granted or recognised in Vietnam;*
2. *Certificates of owners of herbal remedies or treatment methods;*
3. *Certificates of the practice duration, except for herbalists and owners of herbal remedies or treatment methods.*
4. *Certificates for practising medical examination and treatment.*<sup>354</sup>

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<sup>352</sup> From Article 17 to Article 25 - Law on Medical Examination and Treatment.

<sup>353</sup> Article 2.6 - Law on Medical Examination and Treatment.

<sup>354</sup> Article 18 - Law on Medical Examination and Treatment.

173. The licensed medical practitioner does not need to be skilled under peer's evaluation but qualified under the administrative procedure.
174. The licensed person (a licensed health practitioner) has to obligate to the regulations in examination and treatment as the so-called standard of care. Neither the Civil Code nor the LMET defines what the standard of care is. However, the LMET regulates: (1) the *professional and technical requirements for medical examination and treatment*, (2) the *application of new techniques and methods for medical examination and treatment*".<sup>355</sup> According to Vietnam's laws, this could be called the standard of care.
175. Nevertheless, this regulation does not mean "*standard of care*" directly but requires health practitioners to obligate the requirements of medical examination and treatment. The requirements in the medical context would be national and international standards which must be recognised according to Law on Promulgation of a Legal Document.<sup>356</sup> Even if some standard of care has been widely applied internationally, it should be approved for it to be applied in Vietnam. The Ministry of Health is responsible for promulgating and approving the standard of care for medical examination and treatment in each case.<sup>357</sup>
176. As Vietnam applies the statutory law, the requirements for medical examination and treatment will be applied if the national legislature enacts them. The liability of medical practitioners will arise if they fail to obligate to the written requirements. Therefore, the standard of care in Vietnam is not considered based on ordinary skilled professional persons but depends on written, enacted law and allowed for use by the Legislature. However, this can take a long time to enact and might be weak and out of date. Consequently, this would limit medical advances in Vietnamese medical law.

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<sup>355</sup> Article 1 - Law on Medical Examination and Treatment.

<sup>356</sup> Law on Promulgation of Legal Documents 2017 No. 80/2015 / QH13.

<sup>357</sup> Decree on Providing Regulations on the Functions, Tasks, Authorities and Organizational Structure of Ministry of Health - 75/2017/NĐ-CP.

177. The issue mentioned above has been raised not only in legislation but also in practice. There are two main reasons why Vietnam does not apply “standard of care” through a skilled person but written documents.
178. First, the qualifications and distributions of health practitioners are not standardised. The following evidence proves this point:
1. There are a few highly qualified health practitioners with disproportionate distribution. The bulk of public workers with post-graduate degrees (doctorate, masters) is low (2.2 %), and they are concentrated in high-level facilities. Health workers with university qualifications (mainly doctors) account for 29% of the total health workforce and are mostly concentrated at the provincial level hospitals. However, there is no data on the proportion of health workers trained as specialists or resident doctors to analyse the qualifications of the health workforce.
  2. Qualifications of preventive health workers remain poor. The number of universities trained health staff in the preventive system, remains low at 11.2 % and only 2% hold professional preventive medicine degrees/certificates (e.g., public health, occupational, etc.);
  3. The low number of lower-level health workers could be responsible for the poor delivery of health services and the widespread medical errors in diagnosis and treatment. Research statistics indicate that only 64% of patients referred from provincial or district to central services were given an accurate diagnosis at the lower levels.<sup>358</sup>
179. The second reason is the difference in the quality of medical equipment in Vietnam and other countries such as Belgium, France, and England. Directly applying excellent international medical standards in Vietnam is not tenable because most medical equipment operators and professionals are not trained well (not techno-savvy) enough to match the international standards. To avoid these problems, the government has opted

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<sup>358</sup> Health Partnership Group, *Joint Annual Health Review 2009: Human Resources for Health in Vietnam*, Vietnam Ministry of Health, 2009, p. 80-81.

to control the standard of care of practitioners through the current statutory regulations. Even though they are out of date, evidently, medical equipment in district hospitals only meet 30-50% of the official requirements. In some facilities, the equipment only meets 20% of the requirements. Hospitals still lack necessary equipment for diagnosis, emergency response, and treatment such as X-rays, ultrasound, biochemical tests, haematology, ventilators, patient monitors, surgical instruments, and surgical lights. Medical staff lacks adequate training and experience to explore all the features of the existing equipment. Technical staff is inadequately equipped to keep up with the rapid innovations in medical technology.

180. Moreover, the number of domestic medical equipment manufacturers is limited, and they produce just a few types of instruments and equipment, which are of relatively low quality. The medical equipment manufactured in Vietnam tends to be mechanical or electronic products but not high tech products such as digital products. The commercial system for distribution, importation, and exportation of medical equipment is incomplete; it lacks capital, information, qualified staff with financial knowledge and technical qualifications on medical equipment. Moreover, medical equipment investment in hospitals is considered as a strategic tool for competition. However, it has led to high dependency on medical equipment and waste due to lack of knowledge or overprovision of services. Equipment investments are not linked to the capacity for utilisation, nonselective adoption of technologies and lack of state orientation on medical equipment.<sup>359</sup>
  
181. Although the Vietnamese health sector does not meet the world's standard of care, the government has tried to set the standard of care by prescribing standards and quality assurance for medical equipment. The health ministry has developed and issued some documents to regulate standards for medical equipment at different levels. The Ministry of Health has also teamed up with the Center for Standards and Quality (Ministry of Science and Technology) and Vietnam Standards for medical equipment to raise standards. Standards for medical equipment have been developed and promulgated to meet the requirements of production, business, investment, exploitation, use, and

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<sup>359</sup> Health Partnership Group, *Joint Annual Health Review 2012: Improving Quality of Medical Services*, Vietnam Ministry of Health, 2012, p. 102-103.

management. The Ministry of Health has also developed technical standards as required and implemented inspection on a wide range of equipment such as X-ray machines, CT-scanners, electrocardiograms, ventilators, and anaesthesia equipment. A list of essential medical equipment was developed for use by the Project on construction investment to renovate and upgrade district hospitals, regional hospitals, and regional polyclinics funded through government bonds and other legal sources of funds.<sup>360</sup>

182. In short, to improve the standard of care in Vietnam, the issues of skilled personnel and the standard of facilities should be addressed in an equal measure. This amelioration can utilise all the ability of the skilled physician and facilities' functions. For example, in a situation where a skilled physician could treat a cancer patient, but due to outdated medical facilities, the patient died. On the contrary, also in this example, the physician could have been not skilled enough (as mentioned, the qualifications of health workforce are different from level to level) so s/he could not explore the modern equipment in cancer treatment. Consequently, the cancer patient was not saved. The patient lost the chance to live because the health sector does not have enough skilled physicians and modern equipment. Under Vietnamese regulations, these events would be referred to as "*incident in medical examination and treatment.*"<sup>361</sup> Consequently, the physician may be exempted from taking liability.
183. Optimistically, going along with the development of standards for medical equipment, the standards of the medical workforce will also improve. Hence, in a few years from now, Vietnam will have wholly defined standards of care.

#### **5.2.4. Damage**

184. According to the Civil Code, *those who infringe upon the life, health, honour, dignity, prestige, property, rights or other legitimate interests of individuals and thereby cause damage shall have to compensate.*<sup>362</sup> The LMET does not have any regulation for

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<sup>360</sup> Health Partnership Group, *Joint Annual Health Review 2012: Improving Quality of Medical Services*, Vietnam Ministry of Health, 2012, p. 102-103.

<sup>361</sup> Article 2. 13 - Law on Medical Examination and Treatment.

<sup>362</sup> Article 584 - Civil Code.

damage compensation. Hence, the Civil Code is applied in the case of medical compensation.

185. Naturally, the patient can only ask for compensation when the fault has been proven. Otherwise, one cannot be compensated under a legal procedure.
186. Different from Belgium, France, and England, Vietnam does not classify damage to include economic and non-economic damage, but it defines the subjects which suffer from damage such as health, life, and dignity under the following rules:

***Article 590. Damage caused by harm to health***

1. *Damage caused by harm to health shall comprise of:*
  - a. *Reasonable costs for treating, nursing and rehabilitating health, functional losses, and impairment of the aggrieved person;*
  - b. *Loss of or reduction in the actual income of the aggrieved person. If the actual income of the aggrieved person is irregular and cannot be determined, the average income level for the type of work performed by the aggrieved person shall be applied;*
  - c. *Reasonable costs and actual income losses of the careers of the aggrieved person during the period of treatment. If the aggrieved person loses his or her ability to work and requires permanent care, the damage shall also include reasonable costs for taking care of the aggrieved person.*
  - d. *Other damage as prescribed by law.*
2. *A person causing harm to the health of another person must pay an amount of money as compensation for the mental suffering of the aggrieved person. The amount of compensation for mental suffering shall be as agreed on by the parties. If the parties are not able to agree, the maximum sum shall not exceed fifty-month base salary prescribed by the State.*

***Article 591: Damage caused by harm to life***

1. *Damage caused by harm to life shall comprise:*

- a. *Damage caused by harm to life prescribed in Article 590 of this Code;*
- b. *Reasonable funeral costs;*
- c. *Support for the dependents of the aggrieved person;*
- d. *Other damage as prescribed by law.*

2. *A person causing death to another person must pay some amount of money, in compensation for the mental suffering of the closest relatives in the first line of succession (husband/wife and children) to the deceased. If there are no such relatives, this sum shall be paid to the persons who were directly reared by the deceased or to the persons who directly reared the deceased (parent, partner, etc.). The amount of compensation for mental suffering shall be as agreed by the parties; if the parties are not able to agree, the maximum sum shall not exceed 100 months of basic salary prescribed in by the State.*

***Article 592: Damage caused by harm to honour, dignity or reputation***

1. *Damage caused by harm to the honour, dignity or reputation shall comprise:*

- a. *Reasonable costs for mitigating and remedying the damage;*
- b. *Loss of or reduction in actual income;*
- c. *Other damage as prescribed by law.*

2. *A person causing harm to the honour, dignity or reputation of another person must pay compensation for damage for mental suffering of the aggrieved person. The amount of compensation for mental suffering shall be as agreed by the parties; if the parties are not able to agree, the maximum sum shall not exceed ten months of basic salary prescribed by the State.*

187. Although Vietnam does clarify the damage based on the damage's objects, there are also two kinds of damage from the rules: economic damage and non-economic damage just like in Belgium, France, and England's laws. The above regulations serve the same purpose, which is tort compensation for restoring the patients to the same position they were before the damage.

188. For economic damage, the concept that needs to be stressed in these regulations is “reasonable expenses.” Nevertheless, there is no definition of the phrase “reasonable expenses” both in the Civil Code and the LMET.
189. Another significant point for reasonable expenses that the Vietnamese MM law does grant is the patient’s right to be compensated with a free choice of a doctor and the hospital in which to be treated.<sup>363</sup> As such, the patient is not given the best health services as expected. The standard that is usually applied is the “social health care cost.” In other words, the patient goes back to the government health system which has maintained a lot of unreasonable issues. If a patient wishes to use health care services out of the budget covered by SHI, the expenses would not be seen as reasonable expenses. As a result, the patient would have to use his/her own money.<sup>364</sup> The deficiency in this rule diverts the Vietnamese MM law from its purpose, thereby placing the patient in the same financial problem.
190. Belgian, French, and English laws require that if the doctor and patient fail to agree upon the amount to be compensated, the court should decide the amount based on actual losses and expenses which result from the injury, including expenses for medicine, nursing, or the loss of life.<sup>365</sup> However, while Belgian<sup>366</sup> and French laws<sup>367</sup> consider losses of future earning, or a chance to get a promotion, Vietnam law does not recognise the same.
191. Besides economic damage, the non-economic damage is also taken into account while compensating a patient. Same as economic damage, the non-economic damage is only

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<sup>363</sup> Article 8: Circular on Primary Medical Examination and Treatment covered by Health Insurance and Transfer to other Levels for Health Examination and Treatment Covered by Health Insurance, No. 40/2015/TT-BYT, Health Ministry of Vietnam.

<sup>364</sup> Article 22. 3 - Law on Amending and Supplementing Some Articles of Law on Health Insurance, No. 46/2014/QH13, Parliament of Vietnam.

<sup>365</sup> Koch, B, *Medical Liability in Europe: A Comparison of Selected Jurisdictions*, De Gruyter, 2011, p. 81-82.

<sup>366</sup> Vansweevelt, T. and Weyts, B., *Handboek Buitencontractueel Aansprakelijkheidsrecht (Extra-contractual Liability Law Handbook)*, Intersentia, 2009, p. 720.

<sup>367</sup> Tourneau, P., *Droit de la responsabilité et des contrats (Law of Liability and Contracts)*, Dalloz, 2004, p. 364-365;

Bell, J., *Governmental Liability: Some Comparative Reflections*, 2006, InDret, p. 15.

regulated in the Civil Code but not in the LMET. The regulations of non-economic damage (to health and life) are conditional provisions in the same regulations that regulate economic damage. In other words, the non-economic damage is only considered if economic damage takes place. It means that the patients must prove the causation between economic loss and non-economic loss. They cannot separately claim for non-economic damage. Differently, French courts allow patients to be compensated once liability for a tortious act has been established, and do not consider physical or psychological impact as being relevant.<sup>368</sup> In the opinion of the author, this omission in Vietnamese law does not provide enough protection to the patient when he/she is harmed. In practice, some patients are mentally infringed upon despite them having no physical pain. For example, Mr A had some stomach pain.<sup>369</sup> He went for a check-up and was informed that he has stomach cancer, after which he immediately went home. After being checked into another hospital, he was found to have chronic gastritis. He was profoundly shocked and was inclined to commit suicide. He could not ask for moral compensation because he could not prove that his moral pain was a result of physical pain. In his case, his moral pain was a result of misdiagnosis, not physical damage.

192. The author does not find any basis to clarify the kinds of non-economic damage (such as distress, loss of amenity, loss of enjoyment and aesthetic damage, etc.). In practice, the lack of basis most of the time makes the parties fail to have an agreement for compensation as the rule of law states.
193. If they fail to agree, the compensation will be calculated based on the basic income.<sup>370</sup> For example, a person (an accountant or a teacher) who suffers mental damage when his health is harmed, may get maximum 150 euro x 50 months=7500 euro.<sup>371</sup> This application restricts the right to commensurate mental damage compensation. Evidently,

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<sup>368</sup> Lambert-Faivre, Y., *Droit du Dommage Corporel (Right of Personal Injury)*, Dalloz, 2015, p. 39.

<sup>368</sup> Bell, J., *Governmental Liability: Some Comparative Reflections*, InDret, 2006, p. 19.

<sup>369</sup> Minh Nhat, *Extra- contract Liability*, Ministry of Justice, 2015;

<http://moj.gov.vn/qt/tintuc/Pages/nghien-cuu-trao-doi.aspx?ItemID=1806>

<sup>370</sup> Article 590. 2 - Civil Code.

<sup>371</sup> Decree on Regional Minimum Wage Regulation - No. 153/2016. ND-CP.

the law imposes the maximum compensation based on income calculation regardless of how dangerous the patient suffers from mental damage. In Belgium, France and England amount of compensation is not limited, and the calculation is to be based on actual losses.

### **5.2.5. Causation**

#### **5.2.5.1. In general**

194. Similar to Belgian, French, and English laws, in Vietnam when one has proof of causation between fault and damage, he/she is obligated to seek compensation. According to Article 584 of the Civil Code, damage must occur as a result of the unlawful. Damage will be an inevitable result of behaviour if it contains a real reason causing damage.<sup>372</sup> Similarly in Belgium and France, the theory of “*equivalence of conditions*”<sup>373</sup> is considered to establish liability. Also, in England, when making a decision, the courts always argue that the injury would not have occurred “*but for*”<sup>374</sup> the negligence of the defendant. However, Vietnam has never officially recognised the theory of the test “*but for.*”

#### **5.2.5.2. Burden of proof**

195. The patient has a duty to prove the causation. Besides, under the Code of Civil Procedure, Article 85.2<sup>375</sup> notes that “*in the cases stipulated by this Code, the judge may conduct one or some measures to collect documents and evidence*” to supply more

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<sup>372</sup> Phi, L, *Grounds for Liability Arising out of Contract Compensation in the Civil Code 2015*, Journal of Democracy and Law;

<http://tcdcpl.moj.gov.vn/qt/tintuc/Pages/thi-hanh-phap-luat.aspx?ItemID=288>

<sup>373</sup> The theory of the equivalence of the conditions entails that every condition of an injury is a cause. Since it is impossible to specify the exact share of each condition in the production of the result, every factor should be considered as a cause. It is also believed that all conditions are necessary to produce the result and are, therefore, inevitably equivalent. In other words, all the conditions without which the effect would not have occurred are necessarily equivalent.(Richard Goldberg, *Perspective on Causation*, Hart Publishing Ltd, 2011).

<sup>374</sup> *Barnett v Chelsea & Kensington Hospital* [1969] 1 *QB* 428.

<sup>375</sup> Code of Civil Procedure, Article 85.2 of the Law amending and supplementing some articles of the Civil Procedure Code (CPC) (effective from 01/01/2012) noted: In the cases stipulated by this Code, the judge may conduct one or a number of measures to collect documents and evidence.

evidence or make the evidence sufficient. By doing this, neutrally, the Court can protect the right interests of the plaintiff and claimant.

### **5.2.5.3. *Loss of a chance***

196. In its purest form, loss of a chance is a doctrine permitting recovery of damages for the destruction or reduction of prospect for achieving a more favourable outcome. It most often arises from a failure to diagnose cases, but it also has been recognised and applied in a variety of similar instances. The application happens when a patient who is already ill or stricken claims MM that results in the loss of chance of a better outcome. Save for lack of timely diagnosis or another alleged failure, the patient's chances for cure or a more favourable outcome would have been more significant with the result a palpable loss deserving of compensation.<sup>376</sup>
197. Belgium, France, and England have applied the doctrine. However, in Vietnam, this theory has never been implemented in legislation as well as in practice. Practically, although there are no statistics, uncountable patients have lost chances to be diagnosed and treated with better outcomes. As presented, only 64% of patients referred from provincial or district to central services were given an accurate diagnosis at the lower levels. Indeed, among them, 36 % of the patients who got the wrong diagnosis would lose a chance of better outcome. Such patients have not had any legal protection to sue for damages.

### **5.3. *Tort of negligence without fault (strict liability)***

198. No-fault liability, also known as strict liability, has limitedly applied in Vietnam. Most of the strict liability provisions relate to the protection of the interests of consumers in using products and goods. In addition, Vietnam has no definite definition of what goods are and has not yet considered health care services as a commodity. However, in recent times, Vietnam has admitted strict liability in health sectors as to the incidents of vaccination.

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<sup>376</sup> Weigand, A., *Loss of Chance in Medical Malpractice: A Look at Recent Developments*, Defense Council Journal, 2003, p. 301.

199. Strict liability has been recognised in Vietnam under the Law on Consumer Protection (LCP). Before discussing the Law, the author would like to refer to some relevant regulations under the Civil Code. Article 608 of the Civil Code says that “*individuals, legal persons, or other persons, manufacturing [and or] distributing products without ensuring the quality standards thereof, thus causing damage to a consumer, shall be liable for damages.*” The Supreme Court’s Committee of judges has interpreted this article thus. It stipulates that liability in tort arise when the following elements exist: (1) a loss is suffered, material or mental; (2) an illegal act/omission has occurred; (3) there is a causal relationship between the illegal act/omission and the loss; (4) the person who causes the loss must be at fault or was negligent. In other words, when at fault, traders must pay damages for defective products.<sup>377</sup>
200. However, Article 23 of the LCP has changed the standards detailed under Resolution 03.<sup>378</sup> Under Article 23, traders are now liable to pay compensation for death, personal injury, or property damage caused by their defective products (but not "defective services") even the traders were unaware or not at fault for the defects.<sup>379</sup>
201. Traders have real defences under the LCP. Traders can be excused from liability if they can prove that scientific or technical standards could not have found the defects at the time the traders supplied the products to consumers.<sup>380</sup>
202. Under articles 25, 26, and 42 of the LCP, petitioners bear the burden of proof in cases involving a trader's alleged violation of consumers' rights. However, in other articles,

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<sup>377</sup> Pham, A., *Vietnamese Law on Consumer Protection: Some Points for Traders*, Vietnam Law and Legal Forum, 2013;

<http://vietnamlawmagazine.vn/vietnamese-law-on-consumer-protection-some-points-for-traders-3628.html>

<sup>378</sup> Point 1, Part I of Resolution No. 03/2006/NQ-HĐTP dated July 8, 2006.

<sup>379</sup> Pham, A., *Vietnamese Law on Consumer Protection: Some Points for Traders*, Vietnam Law and Legal Forum, 2013;

<http://vietnamlawmagazine.vn/vietnamese-law-on-consumer-protection-some-points-for-traders-3628.html>

<sup>380</sup> Article 24 of the Law on Customers Protection.

the burden is on traders to prove they are not at fault. The provisions placing the burden of proof on petitioners make the most sense about service liability. However, Articles 25, 26, and 42 are difficult to understand when applied to defective products. That is traders bear liability for defective products whether or not they are at fault. Therefore, claims relating to product defects, the burden is on traders to prove that their products are safe for use by consumers. They are exempt from payment or compensation, in cases of other reasons.<sup>381</sup>

203. Oddly, there is no definition of a "product" even in the LCP. Generally, a "product" is an item that has been supplied by a trader, whether or not the item is manufactured in Vietnam. It includes such diverse offerings as agricultural produce, games, components, electricity, vehicles, and pharmaceutical products. As these examples show, the concept of a "product" as the term is used in the LCP is expansive. Traders may have difficulties in determining whether the item they are offering is a "product," and they may also have difficulty assessing defects of the product or determining who is liable for a defect.<sup>382</sup>
204. Remarkably, neither the Civil Code nor LCP defines any strict liability in MM. According to the laws, "medical products and medical services" have not been categorised as other products and services. Evidently, the notion of consumers is defined as "*consumers who buy and use products and services for consumption purposes and uses of individuals, families, and organisations.*" Therefore, medical victims may not be included as consumers in this rule. Moreover, strict liability regulations have not been seen in any medical law. Therefore, according to this regulation, it is legal that any medical error (including MM) is not considered based on strict liability.

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<sup>381</sup> Pham, A., *Vietnamese Law on Consumer Protection: Some Points for Traders*, Vietnam Law and Legal Forum, 2013;

<http://vietnamlawmagazine.vn/vietnamese-law-on-consumer-protection-some-points-for-traders-3628.html>

<sup>382</sup> Pham, A., *Vietnamese Law on Consumer Protection: Some Points for Traders*, Vietnam Law and Legal Forum, 2013;

<http://vietnamlawmagazine.vn/vietnamese-law-on-consumer-protection-some-points-for-traders-3628.html>

205. However, at the moment, there is a Decree on Provisions on Vaccination Activity<sup>383</sup> that allows the victims who suffer damage from vaccination related incidents to seek compensation without proving fault. These issues will be discussed in the part of no-fault compensation in Chapter 4.
206. No-fault liability is primarily regulated in respect of liability when a customer who suffered damage from using a defective product. The law also does not have a consistent and broadly applicable statutory obligation in the case of medical products (blood, organs, etc). It can be said that if most cases of damage occur and there is a claim for compensation, the Civil Code with fault proving is a significant law that applies.

#### 5.4. *Administrative liability*

##### 5.4.1. *Under administrative laws*

207. In parallel with the tort liability, health care practitioners may bear administrative liability. Under the Law on Administrative Sanctions:

*“Administrative violations are acts of the fault committed by individuals or organisations that violate the provisions of the law on state management, which are not crimes and must be sanctioned according to law provisions.”<sup>384</sup>*

208. “Administrative violations” has four basic signs as described above. First, violations are illegal acts they are provisions of the law on state management. Secondly, that is an act or failure to act. Thirdly, the act is done by an individual or organisation. Fourthly, it is an act of the wrong behaviour.
209. In administrative law, the damage is not a compulsory element. To specialize in the field of the healthcare sector, the Vietnamese government enacted a Decree on sanctioning of administrative violations.<sup>385</sup> Concurrently relevant to MM, there is a Decree on

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<sup>383</sup> Decree on Provisions on Vaccination Activity - 104/2016/NĐ-CP.

<sup>384</sup> Article 2.1 - Law on Administrative Sanctions, No. 15/2012/QH13.

<sup>385</sup> Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

Regulations on Sanctioning of Administrative Violations in medical examination and treatment.<sup>386</sup>

210. A physician who infringes the administrative regulations may be punished by following ways:

*1. Warning;*

*2. Fines (of different amounts which are classified in the Decree, maximum 5,000 euro for individuals and 10,000 euro for agents)<sup>387</sup>*

*3. Depriving licenses, professional practice certificates for a duration or suspend the operation for a certain duration;*

*4. Confiscating material evidence of administrative violations, the means used for committing administrative violations.<sup>388</sup>*

211. Also, the Decree on Sanctioning of Administrative Violations supplies more forms of sanctions as follows:

*1. Directly apologising to the patient;*

*2. Reimbursing expenses for medical examination and treatment under the scope of benefits and health insurance that the violated had to pay;<sup>389</sup>*

212. The Decree also specifies the cases in which a violator may be warned, fined or have their license confiscated:

*1. Use of alcohol or cigarette while carrying out medical examination;<sup>390</sup>*

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<sup>386</sup> Decree on Regulations on Sanctioning of Administrative Violations in Medical Examination and Treatment - No. 96/2011/NĐ-CP.

<sup>387</sup> Article 4.4-Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

<sup>388</sup> Article 21- Law on Administrative Sanctions, No. 15/2012/QH13.

<sup>389</sup> Article 28. 1 - Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

<sup>390</sup> Article 28. 1 - Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

2. *Failing to wear a nametag during examination and treatment;*<sup>391</sup>
3. *Selling medicine to the patient;*
4. *Failing to make or making medical records but not fully in accordance with the law;*<sup>392</sup>
5. *Failing to hold a medical consultation when the treatment does not progress or when it worsens;*<sup>393</sup>
6. *Failing to consult when the patient's case goes beyond the professional ability.*<sup>394</sup>
7. *Failing to ensure availability of sufficient quantities and quality of emergency transportation means and equipment, medical equipment and facilities, and medicine for emergencies;*<sup>395</sup>
8. *Failing to monitor medicine's effects and provide timely treatment to the patients when having incidents under their direct care and assign treatment medication...*<sup>396</sup>

#### **5.4.2. Under administrative principles of medical agents**

213. Medical practitioners bear not only administrative liability under the Laws regulated by the State but also principles from medical agents where they work. The sanctions from each medical agent will not change, reduce or replace other sanctions regulated by the State. For example, there are the disciplines which all the staff must compliance. The staff might take responsibility under the State and their employer's regulations if they infringed the disciplines. The disciplines' sanctions would be reprimanding, warning,

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<sup>391</sup> Article 28.4 - Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

<sup>392</sup> Article 30.1 - Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

<sup>393</sup> Article 30.1 - Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

<sup>394</sup> Article 30.3 - Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

<sup>395</sup> Article 30.5: - Decree on Sanctioning of administrative violations, No. 176/2013/ND-CP.

<sup>396</sup> Article 31. 2 - Decree on Sanctioning of Administrative Violations, No. 176/2013/ND-CP.

and dismissal.<sup>397</sup> In addition, in some other hospitals, like in the General hospitals, more kinds of sanctions have been applied such as demotion and decreasing salaries of medical practitioners who did not treat or handle patients as expected.<sup>398</sup>

214. This additional liability is a preventive instrument to limit MM cases where crises happened.<sup>399</sup> Nevertheless, looking at it from another perspective, the author believes it is an instrument for the health professionals. The health professionals, make omissions to deny their responsibilities to the patients in current Vietnam's context. This liability with less serious sanctions will replace other liabilities where they should be applied.<sup>400</sup>

### 5.5. *Criminal liability*

215. Traditionally, redress for patients harmed during the course of medical therapy has been sought in civil courts. "Civil" in the legal sense refers to private rights and remedies that are sought by action or suit. Civil cases, therefore, involve individuals and organisations seeking to resolve legal disputes. In a civil case, the victim brings the suit. Persons found liable in a civil case may only have to give up property or pay money.<sup>401</sup> Vietnam has the same features as Belgian, French and English criminal laws. The Criminal Code of Vietnam defines offences against the community at large, regulates how suspects are investigated, charged and tried, and establishes punishments for convicted offenders. In a criminal case, the state, through a prosecutor, initiates the suit. Persons convicted of a

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<sup>397</sup> Article 15 - Regulations on Emulation, Rewards and Discipline, No. 69/ QD-BVTT 02 May 14 2015, Director of Psychiatric Hospital in Da Nang).

<sup>398</sup>*The Ministry of Health requests the Sanction for the Doctor set foot on the Chair*, Infonet, 2017;  
<http://infonet.vn/bo-y-te-yeu-cau-xem-xet-hinh-thuc-xu-ly-bac-si-dat-chan-len-ghe-post236742.info>

<sup>399</sup> N. V, *Reforming Administration is to Improve the Healthcare*, Suckhoe&Doisong, 2015;  
<http://suckhoedoisong.vn/cai-cach-hanh-chinh-gop-phan-nang-cao-chat-luong-y-te-n110120.html>

<sup>400</sup> Problems after more than one year of implementation of Decree No. 176/2013 / ND-CP stipulating the sanctions of administrative violations in the health sector;  
<http://m.viendongdaily.com/vn-khung-hoang-y-te-bo-truong-bi-ap-luc-tu-chuc-8K8un6rg.html>

<sup>401</sup> Monico, E., Kulkarni, R., Calise, A., Calabro, J., *The Criminal Prosecution of Medical Negligence*, The Internet Journal of Law, Healthcare and Ethics, Vol.5, 2006, p.6.

crime may be incarcerated, fined, or both. Criminal law has the added objective of seeking to achieve deterrence and retribution through punishment.<sup>402</sup>

216. Generally, the basic elements of a crime include a voluntary act coupled with the appropriate mental state. Usually, the criminal law punishes only the affirmative harm the offender inflicts. However, failure to take action may result in crime. That is if the defendant had a legal duty to act or the inaction rises above civil negligence to include a level of risk-taking indifferent to the attendant risk of harm.<sup>403</sup>
217. A legal duty to act may arise out of other laws such as statutes (a law passed by a legislative body), or contract (a binding agreement between two or more bodies enforceable by law). Health care providers are subject to both. For instance, physicians are legally prohibited from refusing to treat patients because the patients are seropositive for the human immunodeficiency virus (HIV).<sup>20</sup>
218. Despite this explanation, what medical acts transform tort negligence into criminal negligence remains everybody's speculation. Courts and common law have not been helpful in clarifying how criminal negligence applies to the practice of medicine.<sup>404</sup> However, current definitions do seem to contemplate that, criminal negligence is more than a mistake in judgment. That notion can be found in the following definitions: "*That degree of negligence or carelessness which is denominated as gross, and which constitutes such a departure from what would be the conduct of an ordinarily careful and prudent man...as to furnish evidence of that indifference to consequences which in some offenses takes the place of criminal intent.*" or "*Negligence, to be criminal, must be reckless and want on.*" In the end, what will tip the criminal vs. civil balance might be whether justice would be better served if a medical act or omission requires the

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<sup>402</sup> Shestokas, D., *The Purpose of Criminal Punishment*, 2012.

<http://www.shestokas.com/general-law/criminal-law/the-purpose-of-criminal-punishment/>

<sup>403</sup> Monico, E., Kulkarni, R., Calise, A., Calabro, J., *The Criminal Prosecution of Medical Negligence*, *The Internet Journal of Law, Healthcare and Ethics*, Vol.5, 2006, p.6-7.

<sup>404</sup> Youngberg, B., *Patient Safety Handbook*, Jones & Bartlett: Learning, Second Ed, 2013, p. 580.

defendant to pay the victim for the loss and whether the defendant should pay society for the loss.<sup>405</sup>

219. The healthcare practitioners may bear criminal liability in accordance with the law if they fail to comply with standards and cause incidents to the patient as apart from civil compensation as prescribed. Under the Penal Code 2015, Article 129: Unintentionally causing death/deaths for violating professional rules or administrative rules:

*1. Those who unintentionally cause death/deaths for violating professional rules or administrative rules shall be sentenced to between one and five years of imprisonment.*

*2. Committing a crime resulting in two or more deaths, the offenders shall be sentenced to between five and twelve years of imprisonment.*

*3. The offenders may be banned from holding certain posts, practising certain occupations or doing certain professional duties for one to five years*

220. Also, Article 315 of this Penal Code regulates Crime of violation of regulations on medical examination and treatment, production and preparation of drugs, drug distribution, the sale of drugs and other medical services, as follows:

*1. Those who violate the regulations on medical examination and treatment, production, dispensing, selling drugs or providing other medical services shall be sentenced from one to five years in one of the cases:*

*a. If a healthcare provider causes a person dies or bodily injury of 61% or more;*

*b If a healthcare provider causes two people die or bodily injury at the rate from 31% to 60%;*

*2. Committing the offence in one of the following circumstances, the health care provider shall be sentenced from three to ten years of imprisonment:*

*a. Causing two people to die;*

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<sup>405</sup> Monico, E., Kulkarni, R., Calise, A., Calabro, J., *The Criminal Prosecution of Medical Negligence*, The Internet Journal of Law, Healthcare and Ethics, Vol.5, 2006, p.1-6.

*b. Causing bodily harm from the rate of 61% to the health of two people;*

*3. Committing an offence in one of the following circumstances, the health care provider shall be sentenced to between 7 and 15 years of imprisonment:*

*a. Causing three people to die or more;*

*b. Causing bodily harm at the rate of 61% to the health of three people;*

221. However, when looking at its practical application in MM, it is applied sparingly. There are very few cases of criminal MM which have been found so far:

**Case 1:** Medical malpractice in vaccination caused the deaths:<sup>406</sup>

The indictment stated on the morning of 20-7-2013, Nguyen Thi Thuan had a duty to inject hepatitis B vaccination to three infants. She went to the fridge where she stored the vaccinations. At that moment, power was off, and she used the light from her mobile phone to look for the vaccine. Then, she injected the infants.

About half an hour later, hearing the cries of the mothers' infants, Thuan responded and saw that the three children were pale and had abnormal breathing. She immediately took the infants to the emergency room, but they died shortly after that.

Then, Thuan realised that she had injected Esmeron<sup>407</sup> instead of hepatitis B vaccination.

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<sup>406</sup> Court of the first sentence of People's Court in Hanoi in December 5<sup>th</sup>, 2014;

<https://caselaw.vn/>

<sup>407</sup> Esmeron is indicated in adult and paediatric patients (from term neonates to adolescents [0 to <18 years]) as an adjunct to general anaesthesia to facilitate Tracheal intubation during routine sequence induction and to provide skeletal muscle relaxation during surgery. In adults Esmeron is also indicated to facilitate tracheal intubation during rapid sequence induction and as an adjunct in the intensive care unit (ICU) to facilitate intubation and mechanical ventilation;

<https://www.medicines.org.uk/>

After investigations, Nguyen Thi Thuan was sentenced to 5 years in prison because she committed MM causing the deaths of the infants (Sentenced based on the previous Penal Code 1999 which expired)

**Case 2: Violation of the process of examination and treatment caused:<sup>408</sup>**

On 19<sup>th</sup> October 2013, Le Thi Thanh Huyen (born in 1974 and resident of Hanoi) used services of breast cosmetic surgery at Cat Tuong cosmetic hospital. Here, Nguyen Manh Tuong was the owner as well as a doctor. Tuong was sentenced for violations in the process of examination and treatment. He was not skilled and was not yet licensed in performing cosmetic surgery. He did not administer first-aid to Huyen after seeing her reaction to the injection. After that, he went to the pagoda with his girlfriend. Later, he threw the body into the river. With the above submissions, he was sentenced to 19 years of imprisonment (for two crimes: Violation in the process of examination and treatment and violation of a dead body) and the victim's family was awarded an amount totaling up to 30,000 USD.

**Case 3: Eight patients died, and ten patients got injuries from kidney dialysis<sup>409</sup>**

This case happened on May 29, 2017, at Hoa Binh General Hospital in Vietnam. Tran Van Son was the officer of the equipment department tasked with the management, repair, and maintenance of the Medical Device's filter. Hence, Son contacted Thien Son Pharmaceutical Joint Stock Company to discuss the need for repair and maintenance of the product and the quotation. The company's representative to offer the service to the hospital was Bui Manh Quoc. However, Quoc infringed the standard of repair and maintenance of the equipment.

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<sup>408</sup> Court of the first sentence of People's Court in Hanoi in December 5<sup>th</sup>, 2014. No. 513/2014/HSST date 5/12/2014;

Court of Appeal of the Supreme People's Court in Hanoi in September 11<sup>th</sup>, 2015. No. 49/2015/HSPT date 11/9/2015.

<sup>409</sup> *Eight People Died of Dialysis: Chemicals Uncleansed*, VietnamNet, 2017;

<http://vietnamnet.vn/vn/thoi-su/vu-8-benh-nhan-chay-than-tu-vong-quen-rua-hoa-chat-trong-duong-nuoc-380065.html>

As a result, ten deaths and eight serious injuries occurred because the fluoride content exceeded the safety threshold hundreds of times.

Subsequently, the case was taken to a Criminal Court with the reference: Van Son, on irresponsible behaviour, caused serious, grievous bodily harm as provided in Article 285 of the Penal Code. The process was assigned to Son who did not monitor, repair and maintain the water filtration system, in line with the duties and responsibilities assigned to him. The court is yet to conclude penalties for Quoc and Son. Predictably, under the Criminal Code, Son (the medical technician) might bear the stipulated twelve years of imprisonment.<sup>410</sup>

222. These three cases discussed above, are typical ones that applied criminal negligence in Vietnam. All the above cases have the same point that the results of MM caused death (s). In the other cases in practice, although there are signs of a criminal offence, the cases are arranged to settle in the trend of civilian compensation. The law enforcement agencies seem to treat MM crime with exceptional tolerance, which deprives the patients of their legal rights and interests.<sup>411</sup> A large number of MM cases have happened in Vietnam, in which health care practitioners should take criminal liability.<sup>412</sup>

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<sup>410</sup> Article 315.3 - Civil Code.

<sup>411</sup>P., Thao, *There No Proper Sanctions for the Doctors Caused Omissions*, Dan Tri, 2013;

<http://dantri.com.vn/suc-khoe/xu-ly-bac-si-sai-pham-thoi-gian-qua-qua-nhe-1383842826.htm>

<sup>412</sup>Khanh Trung, *The Hospital Took Responsibility after Wrongly Amputating a Patient's Leg*, 2016;

<http://news.zing.vn/benh-vien-nhan-sai-sot-vu-cua-chan-hua-se-co-trach-nhiem-post667831.html>

Van Son, *Leg Apputate: If Intentionally, the Doctor will be prosecuted to Criminal Proceedings*, Zing, 2017;

<http://dantri.com.vn/suc-khoe/vu-benh-nhan-bi-cua-chan-neu-co-y-bac-si-se-bi-xu-ly-hinh-su-20160714214817951.htm>

## 6. Conclusion

223. MM called professional negligence, as a type of tort of negligence. The principles of MM law mostly directly apply to the principles of the tort of negligence.
224. MM laws in Belgium, France, England, and Vietnam apply the theory of tort of negligence based on a fault to adjust the wrong actions of health providers, with common vital factors as described. To establish fault, the duty of care, breach of a duty of care, damage and causal link between fault and damage are the required elements to succeed in a MM claim if based on fault system. Although the countries impose these elements as compulsory, the content of each is not the same among countries. In particular, Vietnam has many different points compared to Belgium, France, and England. For instance, in Belgium, France, and England, a fault is a person's failure to obtain an acceptable standard/ behaviour when carrying a duty while in Vietnam, the fault is defined as an act that causes unintended damage. Another difference is that Vietnam does not recognise the standard of care and loss of a chance in determining the responsibility of physicians when they caused damage.
225. The four countries Belgium, France, England, and Vietnam establishes the duty of care based on contract and tort laws. However, England seems to be in favour of establishing a duty of care based on tort law because it has a health care system, in which patients use national health services funded by the government. Hence, the relationship between doctors and patients is non-contractual. While, Belgium, France, and Vietnam can apply either contract or tort law because their health care systems are a mix of public and private partnership. Therefore, the relationship between doctors and patients is based on contract or tort law (for example, tort liability can be an omission out of the contract which injured a third party or failed to inform.)
226. While Belgium and France apply traditional *Mercier*, England uses *Bolam v Friern Hospital Management Company* to explain the reason why they apply the theory of standard of care in MM cases. However, they have a universal perspective in defining the concept of the standard of care. That is the proper treatment generally accepted by

the medical profession for a given medical condition in similar situations.<sup>413</sup> In Vietnam, a standard of care is taken differently based on the written regulations in examination and treatment by a licensed person.

227. Strict liability in the four countries has been in existence but somewhat limited in the field of MM cases. In Belgium, there may not be specific MM cases applying the strict liability under the Act of 25<sup>th</sup> February 1991. The limit may lead to a conclusion that strict liability can be applied in all cases under the Act. It is not the same in France. Strict liability in MM has been applied, for example, from the use of defective products by physicians and hospital-acquired infections. In England, strict liability in MM is also regulated under the Product Liability Directive, for instance, in supplying of blood products infected with hepatitis C. Also, the absence of consent to treatment is also considered as strict liability. In contrast, the law of strict liability is only applied in vaccination activity in Vietnam.
228. Entirely different from the three countries, Vietnam has an additional medical liability system which is called MM administrative liability. Admittedly, this liability can play its role by partly preventing health professional's errors, if it is applied accurately. Nevertheless, administrative liability in some cases is the buoy of physicians to shirk their liabilities which they should be responsible for if the Civil Code and the Criminal Code are applied.
229. Although criminal punishment is not an aim of the tort of negligence, it still exists in the four countries. While Belgium and France, more attention is given to doctor's acts (recklessness or negligence) and the consequences (patient's injury or death) could be responsible for the criminal law. On the other hand, England requires 'guilty mind' on the part of the doctor and death consequence to apply criminal law. Different from England but similar to Belgium and France, under Vietnamese Criminal Code, if an act

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<sup>413</sup> Franklin, C., Marutzky, E. and Sanberg, C., *Medical Professional Liability: Physician's Guide to Understanding Professional Negligence Claims*, Residence & Staff Physician, Vol. 53, 2007, p. 23.

that was done unintentionally but negligently caused death or severe injury, the health care provider may be taken to criminal court.

230. As a result of this study's findings, the MM law in Vietnam should be amended when it has some problems. For example, in the crucial parts such as standard of care, loss of a chance and damage compensation. Moreover, the scope of no-fault compensation should be broadened.

# CHAPTER 4: MEDICAL MALPRACTICE LIABILITY INSURANCE

## 1. Introduction

1. Man is continuously exposed to dangers which threaten his life, person, and property. From man's natural urge to preserve himself in the midst of this uncertainty makes an effort to create a security, which can never be achieved unless precautionary measures are taken against dangers of the kind mentioned above. Such calamities not only give rise to undesirable consequences at the time of their occurrence. However, they can occur, and this creates an element of uncertainty even before they actually take place. This uncertainty may relate to any one of the following contingencies: whether or not the calamity will occur; if it is certain that it will occur, when it may occur; or the extent of the calamity should it occur.<sup>414</sup>
2. To do away with that insecurity, it is indeed imperative that someone come up with a solution and the solution is insurance. Insurance is a form of risk transfer allowing the party initially bearing a risk to shift it to another party more willing or able to bear it. Parties who are in the business of taking on a risk initially borne by others are insurers while those who are relieved of such a burden are the insured. In return for the transfer of risk, insurers demand a price, namely, the premium due under the insurance contract. Where the risk in question is harm to the body, health or property of the insured person, the contract is for first-party insurance. Here, the person injured and the person insured are the same. Third-party insurance is a contract that covers potential harm suffered by others rather than the insured that is the third parties. The third party loss is not insured against out of benevolence or the altruistic motives but because the insured party may be liable for damages towards a third party. Expressed in the language of tort law, third party insurance covers the claim of victims against injurers who are liable for damages.<sup>415</sup>

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<sup>414</sup> Van De Merwe, S., *The Concept of Insurance and the Insurance Contract*, CILSA, 1970, p. 1.

<sup>415</sup> Wagner, M., *Tort Law and Economics*, Edward Elgar Publishing Limited, 2009, p.377.

3. In light of the current crisis, financial stability is the aim of all individuals practising in any risky business. In relation to this, professional liability insurance (PLI) has provided a way in which professionals can attempt to protect themselves as well as the parties that they provide their services.<sup>416</sup> PLI has become society's chief agency for the distribution of the cost of malpractice in the medical profession. It is quite natural that the medical practitioner is conscious of the possibility of a ruinous malpractice judgment and should seek the protection of insurance. The need for PLI in MM is a fact of life for most professions.<sup>417</sup> PLI is explicitly designed to protect physicians, hospitals, healthcare facilities, and other health personnel against the financial and legal risks inherent in providing medical care.<sup>418</sup>
4. The public is becoming increasingly aware of the possibility of successfully suing doctors, and as a result, the relationship between doctor and patient is becoming increasingly less personal.<sup>419</sup> In response, the doctors are purchasing more substantial amounts of MM liability insurance. By practising without proper insurance protection, the doctor endangers his personal assets every time he treats a patient. In the current market, the doctor is unable to barter for a better price. Therefore, the doctor must seek malpractice insurance that offers the broadest possible coverage for the least possible price.<sup>420</sup>
5. In many countries, liability insurance is compulsory for those who are at risk of being sued by third parties for negligence. Hence, the liability insurance provisions are numerous, detailed, and employ more standardised contract terms. If an insurance

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<sup>416</sup> Kourmatzis, D., *Professional Liability Insurance Coverage and Civil Law Jurisdictions*, Revija za pravo osiguranja, 2009, p. 41.

<sup>417</sup>Fontaine, M., *Droit des assurances (Insurance Law)*, Larcier, 2016, p. 518.

<sup>418</sup> *American Academy Pediatrics*;

<https://www.aap.org/>

<sup>419</sup> Goold, D. and Lipkin, M., *The Doctor-Patient Relationship*, JGIM, 1999, p. 26.

<sup>420</sup> Price, J., *Professional Liability Insurance: The Doctor's Dilemma*, Loyola University Law Journal, Vol.7, 1976, p. 459;

<http://lawcommons.luc.edu/lucj/vol7/iss2/9>

company wants to enter a market where many or most rules are mandatory, it needs to adapt its products to specific needs of the market. This means that they will have to review their general terms and possibly alter the prices. This could make it more challenging to enter foreign markets.<sup>421</sup>

6. In addition to the general rules (insurable interest, insured risk, insured premium, indemnification), this study will also indicate the considerable marks such as the third party's rights, kinds of medical malpractice liability insurance (MMLI), and the status of its market.

## **2. Medical malpractice liability insurance**

### **2.1. Insurance**

7. A significant approximation of national insurance laws for all Member States is a fact. Yet, there exist no uniform rules covering the whole life-cycle of an insurance contract. Different definitions of an insurance contract could lead to the similar application of different rules or the same products offered by the same insurer in the several Member States. This may create uncertainty amongst the customers as to whether the same or similar products in different Member States would provide the same or similar contract terms. For example during coverage, payments, etc. Different understanding of what an insurance contract is may create uncertainty among the insurers as to whether the business conditions in different Member States are comparable.<sup>422</sup>
8. Generally, insurance is an agreement where, for a stipulated payment called the premium, one party (the insurer) agrees to pay to the other (the policyholder or his designated beneficiary) a defined amount (the claim payment or benefit) upon the occurrence of a specific loss. This defined claim payment amount can be a fixed amount

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<sup>421</sup> Expert Group on European Insurance Contract Law Meeting of 9-10 September 2013 Discussion Paper 5: Liability Insurance, p.3;

[http://ec.europa.eu/justice/contract/files/expert\\_groups/discussion\\_paper\\_v-liability\\_insurance\\_en.pdf](http://ec.europa.eu/justice/contract/files/expert_groups/discussion_paper_v-liability_insurance_en.pdf)

<sup>422</sup> Expert Group on European Insurance Contract Law, Meeting of 25-26 June 2013, Discussion Paper 3: Insurance Contract Law – General Part, p.1;

[http://ec.europa.eu/justice/contract/files/expert\\_groups/discussion\\_paper\\_iii\\_on\\_general\\_insurance\\_contract\\_law.\\_part\\_1\\_-\\_eg\\_meeting\\_25-26\\_june\\_en.pdf](http://ec.europa.eu/justice/contract/files/expert_groups/discussion_paper_iii_on_general_insurance_contract_law._part_1_-_eg_meeting_25-26_june_en.pdf)

or can reimburse all or a part of the loss that occurred. The insurer considers the losses expected for the insurance pool and the potential for variation to charge premiums that will be sufficient to cover all of the projected claim payments for the insurance pool. The premium charged to each of the pool participants involves the participant's sharing of the total premium for the pool.<sup>423</sup>

9. The "insurance contract" is also an agreement under which one party, the insurer, promises another party which is the policyholder to cover against a specified risk in exchange for a premium.<sup>424</sup> The key elements of an insurance contract are thus the transfer (of the economic consequences) of a risk to the insurer, and the policyholder's obligation is to pay for this transfer.<sup>425</sup> One measure of risk is the standard deviation of the possible outcomes. The risk is the variation in potential economic outcomes. It is measured by the variation between possible outcomes and the expected outcome: the greater the standard deviation, the greater the risk.<sup>426</sup>
10. In other words, insurance is a contract by which one party in consideration of a price (called the premium) paid to him, that is relative to the risk, becomes security to the other. In that, s/he shall not suffer loss, damage or prejudice by the happening of the perils specified to certain things which may be exposed to them.<sup>427</sup> There must be either some uncertainty whether the event will happen or not, or if the event is one which must happen at some time or another and there must be uncertainty as to the time at which it will happen.<sup>428</sup>

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<sup>423</sup> Anderson, B. and Robert, B., *Risk and Insurance*, The Society of Actuaries , 2005, p.2;

<https://www.soa.org/files/pdf/P-21-05.pdf>

<sup>424</sup> Article 1:201: Insurance Contract, *Principles of European Insurance Contract Law*, 2010.

<sup>425</sup> Basedow, J., Birds, J., Clarke, M., *Principles of European Insurance Contract Law (PEICL)*, Sellier.european law publishers, 2009, p.8.

<sup>426</sup> Anderson, J. and Robert, B., *Risk and Insurance*, The Society of Actuaries, (2005), p.2;

<https://www.soa.org/files/pdf/P-21-05.pdf>

<sup>427</sup> As laid down by Lawrence J in *Lucena v Craufurd*, (1806) 2 Bos & PNR 269 at Pg. 301: 127 ER 42 HL.

<sup>428</sup> Prudential Insurance Co v Inland Revenue Commissioners, (1904) 2 KB 65.

11. Some countries have adopted a statutory definition of insurance (e.g., Belgium<sup>429</sup> and France: extend the definition in the Civil Code.<sup>430</sup>) Similarly, in Vietnam, insurance is defined in the law.<sup>431</sup> It is generally acknowledged that defining insurance as an activity or as a contract is a perilous task and arguably a futile one. The insurance is closely linked to human activities and is, therefore, in a constant state of evolution in which a fixed definition may hinder. In addition, the insurance can be defined differently depending on whether one contemplates the legal relationship (insurer, policyholder, the insured, and beneficiaries) and the technical process (the mutualisation of a large number of risks). For instance, in their recent reform of business-to-consumer insurance contract law, the English Commissions decided not to define the insurance.<sup>432</sup>
12. The Belgian Insurance Act of 4<sup>th</sup> April 2014 (Insurance Act 2014) defines the contract of insurance subject to the payment of a fixed or variable premium. A party (the insurer) undertakes another party (the policyholder) to provide a service stipulated in a contract if an uncertain event which the insured or the beneficiary has an interest in and not being realised.<sup>433</sup> The Insurance Act 2014, therefore, requires the presence of four essential elements for an insurance contract: an insurer, an insured party, an existence of a risk, and insurable interest.<sup>434</sup> Applied to the medical liability concerns, medical liability

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<sup>429</sup>Article 5(14) - Belgian Insurance Act 2014;

De Ridder, C., *Essentiële bestanddelen van de verzekeringsovereenkomst (Essential Components of the Insurance Agreement)* in Vansweevelt, T. and Weyts, B. (eds.), *Handboek Verzekeringsrecht (Insurance Law Handbook)*, Intersentia, 2016, p. 253.

<sup>430</sup> French Civil Code.

<sup>431</sup> Vietnamese Law on insurance contract, No. 24-2000 – QH10.

<sup>432</sup> The Law Commission and the Scottish Law Commission, *Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation*, December 2009;

[http://lawcommission.justice.gov.uk/docs/lc319\\_Consumer\\_Insurance\\_Law.pdf](http://lawcommission.justice.gov.uk/docs/lc319_Consumer_Insurance_Law.pdf)

<sup>433</sup> Article 5(14) - Belgian Insurance Act 2014;

for an extended description: Vansweevelt, T. and Weyts, B (eds.), *Handboek Verzekeringsrecht (Insurance Law Handbook)*, Intersentia, 2016, 253 and following.

<sup>434</sup> Fontaine, M., *Droit des assurances (Insurance Law)*, Larcier, 2016, p. 150;

Keulers, H. and Catteau, A., *The Legal Nature of Insurance Contracts: Belgium*, IBA Insurance Committee Substantive Report Project 2013, p.17;

insurance creates an agreement with an insurance company. The policyholder (in this case the care provider, the doctor, the hospital, etc.) undertakes to pay a certain premium while the insurance company, in return, pays a certain or undetermined sum of money when the negative consequences of the insured professional risks occur.<sup>435</sup>

13. In contrast to Belgium, there is no legal definition of an insurance contract under French law. It is exceptional where Article 1964 of the Civil Code provides that such contracts fall into the category of "*aleatory contracts*." These are the contracts which are reciprocal agreements and whose positive or negative effects are from all the parties or one or several of them, depend on an uncertain event. French authors define an insurance contract as an agreement whereby, in exchange for the payment of a premium, one of the parties (the insurer) is obliged towards the other party (the policyholder). To cover risk by performing an obligation in favour of the policyholder or a third party if the risk and the liability occurs.<sup>436</sup> The main features of insurance contracts often result from case law. For example, in France, the *Cour de Cassation*<sup>437</sup> has in the past ruled that an insurance contract has three main characteristics: a risk (defined as a future uncertain event independent from the will of the parties), a premium, and the payment of a sum of money or the performance of an agreed task in case of realization of the risk. The

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[www.mcmillan.ca/Files/168001\\_IBA\\_Insurance\\_Substantive\\_Project\\_2013.pdf](http://www.mcmillan.ca/Files/168001_IBA_Insurance_Substantive_Project_2013.pdf)

<sup>435</sup> Vansweevelt, T., *De Beroepsaansprakelijkheidsverzekering van Artsen en Ziekenhuizen: Een Vergelijkende Analyse (The Professional Liability Insurance of Doctors and Hospitals: A Comparative Analysis)*, Mys & Breesch, 1997, No. 1

Vansweevelt, T., *De Civielrechtelijke Aansprakelijkheid van de Geneesheer en het Ziekenhuis (The Civil Law Liability of the Physician and the Hospital)*, Antwerp, Maklu, 1997, 771-772, No. 1241.

<sup>436</sup> Lambert-Faivre, Y. and Leveneur, L., *Droit des assurances (Insurance Law)*, Dalloz, 2011, p. 484-485;

<https://uk.practicallaw.thomsonreuters.com/>

<sup>437</sup> Cass. Civ., 31 January 1956;

[www.juricaf.org/fr](http://www.juricaf.org/fr)

notion of *aleatory*,<sup>438</sup> which can be translated as uncertainty, is an essential element of the insurance contract and its absence will generally void the contract.<sup>439</sup>

14. Basically, there is no general statutory definition of an insurance contract, and it is left to the court to determine whether a contract is a contract of insurance. There have been relatively few decisions of the English courts, which have dealt with whether a contract is a contract of insurance. The decisions have generally described what a contract of insurance does but have been very careful not to define it. A useful working definition is that given by Channell J. in *Prudential Insurance Co. v Inland Revenue Commissioners*<sup>440</sup> that a legally enforceable contract of insurance is one under which a provider undertakes in consideration of one or more payments to pay money or to provide a corresponding benefit to a recipient, in response to a defined event. The occurrence of which is uncertain (either as to when it will occur or as to whether it will occur at all) and which is adverse to the interest of the recipient (in that she/he must possess an insurable interest in the subject matter insured.)<sup>441</sup>
15. Arguably, the most important features of a contract of insurance are those in bold that the insurer provides money or corresponding benefits in response to an uncertain event. This is in respect to if the insured has an insurable interest. Additionally, insurance contracts must contain an element of risk- and this is relevant to each of the characteristics.

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<sup>438</sup> Article 1964 - French Civil Code;

Lambert-Faivre, Y. and Leveneur, L., *Droit des assurances (Insurance Law)*, Dalloz, 2011, p. 484.

<sup>439</sup> Samothrakis, Y., *Discussion Paper III Differences in Insurance Contract Laws and Existing EU Legal Framework Insurance Contract Law – General Part 1*, p.1;

[http://ec.europa.eu/justice/contract/files/expert\\_groups/report\\_on\\_section\\_3\\_final\\_en.pdf](http://ec.europa.eu/justice/contract/files/expert_groups/report_on_section_3_final_en.pdf)

<sup>440</sup> *Prudential Insurance Co. v Inland Revenue Commissioners* [1904] 2 *K.B.* 658;

MacGillivray, *Insurance Law*, Ed. 11<sup>th</sup>, Sweet & Maxwell, 2008, p.1.

<sup>441</sup> Atkins, N., Tulloch, N., Sails, H., and Merrick, A., *The Legal Nature of Insurance Contracts: United Kingdom*, IBA Insurance Committee Substantive Project, 2013, p.132.

16. In Vietnam, both the Civil Code<sup>442</sup> and Law on Business Insurance define an insurance contract. Specifically, the Law on Business states that “an insurance contract means an agreement between a purchaser of insurance and an insurance enterprise, pursuant to which the purchaser of insurance must pay a premium and the insurance enterprise must pay a sum insured to the beneficiary or indemnify the insured person on the occurrence of the insured event.”<sup>443</sup> Therefore, just like in the contract of insurance definitions of Belgium, France, and England, the essential elements that are required in the contract of insurance are the insured, the insurer, the insured event and insurable interest. However, the laws of Vietnam do not explain or clarify further whether the insured event is uncertain as remarked in the other legal systems. This gap could have arisen from the requirement of uncertainty relating to the insured event. It is especially problematic in some insurance contracts that it may be questioned whether the occurrence of the insured event is uncertain.<sup>444</sup>
17. To summarise, a contract of insurance is a contract regarding which one party (the insurer) undertakes in exchange for the rendering of a performance sounding in money by the other (the insured). He will look upon or after the materialisation of an uncertain event (still in question in Vietnamese law) will unfavourably affect the estate of the insured directly or indirectly or his person and that uncertain event cause damage to the estate or the person.<sup>445</sup>

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<sup>442</sup> Civil Code No. 91/2015/QH13 (was adopted in 2015 and came in to force January 1<sup>st</sup>. 2017).

<sup>443</sup> Article 12.1. Insurance contracts, Law on Insurance business, No. 24-2000-QH10 and Law to amend and supplement a number of articles of the Law on Insurance business, No. 61/2010/QH12.

<sup>444</sup> Basedow, J., Clarke, M., *Principles of European Insurance Contract Law (PETL)*, Sellier.european law publishers, 2009, p.52.

<sup>445</sup> Even when the person of the insured is the object directly exposed to the risk, it is still his means, in the final instance, which are affected when the risk materializes.

## 2.2. *Medical malpractice liability insurance*

### 2.2.1. *Liability insurance*

18. As a kind of insurance (property insurance, pecuniary insurance, motor insurance, life insurance, marine, and aviation insurances, etc.), liability insurance's purpose is to ensure individuals and businesses against this risk.<sup>446</sup>
  
19. Liability insurance means the insurer promises to pay on behalf of the party insured the amount (up to the policy limit) which the insured becomes obligated to pay because of the liability imposed upon him by law for damages.<sup>447</sup> A policy covering the liability imposed on account of bodily injury is called a bodily injury liability policy. This policy is a form of insurance referring to liability for damage or destruction of property of others (including loss of use of the property) while the property is in the care, custody or control of the production company. The regulation is to be used in an insured production.<sup>448</sup> All forms of liability insurance are the same and serve the purpose of protection. The differences are found only in the description of the specific liability insured. In each of the liability insurance forms such as business liability, professional liability, and personal liability, the nature of the protection of the insured is the same. A promise is made by the insurance company to pay on the insured's behalf damages accessed by law. The differences are to be found only in the specific liability insured, the exclusion in their contract because of the specific liability and the premium basis for the contract.<sup>449</sup>

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<sup>446</sup> *Types of Insurance*, 2017;

<http://www.cii.co.uk>

<sup>447</sup> Ohlsson, G., *General Principles of Liability Insurance* in Long, R., (ed.), *The Law of Liability Insurance*, Matthew Bender, 1992, §1.01.

<sup>448</sup> Groner, M., *Third Party Property Damage Liability Explained*, 2016;

<http://www.frontrowinsurance.com/articles/third-party-property-damage-liability>

<sup>449</sup> Riegel, R. and Jerome, S., *Insurance and Practice*, Third Ed, Prentice Hall Press, 1947, p.591.

### ***2.2.2. Professional liability insurance***

20. Whereas liability insurance covers mishaps that can happen to any business owner, professional liability insurance (PLI) is the policy for people who keep their expertise off from risks. A person of limited financial resources becomes liable for a substantial amount of damages to a third party that liability is likely to be met if that person carries liability insurance. Consequently, liability insurance is carried voluntarily by prudent persons whose everyday activities may result in them facing legal action for losses caused. Professions may be required to take insurance against the risks of legal liability arising from the negligent exercise of their profession.<sup>450</sup> Professionals' legal liability towards third parties for injury, loss or damage arises from his professional negligence or that of his employees."<sup>451</sup>

### ***2.2.3. Medical malpractice liability insurance***

21. PLI has become society's chief agency for distribution of the cost of malpractice by the medical profession. It is quite natural that the medical practitioner who is conscious of the possibility of ruinous malpractice judgment should seek the protection of insurance.<sup>452</sup>
22. MMLI is one type of PLI which protects physicians and other licensed healthcare professionals (e.g., dentists and nurses) from liability associated with wrongful practices. This type of liability insurance can cover a result of bodily injury, medical expenses, and property damage as well as the cost of defending lawsuits related to such

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<sup>450</sup> Merkin, R., *Colinvaux's Insurance Law*, Sweet & Maxwell, 2006, p.684.

<sup>451</sup> Smith, C., *Insurance of Liability*, The Burling Press, Foxton, Cambridge, 1988, p. 9-12.

<sup>452</sup> Duke, J., *Risk Control in Professional Liability Insurance*, Duke Law Journal, 1996, p. 106.

claims.<sup>453</sup> More specifically, it protects the physician from the consequences of a patient's claim that he or she was injured as a result of the physician's negligence.<sup>454</sup>

23. MMLI systems serve related purposes. They include covering the liabilities of medical practitioners and health organisation, compensating victims of injuries sustained from medical procedures, and deterring MM.<sup>455</sup>
24. In many countries, to ensure that physicians and medical establishments remain solvent in case of major claims, the insurance cover for medical liability is made mandatory by law or through medical deontology or good practices codes. Usually, this requirement mainly applies to individual physicians and physicians practising in establishments but not necessarily establishments as those. Moreover, this obligation has sometimes been associated with a legal requirement mandating insurers to cover the medical liability risks without a specified ceiling. For example, in France, since the Kouchner Act of March 2002, the insurance coverage has been denied twice by market carriers for a particular health care provider. The latter can refer to the "*Bureau Central de Tarification*" which will assess and set a rate for the insurers.<sup>456</sup> Vietnam also enforced compulsory MMLI.<sup>457</sup> However, this one has not yet been made mandatory in Belgium and England.<sup>458</sup>

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<sup>453</sup> Jackson, J. and Powell, R., *On professional Liability*, Sweet & Maxwell, 2012, p. 305;

*Medical Professional Liability Insurance Commissioners*, National Association of Insurance 2016, p. 2;  
<http://www.naic.org/>

<sup>454</sup> Rhodes, M., *Professional Liability Insurance* in Long, R. (ed.), *The Law of Liability Insurance*, Matthew Bender, 1992, §12.10;

Kourmatziz, D., *Professional Liability Insurance Coverage and Civil Law Jurisdictions*, Revija za pravo osiguranja, 2009, p. 41.

<sup>455</sup> Houses of the Oireachtas Joint Committee on Health and Children, *Joint Committee on Health and Children*, 2015, p. 9.

<sup>456</sup> OECD, *Medical Malpractice: Prevention, Insurance, and Coverage Options*, OECD-Publishing, 2006, p. 4;  
[pcsi.pa.go.kr/files/2106051E.pdf](http://pcsi.pa.go.kr/files/2106051E.pdf)

<sup>457</sup> Decree on Liability insurance in Medical examination and treatment, No.102/2011/NĐ-CP.

<sup>458</sup> Jackson, J. and Powell, R., *On Professional Liability*, Sweet & Maxwell, 2012, p. 305-309.

25. Even though Belgium's Insurance Act of 2014 does not define liability insurance, it stipulates the relevant issues from Article 143 to Article 154. Also, the professional liability of a physician is except the disciplinary liability and not governed by special laws. This means that the civil liability of the physician for damage or injury caused by improper treatment is governed by the general rules of Civil Law and the Insurance Act of 2014 as (professional) liability.<sup>459</sup> Moreover, the Belgian Civil Code does not contain an obligation to take out insurance for professional liability. The agent is therefore not required to take out professional insurance, unless for certain professions (e.g., the legal profession). On the other hand, certain specific legislations require professional agents to take insurance, e.g., insurance agents,<sup>460</sup> barristers, and solicitors.<sup>461</sup> In addition, the agent is not required to take professional insurance.
26. Nevertheless, it is mandatory for the physician to have liability insurance. Although it is not contained in the Civil Code, it is defined in the Deontological code of Physicians, 2016 of Belgium. The victim of MM is entitled to compensation for the damage caused by this fault, and any physician must be insured for this purpose.<sup>462</sup>
27. In France, similar to Belgium, the Civil Code does not contain an obligation to take insurance for professional liability.<sup>463</sup> On the other hand, the obligation of concluding a civil liability insurance agreement by specific medical entities has been introduced by Article L 1142-2 of the Public Health Code. The law was adopted on March 4<sup>th</sup>, 2002 and article L251-2 of the Insurance Code.<sup>464</sup> According to the law, "health professionals

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<sup>459</sup> Fontaine, M., *Droit des assurances (Insurance Law)*, Larcier, 2016, p. 520;

R. Kruithof, *Tendenzen inzake medische aansprakelijkheid (Trend in Medical Liability)*, Vl.T.Gez., 1982-1983, p.177;

Faure, M. and Koziol, H., (eds), *Cases on Medical Malpractice in a Comparative Perspective Country Reports*, Belgium: Wien, Springer, 2001, p. 84-101.

<sup>460</sup> Article L.150- French Insurance Code.

<sup>461</sup> Article 27-Belgian Law of 31 December 1971.

<sup>462</sup> Article 34 §2 - Deontological Code of Physicians, 2016.

<sup>463</sup> Loos, M. and Díaz, B., *Principles of European Law: Mandate Contracts*, First Ed, Oxford: University Press, 2013, p.254.

<sup>464</sup> Serwach, M., *Medical Insurance in Polish and French Legal Systems*, Prawo Asekuracyjne, 2015, p.54.

who practice independently, health institutions, health services and organizations and any legal person other than the state, that is engaged in activities of prevention, diagnosis or care shall be obliged to subscribe to an insurance destined to cover their third party and administrative liabilities susceptible to be engaged when third parties suffer damages or as a result of personal injuries incurred within the framework of their activities of prevention and diagnosis or care.”<sup>465</sup>

28. Quite different from France, the National Health Service (NHS) in England indemnifies physicians, along with dentists and other health workers, such that, no compulsory insurance is required while undertaking NHS work.<sup>466</sup> No such protection is afforded when they are working as independent contractors although the Medical Defense Union customarily insures them. The Secretary of State is empowered to require doctors to ensure, but the power has not been exercised.<sup>467</sup> Although there is no statutory obligation upon them,<sup>468</sup> their professional associations require them to do so.<sup>469</sup>
29. With the above presentation, MMLI has existed compulsorily both in France and Vietnam. While England has not enforced the law but in the practice of medicine, MMLI is required. Similar to Belgium and France, MMLI has been compulsory in the law, but it has not been completely taken into practice. Evidently, a decree on Liability insurance for medical examination and treatment<sup>470</sup> came in to force, but it seems inapplicable and unrealistic in practice. Article 16 of the Decree indicated that not later than December 31<sup>st</sup>, 2015, all the medical examination and treatment activities that were organised in the form of hospitals, including general hospitals, specialty hospitals, and traditional medicine hospitals ought to have bought liability insurance coverage for medical examination and treatment. The Article also stipulated that before December 31<sup>st</sup>, 2017,

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<sup>465</sup> Article L251-1- Public Health Code, March 4<sup>th</sup> 2002.

<sup>466</sup> McHale, J., Fox, M., Gunn, M. and Wilkinson, S., *Health Care Law: Text and Materials*, Sweet & Maxwell, 2007, p. 30-39.

<sup>467</sup> The Health Act 1999, s9

<sup>468</sup> Jackson, J. and Powell, R., *On professional liability*, Sweet & Maxwell, 2012, p. 305-309.

<sup>469</sup> A Bill requiring both doctors and dentists to arrange an indemnity against liability (the Medical Practitioners and Dentists (Professional Negligence Insurance Bill 2003) failed to pass through the necessary Parliamentary stages in 2003.

<sup>470</sup> Decree on Liability insurance for medical examination and treatment, No: 102/2011/ND-CP.

the rest of the medical examination and treatment establishments had to purchase medical professional liability insurance. Explaining product deployment difficulties, some insurance industry experts said that private practitioners were not interested in buying insurance while hospitals claimed to lack funds to purchase insurance covers for doctors, nurses, and the staff working at the hospitals.<sup>471</sup>

30. In addition, Global Insurance representatives shared that “This product was deployed from 2009, but so far, there has not been contracting business. Some doctors had requested to purchase the cover for private clinics, but they claimed that it was too costly. Business insurers take a majority of the money to compensate a few. Therefore, if the buyers are few, the cost is very high. Also, the deployment in public hospitals is difficult.” A representative of a hospital in Hanoi said that “Some companies have offered this product, but the hospital refused because the product was not reasonable as yet to meet the specific occupational health services since there is no clear distinction between occupational accidents and negligence while hospital funding remains difficult.”<sup>472</sup>

31. With this fact, the Vietnamese government has not yet deployed any policy to solve the problem. Although MMLI has existed, it has not well implemented.

### ***2.2.3.1. Insurable interest***

32. While one cannot define an insurable interest with complete certainty or precision, it exists when the policyholder derives pecuniary benefit or advantage by the preservation or continued existence of the property or will sustain a pecuniary loss from its destruction.<sup>473</sup> In other words, the insurable interest doctrine requires a person or entity which holds an insurance policy to have some significant interest in the property insured

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<sup>471</sup>An Nhlen, *No Proper Professional Liability Insurance for Physician*, Infonet, 2016;

<http://infonet.vn/khong-mot-bao-hiem-nghe-nghiep-cho-bac-si-nao-co-tinh-thuc-te-post192985.info>

<sup>472</sup>Hong Chi, *Why is Medical Liability Insurance Delayed to Implement?*, ThoibaotaichinhVietnam, 2013;

<http://thoibaotaichinhvietnam.vn/pages/tien-te-bao-hiem/2013-11-01/bao-hiem-trach-nhiem-bac-sy-co-luat-sao-cham-trien-khai-4941.aspx>

<sup>473</sup>Fontaine, M., *Droit des assurances (Insurance Law)*, Larcier, 2016, p. 525.

by the policy. Traditionally, the insurable interest requirement has been very broadly read and interpreted with hardly any interest being found to create an “insurable” interest.<sup>474</sup>

33. A superficial survey of the insurance law in the several Member States revealed that the existence or non-existence of interest for the insured to enter into an insurance contract is subject to different regulations. In some Member States, the existence of an insurable interest, i.e., the reason that leads the party to enter into a legally binding agreement, is a key element to the contract. It is defined either in the law or at least in the jurisprudence. Some legal systems expressly declare null and void any insurance contract that is concluded without an insurable interest. Others display a more nuanced approach by declaring an insurance contract void only where the policyholder has insured a non-existent interest with the intention of thereby gaining an illegal pecuniary benefit. In contrast, some other legal systems lack an insurable interest at the moment of conclusion of the contract and do not entail such severe consequences.<sup>475</sup>
34. A contract of insurance is one whereby one person promises to compensate another for any loss which the latter might have to suffer on being exposed to certain dangers in consideration of a price known as premium. Thus it is apparent that a contract of insurance is a contract of indemnity based on the principles of “*uberrimae fidei*” (utmost good faith) and insurable interest. Insurable interest means that it is an interest which can be or is protected by a contract of insurance.<sup>476</sup> It is a relationship between the insured and the event insured against such that the occurrence of the event will cause substantial loss or injury of some kind to the insured.<sup>477</sup> Hence, the insurable interest

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<sup>474</sup> Sorensen, E. and Zielinski, K., *The Insurable Interest Doctrine: What is it? And What Does It Mean?*, Tressler LLP, p.1.

<sup>475</sup> Samothrakis, Y., *Differences in Insurance Contract Laws and Existing EU Legal Framework, Insurance Contract Law – General Part 1*, p.2;

[http://ec.europa.eu/justice/contract/files/expert\\_groups/report\\_on\\_section\\_3\\_final\\_en.pdf](http://ec.europa.eu/justice/contract/files/expert_groups/report_on_section_3_final_en.pdf)

<sup>476</sup> Prashanth, V., *Necessity of Insurable Interest in Insurance Contracts*, 2008;

[https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1302372](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1302372)

<sup>477</sup> Patterson, E., *Elements of Insurance Law*, p. 109;

[https://papers.ssrn.com/sol3/Delivery.cfm/SSRN\\_ID1302372\\_code941145.pdf](https://papers.ssrn.com/sol3/Delivery.cfm/SSRN_ID1302372_code941145.pdf)

may be defined as an interest of such a nature that the occurrence of the event insured against would cause financial loss to the insured.<sup>478</sup>

35. It is the existence of an insurable interest that alone differentiates a contract of insurance, being a contract of indemnity, from a mere wager. Therefore, for the validity of an insurance contract, the existence of an insurable interest is a mandatory precondition. The nature of insurable interest can thus be, briefly, understood by the following points:

1. *The interest should not be a mere sentimental or emotional right or interest;*

2. *It should be a right in a property or a right arising from a contract made in respect to that property;*

3. *The interest must be pecuniary; mere inconvenience or disadvantage cannot be regarded as an insurable interest;*

4. *The interest should be lawful and must not be illegal, immoral or opposed to public policy.*<sup>479</sup>

36. An insurable interest may be described loosely as the assured's pecuniary interest in the subject matter of the insurance arising from the relationship recognised in law. There is nothing in the common law which prohibits contracts of insurance made without interest.<sup>480</sup> However, a person insured under a contract of insurance is required to possess the insurable interest either because the requirement is inherent like the particular contract of insurance for it to be enforceable or because statute stimulates it as a condition of the validity of the policy. The insurable interest stipulated by law must

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<sup>478</sup> Rodda, W., *Fire and Property Insurance*, p. 22;

[https://papers.ssrn.com/sol3/Delivery.cfm/SSRN\\_ID1302372\\_code941145.pdf?](https://papers.ssrn.com/sol3/Delivery.cfm/SSRN_ID1302372_code941145.pdf?)

<sup>479</sup>Prashanth, V., *Necessity of Insurable Interest in Insurance Contracts*, 2008;

[https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1302372](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1302372)

<sup>480</sup> *Williams v Baltic Ins. Assoc. of London* [1924] 2 K.B. 282, 288.

be distinguished at the outset from that required by the character of the contract of insurance.<sup>481</sup>

37. In liability insurance, a person has an insurable interest to the extent of any potential liability which may be incurred due to damages and other costs. It is not possible to foretell how much liability or how often a person may incur liability and in what form or shape it arises. Therefore, the insurable interest in liability insurance is different from the insurable interest in life and property, where it is possible to predetermine the extent of insurable interest. Hence, in liability insurance, the insured is asked to choose the sum insured because the maximum figure that he estimates is likely to be required to settle the liability claims.<sup>482</sup>
38. In Belgium, the existence of a person and legitimate the insurable interest is one of the requirements for an insurance contract to be deemed valid. There is an insurable interest where the realisation of an uncertain event leads to a loss suffered by a person or entity. About liability insurance, the insurable interest is the economic or personal interest which the insured has to avoid the realisation of the risk and its consequence.<sup>483</sup> Article 91 of the Insurance Act of 2014 states that “the insured must demonstrate an economic interest in the preservation of the property or the integrity of the estate.”<sup>484</sup>
39. Similar to the rule of the Belgian Insurance Act of 2014, Article L.171-3 of the French Insurance Code also defines the insurable interest and the requirements that it has to meet for it to be considered legitimate. The French Civil Code, in Article 6, prohibits all contracts which go contrary to public policy. The existence of the insurable interest is not a must at the time of conclusion of the contract, but it is necessary to be indicated in the contract. The insurance contract cannot be concluded if the subject-matter insured is

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<sup>481</sup> Legh-Jones, N., Birds, J. and Owen, D., *Mac-Gillivray on Insurance Law*, Eleven Ed, Sweet & Maxwell, 2008, p.7.

<sup>482</sup> Fundamentals/Principles of General Insurance;  
[www.nios.ac.in/media/documents/VocInsServices/m2--f5.pdf](http://www.nios.ac.in/media/documents/VocInsServices/m2--f5.pdf)

Fontaine, M., *Droit des assurances (Insurance Law)*, Larcier, 2016, p. 525.

<sup>484</sup> Belgian Insurance Act 2014.

already lost before the contract's conclusion as per Articles 1108 and 1126 of the Civil Code.<sup>485</sup>

40. Under English law, the insurable interest is a right to the property, or a right derivable out of some contract about the property, which in either case may lose upon some contingency affecting the possession or enjoyment of the property.”<sup>486</sup> In liability insurance, the subject matter or the property must be precisely defined. Liability insurance is the insurance of the wealth, the “patrimony,” of the insured against awards of damages. An "insurable interest" is an essential element to a contract of insurance. It has been loosely defined as the "insured's pecuniary interest in the subject matter of the insurance." The principle behind the concept of the insurable interest is mainly concerned with ensuring that a person who cannot suffer a loss is prevented from insuring in the first place. The requirement of the insurable interest in a contract of insurance is simply another way of expressing that an insurance contract must be a contract against the risk of loss.<sup>487</sup>
41. According to Vietnamese law, the insurable interest means a right of ownership, the right of possession, right of use, or a property right, [or] the right and obligation to bring up and support the subject-matter insured.<sup>488</sup> Understandably, it is the subject-matter insured in the context of the civil liability of the insured person to a third party as stipulated by the law.<sup>489</sup> As mentioned, the insurable interest may be defined as an interest of such a nature that the occurrence of the event insured against would cause financial loss to the insured.<sup>490</sup> Comparing the two concepts, the one regulated in Vietnam seems vague. It does not clarify whether, in liability insurance, a person has an

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<sup>485</sup> Noussia, K., *The Principle of Indemnity in Marine Insurance Contracts: A Comparative Approach*, Springer, 2007, p. 51.

<sup>486</sup> *Ebaworth v Alliance Marine Insurance Cp* (1973) 1.R. 8 Cp.P. 596.

<sup>487</sup> Clarke, M., *English Insurance Contract Law*, First Ed, bookboon.com, 2016, p.13.

<sup>488</sup> Article 3.9 - Law on Insurance Business, No. 24-2000 - QH.10.

<sup>489</sup> Article 53 - Law on Insurance Business, No. 24-2000 - QH.10.

<sup>490</sup> WH Rodda, *Fire and Property Insurance*, p. 22;

[https://papers.ssrn.com/sol3/Delivery.cfm/SSRN\\_ID1302372\\_code941145.pdf?](https://papers.ssrn.com/sol3/Delivery.cfm/SSRN_ID1302372_code941145.pdf?)

insurable interest to the extent of any potential liability which may be incurred due to damages and other costs. In other words, the law does not define whether the insurable interest is to cover the loss of the subject-matter (the third party) on behalf of the insured or not. Additionally, the author cannot explain the reason why the law mentions the word “obligation” and no more legal explanation which does not go along with any laws in Belgium, France, and England. The pertinent question is whose obligation is it in this context? Is it the obligation of the insurer, the insured or the third party? What kind of obligation is it if any exists?

42. Similar to the three countries Belgium, France, and England, Vietnam also indicates that a valid insurance policy requires an “insurable interest”. Different insurance policies have different insurable interests.<sup>491</sup>

#### **2.2.3.2. Insured risk**

43. The professional liability insurer must accurately delimit the scope of the risk assumed. Insurance underwriters seek to control the risk by the wording of the insurance contract and by the careful selection of those whom they will insure. It is commonly used to define the scope of the risk assumed by the professional liability. The insured risk is “malpractice, error, or mistake in the practice of the insured’s profession.” Defining the activity from which the liability of the insured arises is basic to all liability insurance. Before there can be any duty of performance of the insurer’s promise to defend or indemnify, the insured must have incurred a possible liability for MM.<sup>492</sup>
44. It is generally acknowledged that insurance contracts are concluded to provide cover against specific events, which are largely regarded as a risk.<sup>493</sup> The presence of an element of uncertainty or risk is an essential element of every valid insurance contract. In exchange for the undertaking to pay a premium, the insurer takes over and bears a

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<sup>491</sup> Article 13 - Law on Insurance Business, No. 24-2000 - QH.10.

<sup>492</sup> Duke, J., *Risk Control in Professional Liability Insurance*, Duke Law Journal, 1996, p.108.

<sup>493</sup> Samothrakis, Y., *Differences in Insurance Contract Laws and Existing EU Legal Framework Insurance Contract Law – General Part 1*, p.4;

[http://ec.europa.eu/justice/contract/files/expert\\_groups/discussion\\_paper\\_iii\\_on\\_general\\_insurance\\_contract\\_law.\\_part\\_1\\_-\\_eg\\_meeting\\_25-26\\_june\\_en.pdf](http://ec.europa.eu/justice/contract/files/expert_groups/discussion_paper_iii_on_general_insurance_contract_law._part_1_-_eg_meeting_25-26_june_en.pdf)

circumscribed risk of the insured. The risk may be described as the possibility that a specified but uncertain event may occur.<sup>494</sup> It may also refer to the possibility of an undesirable change in the patrimonial circumstances of the insured or as the possibility of harm.<sup>495</sup>

45. It is repeated that in the absence of any risk, such as when the uncertain event has already taken place or when the object concerning which the insurer has described and taken over the risk has already been destroyed before the conclusion of the relevant insurance, there is no valid insurance contract.<sup>496</sup>
46. Insurance contract by their assessment of the risk, at the time, that the contract of insurance is concluded. Once the policy has been issued, they hope that the risk undergoes no significant aggravation or increase during the insurance period. Policyholders, however, do not want their activity during the period to be unduly restricted. Moreover, society, which has an interest in an effective and solvent insurance sector, also has an interest in fostering useful entrepreneurial activity. The insurance contract seeks to balance these sometimes conflicting interests.<sup>497</sup>
47. The provision most commonly used to define the scope of the risk assumed by the professional liability insurer is “malpractice, error or mistake in the practice of the insured’s profession.”<sup>498</sup> Defining the activity from which the liability of the insured

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<sup>494</sup> Reinecke, M and Van De Merwe, S. *General Principles of Insurance*, LexisNexis, 2007, p.26.

<sup>495</sup> Reinecke, M and Van De Merwe, S. *General Principles of Insurance*, LexisNexis, 2007, p. 170-171.

<sup>496</sup> Van Niekerk, J., *Assumptions, Risk and the Insurance Contract*, SA Merc U, 1998, p.123;

<sup>497</sup> Basedow, J., Birds, J., Clarke, M., *Principles of European Insurance Contract Law (PEICL)*, Sellier.european law publishers, 2009, p.181.

<sup>498</sup> The insuring agreement usually provides: “The Company agrees with the insured in consideration of the premium and in reliance upon the statements in the declarations and subject to the limits of liability, exclusions and conditions...to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of injury arising out of malpractice, error or mistake in rendering or failing to render professional services in the practice of the insured’s profession....” North River Insurance Company, Form No. L4007J.

arises is basic to all forms of liability insurance before establishing whether there can be any duty of performance of the insurer's promise to defend or indemnify.<sup>499</sup>

48. In Article 5.14 of the Insurance Act 2014 of Belgium,<sup>500</sup> the risk is defined as an occurrence in which the insured or the beneficiary has an interest which is not in a proceeding. In order to be insured, the risk must be: (1) uncertain: the uncertainty may concern either the realization of the event or the moment of such realization; (2) possible: the insurance contract is null and void if the risk does not exist or has already realized itself at the conclusion of the insurance contract; (3) and independent from the will of the insured.<sup>501</sup> Moreover, Belgian law expresses that the insurance is null and void when the risk does not exist or has already occurred at the time of the conclusion of the contract.<sup>502</sup>
49. Just like Belgium, the uncertainty is a key element of an insurance contract in French law. France's highest ordinary court, the *Cour de Cassation*, considers that the uncertainty is the essence of an insurance contract (Cass., 1st Civ. Div., 4<sup>th</sup> November 2003, appeal on the point of law No 01-14942). The uncertainty in an insurance contract is so important such that, in its absence, either the insurer or the policyholder may see it as a condition to nullify the contract. Professional liability policies are designed for a specific risk - the risk of loss caused by the negligent performance of a professional services provider by design professionals.<sup>503</sup>
50. Similarly, in Belgium and France, a contract of insurance must be a contract based on an uncertain event. A contract of insurance is a contract against a contingency and not a

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<sup>499</sup> *Risk Control in Professional Liability Insurance*, *Duke Law Journal*, Vol. **106**, p. 106;

<http://scholarship.law.duke.edu/dlj/vol9/iss1/6>

<sup>500</sup> Belgian Insurance Act 2014.

<sup>501</sup> Fontaine, M., *Droit des assurances (Insurance Law)*, Larcier, 2016, p. 201;

Keulers, H. and Catteau, A., (IBA Insurance Committee Substantive Project 2013), *The Legal Nature of Insurance Contracts*, International Bar Association, p.17.

<sup>502</sup> Article 79 - Belgian Insurance Act 2014.

<sup>503</sup> *Intro to Professional Liability Insurance*, 2012;

[www.schinnerer.com](http://www.schinnerer.com)

certainty. The benefits under an insurance contract must be payable on the occurrence of an event, which is uncertain regarding either *if* it will happen or *when* it will happen.<sup>504</sup> There must always be an element of uncertainty.<sup>505</sup> Uncertainty relates to the risk of the occurrence of an event which leads to loss. From a practical point of view, risk managers often make a distinction between risk and uncertainty. The term “risk” is associated with a loss, which can be predicted and therefore insured. On the other hand, the uncertainty cannot be predicted and therefore cannot be insured. The purpose of this somewhat artificial distinction is to classify and categorise risks and the chances of loss associated with the risks.<sup>506</sup>

51. In Vietnam, “the insured event is an external event agreed upon by the parties or provided for by law. Upon the occurrence of which, the insurance enterprise must pay the insurance proceeds to the beneficiary of the insurance or indemnify the insured person.”<sup>507</sup> There are no more rules to assert that “the occurrence of the insured event” is foreseeable or uncertain. This point is different from the rules of Belgium, France, and England which state that the event must be uncertain. However, the insurance company, for example, Bao Viet Insurance Company, defines risk as an unfortunate and unpredictable event regarding time, space, severity, and consequences.<sup>508</sup>
52. Considering the insurance market as a whole, the risks assumed by insurance arrangements can be classified for the present purposes into the following four categories: (1) “baseline risk”, which is the existing risk of loss based on past experience, assuming no change; (2) “developments risk”, which is the risk relating to developments that change the rate or cost of loss during the insured period; (3) “contract

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<sup>504</sup> Prudential Insurance Co v Commissioners of Inland Revenue, [1904] 2 KB 658.

<sup>505</sup> Etzbach, P., Atkins, N., Tulloch, N., Sails, H., and Merrick, A., (IBA Insurance Committee Substantive Project 2013), *The Legal Nature of Insurance Contracts*, International Bar Association, p.132.

<sup>506</sup> Nicholas G., *Partner Insurance*, p.3;

<https://www.fenwickelliott.co.uk>

<sup>507</sup> Article 3.10, Vietnamese Law on Insurance Business.

<sup>508</sup> *Risk and the Relevant Definitions of Insurance*;

<http://www.baoviet.com.vn/>

risk”, which is the risk relating to the drafting and interpretation of insurance policies; and (4) “financing risk”, which is the risk relating to changes in investment performance and the insurance pricing cycle. It should be noted that all types of insurance face “development risk” of one sort or another. No other form of insurance faces a broad range of development risk as liability insurance. However, almost all of the developments that affect other kinds of insurance also affect liability insurance. This is because nearly any kind of harm that can be covered by other kinds of insurance can also be subject to a liability action. In addition, liability insurance faces its own unique developments risk. For this purpose, liability developments risk can be classified into five categories: injury developments risk, injury cost developments risk, standard of care developments risk, legal developments risk, and claim developments risk. Among these, only standard of care developments risk is unique to liability insurance, but the other four pose special problems in the liability context.<sup>509</sup>

#### **2.2.3.3. *Insured premium***

53. The premium is the consideration required of the insured in return the insurer undertakes his/her obligation under the contract of insurance.<sup>510</sup> The amount or adequacy of the premium about the risks is a matter for the insurer rather than a court.<sup>511</sup> However, the amount of premium charged might be of help in determining what risks the insurer intended to run if the premium was assessed on a fixed scale commensurate with the scope of risks.<sup>512</sup>

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<sup>509</sup> Baker, T., *Insuring Liability Risks*, Blackwell Publishing Ltd, Vol.29, 2004, p.128.

<sup>510</sup> *Lewis Ltd v Norwich Union Fire Ins. Co.* [1916] A.C. 509, 519. This definition was cited with approval in *Re Claims Direct Test Cases* [2003] Lloyd’s Rep. I.R. 680, in the context of issues as to recovery of premium for after the event insurance by way of costs, under s.29 of the Access to Justice Act 1999;

The description of the premium as “a price paid adequate to the risk” in the old case of *Lucena v Craufurd* (1806) 2 Bos. & Pul (N.R.) 269, 301, was presumably a reference to insurance practice rather than to legal requirements.

<sup>511</sup> The description of the premium as “a price paid adequate to the risk” in the old case of *Lucena v Craufurd* (1806) 2 Bos. & Pul (N.R.) 269, 301, was presumably a reference to insurance practice rather than to legal requirements.

<sup>512</sup> *Re George and Goldsmiths’ Ins.* [1899] 1 Q.B. 595, 611.

54. In Belgium, the insurance contract specifies the contained element, the amount of the premium and the manner of determining it must also be specified.<sup>513</sup> Also, failure to pay the premium by the determined date may lead to termination of the contract provided the debtor has been given formal notice.<sup>514</sup> The formal notice referred to is made either by a bailiff or by registered letter. It involves a summons to pay the premium within the period fixed by it. This period may not be less than fifteen days from the day after service or the day following the filing of the registered letter. The notice of default summarises the maturity date of the premium and the amount of the premium. It also refers to the consequences of the failure to pay the premium within the time set. The starting point of this period also specifies that the termination of the contract shall take effect from the day after the expiry of the period.<sup>515</sup> Where the contract is terminated for any reason, the premiums paid in respect of the period of insurance after the effective date of the termination shall be reimbursed within thirty days of the date on which the contract is terminated.<sup>516</sup>
55. The French Government has the power to define standard contract clauses and render their use compulsory (*Article L. 111-4, Insurance Code*). The regulated professions cover PLI contracts. They impose minimum conditions on the limit of cover and the amount deductible.<sup>517</sup> Article L113-2 states that “the insured shall be obligated to pay the premium or contribution at the agreed time”. Article L113-3 states that “the premium may be payable at the address of the insurer or the representative that has been appointed for this purpose. However, the premium may be payable at the address of the insured or any other place agreed upon in the cases and terms restrictively set by decree in Conseil

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<sup>513</sup> Article 2 - Belgian Insurance Act 2014.

<sup>514</sup> Article 68 - Belgian Insurance Act 2014;

Fontaine, M., *Droit des assurances* (Insurance Law), Larcier 2016, p. 259.

<sup>515</sup> Article 70 - Belgian Insurance Act 2014.

<sup>516</sup> Article 73 - Belgian Insurance Act 2014.

<sup>517</sup> Pierre-Olivier, L., Arroyo, P., Lefort, C., and Willan, H., France LLP, *Insurance and Reinsurance in France: Overview*, France LLP, 2017;

<https://uk.practicallaw.thomsonreuters.com>

d'Etat. In the event of non-payment of a premium or a part of a premium within ten days as of its due date, and irrespective of the insurer's right to sue for performance of the contract, the cover may be suspended thirty days after the insured has been served with formal notice. The premium or premium instalment shall be payable at the insurer's premises in all events after formal notice has been served on the insured. The insurer shall be entitled to terminate the contract ten days after the expiry of the thirty day period."<sup>518</sup>

56. In England, the requirements for payment of a premium are made on a contractual basis. Generally, the requirements for payment of premium will be governed by the terms of the contract of insurance. An insurance contract may contain a premium to be paid at given times.<sup>519</sup> The insurer may repudiate a contract of insurance where there has been a failure to pay a premium on the due date. Commercial Court authority emphasized that an insurer could repudiate if: (a) time was stipulated to be of the essence; (b) circumstances of the contract or the nature of the subject matter showed that time was implied of the essence; or (c) where time was neither expressly nor impliedly of the essence, but the insured had been guilty of unreasonable delay, and the insurer had given notice requiring the premium to be paid within a reasonable time.<sup>520</sup> Grace periods are sometimes offered in respect of premium payments, where an insured is given a certain amount of time after the expiry of their current policy to pay their next premium. There are some ways in which this might work depending on the class of business. For example, the insured might be given a temporary cover note. The insurer holds cover for a certain period provided the premium is paid within that period, then the cover will be backdated to the beginning of that period (or the expiry of the previous policy). The insurer is presumably able to revoke the cover note by notice before the premium has been paid. A cover note of this sort is commonly issued on expiry by motor insurers.<sup>521</sup>

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<sup>518</sup> Article 252-1, French Insurance Code.

<sup>519</sup> *J A Chapman & Co Limited v Kadirga Denizcilik Ve Ticaret* [1998] *Lloyd's rep IR* 377).

<sup>520</sup> *Figre Limited v Mander* [1999] *Lloyd's Rep IR* 193.

<sup>521</sup> Merkin, R., *Colinvaux's Law of Insurance*, Ninth Ed, Sweet & Maxwell, 2009, p.379.

57. In England, the premium-the payment for insurance<sup>522</sup> may be paid when the cover commences, or instalments are paid during the period of cover.<sup>523</sup> Standard formulae normally determine the amount of premium payable by the assured before the inception of the contract. This may not always occur. However, a policy under which the amount of premium is to be established at a later date by fixed criteria is perfectly valid.<sup>524</sup> The policy provides for a premium which is to be paid by the insured as consideration for the policy. The premium may be paid periodically or as a one-off payment. Moreover, an absence of a premium was not fatal to the formation of insurance. In practice, policies state that the payment of the premium is a condition precedent to the insurer's liability.<sup>525</sup> Late payment of the premium, is not excused by the fact that there have been previous instances of late payment to which the insurer has not objected.<sup>526</sup> Where the assured has not paid the premium by the due date, the insurer may have a choice of remedies: proceedings for payment may be brought; claims may be rejected until the premium has been paid; the policy may be forfeited or determined for breach.<sup>527</sup>
58. Likewise in Vietnam, insurance premium means an amount of money which the purchaser of insurance must pay to the insurance enterprise within the time-limit specified and by the method agreed on by the parties in the insurance contract.<sup>528</sup> Similar to Belgium, France, and England, the premium rate and the method of paying the premium must be contained in the insurance contract.<sup>529</sup> In case of termination of an

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<sup>522</sup> *Wasa v Lexington* [2009] *UKHL* 40, at [33].

<sup>523</sup> *Merit Fire & Marine Co v Jan de Nul* [2011] *EWCA Civ* 827.

<sup>524</sup> Longmore L.J. in *Petromec Inc v Petroleo Brasileiro SA Petrobas* [2005] *EWCA Civ*. Has noted that the refusal of the common law to recognize agreement to agree, and in particular on obligations to negotiate in good faith, is ripe for consideration.

Robert M. and Raoul, P., *Law of Insurance*, Ninth Ed, Sweet & Maxwell, 2009, p.286.

<sup>525</sup> Court of Appeal in *Hampton v Toxteth Co-operative Provident Society Limited* [1915] 1 Ch 721.

<sup>526</sup> *Laing v Commercial Union Assurance Co Ltd* (1992) 11 L.L.R. 54.

<sup>527</sup> Merkin, R., *Colinvaux's Law of Insurance*, Ninth Ed, Sweet & Maxwell, 2009, p.289.

<sup>528</sup> Article 3.11 - Vietnamese Law on Business Insurance 2000.

<sup>529</sup> Article 13.1.g - Vietnamese Law on Business Insurance 2000.

Article 23.2 - Vietnamese Law on Business Insurance 2000.

insurance contract, under the provisions in this regulation, the insurer must refund the insured part of the paid premium which corresponds to the remaining duration of the insurance contract after deducting legitimate expenses relating to the insurance contract.<sup>530</sup> According to the regulations of this law, the insurer has the right to deduct legitimate expenses from the amount of premium paid by the insured. This one has caused losses for the insured. Until now, Vietnam has not adopted any rule of legitimate expenses in case of contract termination. Hence, the insurer can freely deduct expenses which may not be reasonable and actual. Consequently, the amount to be refunded to the insured is much less than the one he paid before the contract was terminated. In addition, this rule also states that in a case of termination of an insurance contract, the insured must still pay the full amount of the premium up to the date of termination of the insurance contract.<sup>531</sup> This regulation sets the insured's obligation to continue paying the premium until the date the contract is terminated. Illogically, the law does not mention any obligation of the insurer to refund the premium which the insured paid before the termination of the contract.

59. In a case of termination of an insurance contract, under this provision, the insurer shall remain liable to indemnify the insured person upon the occurrence of the insured event within the duration of the grace period. In the same situation, the insured must still pay up the full amount of the premium until the end of the grace period as agreed in the insurance contract.<sup>532</sup> This rule seems similar to English regulations. The insurer's liability under the policy has to be taken to the end although the insured remains liable for the premium. However, in Vietnamese law, the insured's obligation is to pay the premium until the end of the grace period. In this circumstance, a question arises: If the insured fails to pay the grace premium as agreed, will the insurer still keep his liability to indemnity in case the risk insured against occurs? There is no regulation found to support this case. The author opines that this question should also be defined in the

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<sup>530</sup> Article 24.2 - Vietnamese Law on Business Insurance 2000.

<sup>531</sup> Article 23.3 - Vietnamese Law on Business Insurance 2000.

<sup>532</sup> Article 23.4 - Vietnamese Law on Business Insurance 2000.

insurance contract. The insured and the insurer can both suggest the solutions for this instance, which do not go against the regulations.

#### **2.2.3.4. Indemnification**

60. The term “indemnity” means reimbursement or to compensate. The principle of indemnity is strictly observed in liability insurances. These insurances are designed to provide the insured person protection against the financial consequences of legal liability. The policy is meant for professionals to cover liability falling on them as a result of error and omissions committed by them while rendering professional service. An important level of protection against the outcome of litigation would be taken to the insurance cover. Profession indemnity insurance is a tool which not only meets the claim of compensation awarded against doctor/hospital but also gives a sense of mental security. This means that even if some negligence is proved, the insurance company will take care of it.<sup>533</sup>
61. All forms of insurance can be divided into two categories. One of them is loss or "first-party" insurance; the other is liability or "third-party" insurance. Liability insurance is the protection against the legal judgment or award which could be recovered from the policyholder as a consequence of his injuring or wrongdoing to a third party. "Professionals" are expected by the public to be less prone to error than ordinary people, and the force of law backs this expectation. An insured doctor's malpractice policy provides the doctor concerning the professional acts or omissions defined in the policy in consideration of a specified premium for a specified term. After that, the carrier will protect the doctor against any suit or claim alleging injury or death and on account of which damages are sought. This protection includes the furnishing of legal defence and indemnification to the limits of the policy against any recovery made.<sup>534</sup>

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<sup>533</sup> Sweta, A and Swapnil, A., *Professional Indemnity Insurance vis-a-vis Medical Professionals*, J Indican Acad Fornsensic Med, p.73;

[medind.nic.in/jal/t09/i1/jalt09i1p73.pdf](http://medind.nic.in/jal/t09/i1/jalt09i1p73.pdf)

<sup>534</sup> Uthoff, D., *Medical Malpractice - The Insurance*, St. John's Law Review, Vol. 43, 2012, p.527.

62. Similar to the common policy of coverage, Belgian laws also state that the benefit payable by the insurer is limited to the loss suffered by the insured. Such damage may include loss of use of the insured property and loss of profit.<sup>535</sup> Unless otherwise agreed, benefits payable under a contract of insurance of an indemnity nature shall not be reduced by the benefits payable under a lump-sum insurance contract.<sup>536</sup>
63. Belgian law is similar to French law. French law states that a loss means for the purpose of risks mentioned under Article L1142-2 of Public Health Code, any damage or group of damages caused to third parties, engaging the liability of the insured, resulting from one event or group of events, having the same technical cause attributable to the activities of the insured covered by the insurance policy and having given rise to one or several claims.<sup>537</sup>
64. In English law, non-marine insurance recognises only total and partial loss, but there is an intermediate form of loss.<sup>538</sup> The loss must first occur during the period of cover although the full extent of the loss is not yet apparent. If there is no loss during that period, there is no right of recovery.<sup>539</sup> Moreover, the recoverable loss does not extend consequential loss. In liability insurance, the insurer is obliged to pay when the insured's liability to an injured person "has been established either by the judgment of the court or by an award in arbitration or by agreement."<sup>540</sup>
65. Liability insurance (such as professional liability) will have a 'limit' of indemnity which is the sum insured. This is the maximum amount the policyholder will pay out in respect

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<sup>535</sup> Article 93 - Belgian Insurance Act 2014.

<sup>536</sup> Article 94 - Belgian Insurance Act 2014.

<sup>537</sup> Methodological Guide E11 templates relating to medical professional liability, p.3;

<https://acpr.banque-france.fr>

<sup>538</sup> Merkin, R., *Colinvaux's Law of Insurance*, Ninth Ed, Sweet & Maxwell, 2009, p.379, *Law of Insurance*, Ninth Ed, Sweet & Maxwell, 2009, p.233.

<sup>539</sup> *Moore v Evans* [1918] AC 185. 193ff.

<sup>540</sup> *Post Office v Normich Union Fire Ins Sy Ltd* [1967] 2 QB 363, 373 (CA), see also *West Wake Price and Co v Ching* [1957] 2 WLR 45, 49 and *Teal Assurance WR Berkley* [2013] UKSC 57 at [15];

Malcolm Clarke, *English Insurance Contract*, First Ed, 2016, p. 34-38, [booboon.com](http://booboon.com)

of any one claim or series of claims resulting from any one event. Sometimes, it also limited to the total amount payable in the aggregate (the total payable in any one annual period of cover).<sup>541</sup>

66. Compared to the laws of Belgium, France, and England, the law of Vietnam also has the same spirit of indemnification to the third party's loss. For example, the law states that the amount of indemnity which an insurance enterprise shall pay to the insured person shall not exceed the amount of the sum insured unless the insurance contract otherwise provides.<sup>542</sup> In addition to the amount of indemnity, an insurance enterprise must also pay to the insured person the necessary and legitimate expenses of taking measures to avoid and minimise loss and damage. In addition, the costs arising must also be paid, and the insured person must bear to implement instructions from the insurance enterprise.<sup>543</sup> Vietnam has regulated MM liability insurance by Decree on Liability insurance for medical examination and treatment.<sup>544</sup> This is by specifically applying the same payment principle of the Law on Business Insurance of 2002. The Decree says that on liability insurance, there is the maximum amount to be paid by an insurer for each complaint of coverage. However, it should not exceed the amount of insurance liability for care facilities and treatment as agreed on in the insurance contract. The level of insurance liability, including legal expenses in case of medical establishments, must be paid by the law. The total insurance liability on the basis of medical examination and treatment is the maximum amount an insurer should pay as agreed in the insurance contract. Insurers and medical examination and treatment establishments can arrange the premium and the scope of the liability based on risk assessment of the medical examination and treatment and related factors.<sup>545</sup>

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<sup>541</sup> Supplier Indemnity & Insurance Cover, 2015;

<http://www2.le.ac.uk>

<sup>542</sup> Article 46.2 - Vietnamese Law on Insurance Business.

<sup>543</sup> Article 46.3 - Vietnamese Law on Insurance Business.

<sup>544</sup> Article 5.3 - Decree on Liability Insurance for Medical Examination and Treatment, No. 102/2011/NĐ-CP.

<sup>545</sup> Article 5- Decree on Liability Insurance in Medical Examination and Treatment, No. 102/2011/NĐ-CP.

67. On the other hand, some elements under Vietnamese law appear as “extra regulations” compared to the other systems. The rule states that the amount of indemnity which an insurance enterprise must pay to the insured person shall be fixed by the market price at the point of time. Also, in the place where the loss is suffered and on the actual level of loss and damage unless the insurance contract otherwise provides. An explanation for this exception originates from the unstable and unequal market prices in different periods and different areas in Vietnam when assessing the extent of the damage. For example, upon getting treated after a medical incident if the third party went for treatment in a private hospital where fees are higher than in public ones or where fees in big city hospitals are higher than rural area hospitals even though the third party had Social Health Insurance.<sup>546</sup> The same Article raises another question. That is to say the cost of price appraisal at market price, and the level of loss and damage shall be borne by the insurance enterprise.<sup>547</sup> The author is not at all convinced by this existing rule yet Vietnam has a law on Price<sup>548</sup> and should take responsibility to price appraise at market price and appraise the level of loss and damage instead of the insurance enterprise. In this opinion, the licensed agency/person who works on price appraisal governed by the Law on Price may objectively ensure the market price and damage’s value for the third party as mentioned in the example.

#### **2.2.3.5. *Third party***

68. In order to facilitate the enforcement of claims for the injured, some Member States,<sup>549</sup> for example, France and Belgium,<sup>550</sup> recognise a right of the third party, in general, to directly claim the damage with the insurer although the details differ. In the other Member States, this third party’ rights is only exceptionally granted in certain and

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<sup>546</sup> Joint Circular No. 41/2014 / TTLT-BYT-BTC of November 24, 2014 of the Ministry of Health and the Ministry of Finance guiding the implementation of health insurance.

<sup>547</sup> Article 46.1 - Vietnamese Law on Insurance Business.

<sup>548</sup> Law on Price – No. 11/2012/QH13.

<sup>549</sup> Insurance Day, *International Comparative Review of Liability Insurance Law*, Barlow Lyde & Gilbert, p. 19-20;

[www.houthoff.com/.../InternationalComparativeReviewofLiabilityInsuranceLaw.pdf](http://www.houthoff.com/.../InternationalComparativeReviewofLiabilityInsuranceLaw.pdf)

<sup>550</sup> Belgium (Art. 150 Insurance Act), France (Art. L 124-3 Insurance Code).

insufficient cases. Under English Law,<sup>551</sup> there is no common law of right afforded to a third party against the insurer of the person who caused the injury. However, third parties are entitled to compensation under the conditions set out in the third parties (Rights against Insurers) Act of 2010.<sup>552</sup>

69. In Belgium, for insurance contracts falling under the Insurance Act 2014, the third parties have a direct legal action right against the liability insurer of the party who caused the damage or loss (*Article 86, Insurance Contract Act 1992*).<sup>553</sup> This rule is repeated in Article 50 of the current Insurance Code 2014 of Belgium.<sup>554</sup> All types of loss or damage can be claimed from the liability insurer (physical damage, property damage or financial loss) and if to the extent that is obviously covered by the policy. Such direct third-party access is granted to all types of non-marine or non-transport liability insurance (e.g. professional liability insurance, contractual liability insurance, and non-contractual liability insurance).<sup>555</sup>
70. Equally, French law also accepts that the third party insured can claim directly under the policy.<sup>556</sup> In relation to property damage, there is no statutory right of direct action,

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<sup>551</sup> Insurance Day, *International Comparative Review of Liability Insurance Law*, Barlow Lyde & Gilbert, p. 8;

[www.houthoff.com/.../InternationalComparativeReviewofLiabilityInsuranceLaw.pdf](http://www.houthoff.com/.../InternationalComparativeReviewofLiabilityInsuranceLaw.pdf)

<sup>552</sup> Expert Group on European Insurance Contract Law Meeting of 9-10 September 2013 “Discussion Paper 5: Liability Insurance, p.10-11;

[ec.europa.eu/.../contract/.../expert\\_groups/discussion\\_paper\\_vliability\\_insurance\\_en.pdf](http://ec.europa.eu/.../contract/.../expert_groups/discussion_paper_vliability_insurance_en.pdf)

<sup>553</sup> Fontaine, M., *Droit des assurances (Insurance Law)*, Larcier, 2016, p. 561;

Hugo Keulers, H. and Lodewijckx, S., Lydian, *Insurance and Reinsurance in Belgium: Overview*, 2012;

[https://www.lydian.be/sites/default/files/uploads/publications/plc\\_insurance\\_and\\_reinsurance\\_handbook\\_2011\\_belgium.pdf](https://www.lydian.be/sites/default/files/uploads/publications/plc_insurance_and_reinsurance_handbook_2011_belgium.pdf)

<sup>554</sup> Article 50 - Belgian Insurance Act 2014.

<sup>555</sup> Keulers, H., and Catteau, A (IBA Insurance Committee Substantive Project 2012), *Direct Third-Party Access to Liability Insurance in Belgium*, *International Bar Association*, p.21;

<https://webcache.googleusercontent.com/search?q=cache:BXKvbnKFzGIJ:https://www.ibanet.org/Document/Default.aspx%3FDocumentUId%3D334C288E-984D-4870-9905-192AFF65A398+&cd=1&hl=en&ct=clnk&gl=vn>

<sup>556</sup> Article L124-3 - French Insurance Code.

but case law recognises the right of a third party to claim against the insurer on behalf of the insured. This is when the insured fails to do so by way of an *action oblique* subject to Article 1166 of the Civil Code (*Article 1341-1, revised Civil Code*). However, the funds recovered are not paid directly to the third party but the insured.<sup>557</sup>

71. Although England does not allow the third party to lay claim for indemnification directly, the new Act has shown that it also protects the third party's rights. Specifically, the Third Party (Rights against Insurers) Act 2010 (the "2010 Act"), finally comes into force on 1<sup>st</sup> August 2016. The 2010 Act makes it easier for a third party to bring a claim against an insurer when the insured party has become insolvent. The 2010 Act will replace the Third Parties (Rights against Insurers) Act of 1930 (the "1930 Act") and is designed to extend and improve the rights of third party claimants. The 2010 Act will result in a number of key changes:

1. *The third party will only have to issue one set of proceedings against the insurer seeking declarations both as to the insured's liability to the third party and the insurer's liability under the policy;*
2. *The automatic transfer of rights to the third party is retained, but the legislation enables the third party to pursue its claim in a single set of proceedings. It also makes it easier for the third party to find out information about the insurance policy from an early stage;*
3. *The insurer can no longer rely on the defence that the insured failed to notify them of the claim when the third party has notified them;*
4. *The 2010 Act reflects changes in insolvency law by widening the definition of insolvent companies to include, for example, companies subject to voluntary arrangements or schemes of arrangement.*
5. *Removal of the requirement for the third party to have an insolvent company which has been completely dissolved restored to the register of companies before*

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<sup>557</sup> Pierre-Olivier, L, Arroyo, P. and Lefort, C., Holman Fenwick Willan France LLP, *Insurance and Reinsurance in France: Overview*, 2017;

<https://webcache.googleusercontent.com/search?q=cache:lFrq7CFIbA4J:https://uk.practicallaw.thomsonreuters.com/9-501-3248+&cd=1&hl=en&ct=clnk&gl=vn>

*the third party can bring proceedings. Transfer of rights to a relevant Person Under the 2010 Act. The rights of the insured under the policy are transferred to the third party if the insured is already a relevant person when s/he incurs the liability to the third party, or the insured has already incurred the liability when it becomes a relevant person.*

72. Entirely different from Belgium, France, and England, Vietnam’s law does not allow the third party to claim for indemnity directly. The law clearly expresses that a third party shall not have the right to directly require an insurance enterprise to indemnify the third party unless otherwise specified by the law.<sup>558</sup> The law does not specify any more exceptions for the third party to claim directly. Liability of the insurer only arises if the third party claims an insured person for indemnity, loss or damage caused by the insured’s fault during the duration of the insurance.<sup>559</sup> Apparently, the third party’s rights are not given enough attention. An excellent example of English law is that the third party can carry out a claim if the insured is in insolvency to make sure that, in the end, third party’s rights are secured.

#### ***2.2.4. Trigger of coverage***

73. The term “trigger of coverage” or “policy trigger” refers to the legal test used to determine if the policy has coverage obligations, regarding the claim asserted against the policyholder. As conceptualised, the trigger concept is not obliged to determined coverage; rather, it acts as a gatekeeper, matching particular claims with particular periods of time and hence particular policies.<sup>560</sup>
74. Traditionally, the choice of a trigger is often based on practicability, legal requirements, and traditions in the country where the liability policy is placed. Some countries also have legal restrictions on the choice of the trigger. For instance, the occurrence trigger

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<sup>558</sup>Article 53.2 - Vietnamese Law on Insurance Business.

<sup>559</sup> Article 53.1 - Vietnamese Law on Insurance Business.

<sup>560</sup> Fischer, J., *Insurance Coverage for Mass Exposure Tort Claims: The Debate over the Appropriate Trigger Rule*, Drake Law Review, Vol. 45, 1997, p.631-632.

is not allowed in France (only fact occurrence and claim-made).<sup>561</sup> Belgium allows three systems of trigger coverage: fact occurrence, loss occurrence, and claim-made.<sup>562</sup> In England, public liability and product liability are usually written on an occurrence basis covering injury, loss or damage occurring during the period of insurance, whereas professional indemnity policies are usually written on a claims-made basis.<sup>563</sup> Regarding Vietnam, only Article 12 of the Law on Insurance Business mentions the occurrence policy. However, the Article does not define it.<sup>564</sup> The regulation fails to clarify the conditions of the occurrence (which is going to be analysed later). Supposedly, the conditions of the occurrence policy are freely agreed on an insurance contract.<sup>565</sup>

75. An essential element in liability insurance policies is the determination of the so-called triggers for coverage. Contract solutions for determining what moment the insurer's liability is triggered and until when the extension of the coverage in time can play a crucial role not only for the insured but also for the third parties. As it has been suggested earlier, triggers and in particular, the alternative between fact occurrence, claim made,

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<sup>561</sup> Under article L.124-5 of the French Insurance Code, the cover shall be, according to the choice of the parties, triggered either by the event causing liability or by a claim. However, where it covers the liability of natural persons outside their professional activity, the cover shall be triggered by the event causing liability;

<https://gettingthedealthrough.com/area/62/jurisdiction/28/insurance-litigation-france/>

Rasmussen, R., *The Trigger on A Liability Policy*, 2010;

[https://www.ifinsurance.com/web/industrial/ifnews/pages/liability\\_newsletter\\_4\\_2010.aspx](https://www.ifinsurance.com/web/industrial/ifnews/pages/liability_newsletter_4_2010.aspx)

<sup>562</sup> Article 142: Insurance Act 2014; Weyts, B., “*De dekking in de tijd van aansprakelijkheidsverzekeringen: een delicaat evenwicht tussen contractuele vrijheid en dwingende regelgeving*” in Vansweevel, T. and Britt Weyts (eds), *De aansprakelijkheidsverzekering in ontwikkeling*, ALLIC II, Intersentia, 2016, p. 97-120;

Dubuisson, B., *Rapport belge concernat l'assurance de la responsabilité civile: couverture dans le temps* (Belgian Report on Liability Insurance: Cover over time), *Assurance de la responsabilité: couverture dans le temps (Liability Insurance : Cover intime*, Maklu, 1997, p. 69.

<sup>563</sup> Clarke, M., *Report of the United Kingdom Concerning the Duration of Cover in Liability Insurance in Assurance de la responsabilité: couverture dans le temps (Liability Insurance: Cover over time)*, Maklu, 1997, p.16;

Jackson, J. and Powell, R., *On professional Liability*, Sweet & Maxwell, 2012, p. 313.

<sup>564</sup> Article 12 - Law on Insurance Business, No. 24-2000-QH10.

<sup>565</sup> Article 13 - Law on Insurance Business, No. 24-2000-QH10.

and occurrence is key aspects of the liability insurance contracts. In addition, the choice to adopt one system or the other is a fundamental condition of financial capacity to cover long-term risks and safeguard insurer's solvency adequately.<sup>566</sup>

#### **2.2.4.1. Fact-occurrence policies**

76. In the system of "fact occurrence" or "act committed" coverage is provided on condition that the damage-causing fact occurred during the term of the insurance contract. The damaging fact can exist in an unlawful act of the insured person (doctor/hospital).<sup>567</sup>
77. In a fact occurrence system,<sup>568</sup> the insurer offers guarantees for damaging facts from the date of commencement of the agreement. The damage caused before the entry into force of the liability insurance is not covered. For instance, when the duration of the policy is from 1995 to 2005 then all damaging facts (errors, negligence) committed during this period are covered. The errors committed before 1995 are not covered (no anteriority risk). On the other hand, the outflow or posteriority risk is covered all damage occurring after 2005 or claims filed after 2005 until the end of the limitation period is covered in this system.<sup>569</sup>
78. This system is beneficial to the doctor in respect of his liability which remains covered even after the insurance contract has been terminated. It often happens that the harmful event does not coincide with the emergence or the determination of the damage.<sup>570</sup>
79. A possible disadvantage of this system is that the insured amount may prove to be insufficient if there are several years between the harmful claim and the claim for

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<sup>566</sup> Perram, N., *The Law of Torts in Eastern and the vital Role of Liability Insurance in an Emerging market Economy*, Kluwer Academic Publishers, 1992, p. 3.

<sup>567</sup> Vansweevelt, T., *De Beroepsaansprakelijkheidsverzekering van Artsen en Ziekenhuizen: een Vergelijkende Analyse* (The Professional Liability Insurance of Doctors and Hospitals: A Comparative Analysis), Mys en Breesch, 1997, p.56.

<sup>568</sup> Rhodes M., *The Law of Liability Insurance*, Long, R. (ed.), New York, Matthew Bender, 1990, § 12.11.

<sup>569</sup> Vansweevelt, T., *De Beroepsaansprakelijkheidsverzekering van Artsen en Ziekenhuizen: een Vergelijkende Analyse* (The Professional Liability Insurance of Doctors and Hospitals: A Comparative Analysis), Mys en Breesch, 1997, p.57.

<sup>570</sup> Vansweevelt, T., *De Civielrechtelijke Aansprakelijkheid van de Geneesheer en het Ziekenhuis* (The Civil Liability of the Doctor and the Hospital), Antwerpen, Maklu, 1997, 797, nr. 1296.

damages although this can be high enough to meet the insured amount determined. For the insurer, this system has the disadvantage of making reservations for claims submitted after the termination of the insurance contract.<sup>571</sup> After the end of the insurance contract, the insurers may still be faced with a prolonged period in which they may have to cover. This is the "long tail" effect or so-called post-impact.<sup>572</sup>

80. Many Belgian medical liability insurances apply this system.<sup>573</sup> This system is beneficial to the physician in the sense that his liability remains covered even after the insurance contract has been terminated. It often happens that the harmful event does not coincide with the emergence or the determination of the damage. This system is disadvantageous for the insurer because, after the end of the insurance contract, it can still be confronted with a sometimes lengthy period in which it must provide cover (the after-effects).

#### **2.2.4.2. Loss occurrence policies**

81. On the losses occurring basis, the policy covers all losses occurring during the insurance period irrespective of when the original cause led to the loss happened. This scope of indemnity at the time is a valuable one if the occurrence can be allocated to a specific point in time.<sup>574</sup> In this case, the insurer is obliged to defend and indemnify any loss which allegedly occurred as a result of an act or omission of the insured during the policy period. It is not necessary for the injured to claim the damage during the duration of the insurance contract. Thus, it might happen that even after the termination of the insurance contract, a third party could evoke a claim for an event that happened during the duration of the insurance contract.<sup>575</sup>

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<sup>571</sup> Vansweevelt, T and Weyts, B., *Handboek Verzekeringsrecht (Insurance Law Handbook)*, Intersentia, 2016, p. 712.

<sup>572</sup> Fischer, M., *Insurance Coverage for Mass Exposure Tort Claims: The Debate over Appropriate Trigger Rule*, Drake Law Review, Vol. 46, 1997, p.646.

<sup>573</sup> Vansweevelt, T., *De Civielrechtelijke Aansprakelijkheid van de Geneesheer en het Ziekenhuis (The Civil Liability of the Doctor and the Hospital)*, Antwerpen, Maklu, 1997, 797, nr. 1296.

<sup>574</sup> Fenyves, A., Kissling, C., Perner, S., Rubin, D., *Compulsory Liability Insurance from a European Perspective*, De Gruyter, 2016, p. 357.

<sup>575</sup> Cerini, D., *Report on Commission Expert Group on European Insurance Contract Law*, 2013, p. 4; [ec.europa.eu/justice/contract/files/expert\\_groups/insurance/final\\_report\\_en.pdf](http://ec.europa.eu/justice/contract/files/expert_groups/insurance/final_report_en.pdf)

82. One of four legal theories is used to determine the date(s) of “occurrence” depending on the type of injury or damage. Each jurisdiction looks to its own case law and legal precedent to decide which theory of occurrence pertains to a particular incident:<sup>576</sup>
1. “Injury-in-Fact theory”: a liability insurance policy is triggered if the claimant was actually injured during the policy period; or
  2. The “Manifestation theory”: claims are identified to the policy in effect when the injury became reasonably apparent or known to the claimant; or
  3. The “Exposure theory “: Courts consider the dates of exposure to be the dates of the “occurrence” (multiple policy potentials); or
  4. The “Continuous trigger theory“: (or multiple triggers) theory provides that all policies in effect during the aggregate trigger, for example, during the period of exposure or injury, are activated and may be called on to respond to a loss.<sup>577</sup>
83. The occurrence policy has the advantage of permanency. The insured does not have to renew the policy to maintain coverage for the year he is insured. The separate insured

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<sup>576</sup><http://www.insurancejournal.com/blogs/academyjournal/2016/06/13/411266.htm>;

more in detail: Vansweevelt, T., *De Beroepsaansprakelijkheidsverzekering van Artsen en Ziekenhuizen: een Vergelijkende Analyse* (The Professional Liability Insurance of Doctors and Hospitals: A Comparative Analysis), Mys en Breesch, 1997, p.60-65.

<sup>577</sup> Occurrence vs. Claims Made Coverage Forms, Insurance Journal, 2016;

[www.insurancejournal.com/blogs/academy-journal/2016/06/13/411266.htm](http://www.insurancejournal.com/blogs/academy-journal/2016/06/13/411266.htm)

limits each year he is insured so past claims will not erode the limits of future years of coverage.<sup>578</sup>

84. Because a claim can sometimes be filed many years after a professional liability incident, the policyholder may have the following uncertainties:

1. Tracking which occurrence policy in the past will respond to the claim just filed;

2. The former Insurance Company may no longer be solvent;

3. Whether the past policy has adequate limits now due to inflation.<sup>579</sup>

85. Each case will be looked at and decided upon an ad hoc basis, therefore not providing for uniform legal regulation. Each case law arises that each judge, in each court and each jurisdiction, has created his theory relating to when an event should be calculated. This is when a case has occurred within the insurance policy period. Such an inconsistent manner of adjudicating differences makes the job of the insurer even more difficult, seeing as though no one set standards or method of operation is applicable. Either way, the event made policy shows that the divergence in the decision-making in such cases is unattractive for those who enter into said policies.<sup>580</sup>

#### **2.2.4.3. *Claims-Made policies***

86. A claims-made policy will operate in respect of any claim made against an insured during the period of insurance. This policy excludes liability for any claim or circumstance which might give rise to a claim, which an insured is aware before the

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<sup>578</sup> Benas, S. and Bennett, B., *Medical Malpractice Insurance: Claim Made vs. Occurrence Coverage*, 2010;

<https://www.gallaghermalpractice.com/resources/claims-made-vs-occurrence/>

<sup>579</sup> Claims Made vs. Occurrence Form Professional Liability Policies;

[www.americanprofessional.com/wp-content/.../Claims-Made-vs-Occurrence\\_AC.pdf](http://www.americanprofessional.com/wp-content/.../Claims-Made-vs-Occurrence_AC.pdf)

<sup>580</sup> DitrimiI, K., *Professional Liability Insurance Coverage and Civil Law Jurisdictions*, Revija za pravo osiguranja, 2009, p. 44.

inception of the policy.<sup>581</sup> This kind of policy also excludes claims which are filed after the expiration of the policy. These problems must be taken seriously since claims-made policies are the most widely available form of MM coverage today.<sup>582</sup>

87. For the said cover to be applicable, there are generally four conditions which must be present:

1. The insured professional must receive his/her first notification of a claim or potential claim during the policy period;
2. The claim or potential situation must be reported to the insurer during the policy period;
3. The negligent act, error, and omission giving rise to the claim must occur after a “prior acts” or retroactive date that is set forth in the policy declarations (in other words, claims resulting from actions or services, respectively, which occurred or were provided prior to the inception date of the current or new policy covered or no retroactive data is applicable);
4. The insured must take a “good faith” statement (in some cases, a certification or warranty) that the professional and the firm had no knowledge about the mistake, error, or controversy in the date the coverage was purchased.<sup>583</sup>

88. In Belgium and France, the legislator has tried (partially) to address this problem of posteriority coverage. Every claims made policy has a mandatory sunset clause or reporting period in which claims can be reported after the end of the policy period to

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<sup>581</sup> Jackson, J. and Powell, R, *On professional liability*, Sweet & Maxwell, 2012, p. 313.

<sup>582</sup> *Types of Medical Malpractice Insurance Policies*, American Academy of Actuaries, 2008, p.1;  
[www.actuary.org](http://www.actuary.org)

<sup>583</sup> Cavnignac and Associates, Professional Liability Update, *Understanding Claims-Made Insurance*, 1998, p.2;

<http://www.cavnignac.com/publications/professional-liability-update-understanding-claims-made-insurance/>

protect insured persons who are confronted with claims after the policy period. In Belgium, this reporting period is 36 months<sup>584</sup> and in France a minimum five years.<sup>585</sup>

89. With a claims-made policy, the insured can increase his/her policy limits or add coverage as the need arises or as new coverage becomes available. The claims-made policy is more flexible and provides considerable cost saving during the early years. This could be important when someone is starting a practice.<sup>586</sup>
90. From the insured's point of view, the claims-made form presents some problems since it is precisely the open-ended aspect of professional liability that causes most professionals to carry insurance. While the cost of a claims-made policy would be less, thus enabling the professional to carry some protection, the cover would also be less since the annual payment bought protection for only one year. Furthermore, if the claim-made form was not well suited to protecting an ongoing business or professional practice, coverage would be renewed from year to year and protection would be required to continue indefinitely.<sup>587</sup> Another disadvantage is the necessity of following precisely the notification procedures for claims and potential claims situations. Because coverage

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<sup>584</sup> Art. 142 Insurance Act 2014; for a more detailed analysis: Weyts, B., *De dekking in de tijd van aansprakelijkheidsverzekeringen: een delicaat evenwicht tussen contractuele vrijheid en dwingende regelgeving (The Coverage in time of Liability Insurance: a Delicate Balance between Contractual Freedom and Mandatory Regulations)* in Vansweevelt, T and Weyts, B. (eds), *De aansprakelijkheidsverzekering in ontwikkeling (The Liability Insurance in Development)*, ALLIC II, Intersentia, 2016, p.116; this reporting period is subject to two conditions: the damage occurred during the policy period and the risk is not covered by another insurer, and the act committed must have been reported to the insurer.

<sup>585</sup> L. 124-5 French Insurance Code; for a more detailed analysis: Bloch, L., *Assurances terrestres* in Jurisclasseur Civil Annexes, Fasc. 11-10, 2017, n° 78,

[www.LexisNexis.com/fr](http://www.LexisNexis.com/fr)

<sup>586</sup> Benas, S and Bennett, B., *Medical Malpractice Insurance: Claim Made vs. Occurrence Coverage*, 2010;

<http://nationalpsychologist.com/>

<sup>587</sup> Dorroh, P. and Whisenand, M., *Understanding Your Claims-Made Professional Liability Insurance Policy*, 2000, p.2;

[https://www.soa.org/Files/static-pages/sections/entrepreneur-innovate/eact\\_dorroh-whisenand-claims.pdf](https://www.soa.org/Files/static-pages/sections/entrepreneur-innovate/eact_dorroh-whisenand-claims.pdf)

is triggered by the awareness and notification of a claim or potential claim situation, failure to properly provide notification to the insurer will eliminate coverage.<sup>588</sup>

### **3. Challenges in medical malpractice liability insurance**

91. One of the first principles of tort liability is to pay for any damages inflicted upon an innocent victim. In the simple paradigm of torts, if a physician makes a fault, s/he has to pay for the injured. It is common that an insurer will settle financial issues on behalf of the physician who is insured by that insurer.

92. A series of problems in MMLI includes the inherent problems of lacking litigation, high costs in using the court system, and increasing premium. Because of these realities, MMLI has received considerable attention.<sup>589</sup>

#### **3.1. *Conflict purposes between tort law and medical malpractice liability insurance***

93. The primary purpose of tort law is to find the fault for wrongdoing and to deter the wrongdoer by compelling him/her to pay damages to the victim. The system was initially intended to provide damages to those victims who were only entitled to compensation as a result of a physician's negligence.<sup>590</sup> Over the years, the system has moved in the direction of compensating not only for the results of negligence but also for a variety of severe medical outcomes. This is a case where there is negligence.<sup>591</sup> The presence of liability insurance in the system serves a dual purpose. It protects the assets of the physician, and it also assures the victim a more certain recovery. However, liability insurance largely defeats the purposes of implicit in the law of MM because it

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<sup>588</sup> Cavnac and Associates, *Professional Liability Update, Understanding Claims-Made Insurance*, 1998, p.2;

<http://www.cavnac.com/publications/professional-liability-update-understanding-claims-made-insurance/>

<sup>589</sup> Brant, J., *Medical Malpractice Insurance: The Disease and How to Cure It*, The Berkeley Electronics Press, 1972, p.153.

<sup>590</sup> Meisel, A., *The Expansions of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, NED L. REV, Vol.51, 1977, p. 52-53.

<sup>591</sup> Frank, P., *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, Case Western Reserve Law Review, Vol. 36, 1986, p. 1062.

effectively insulates the physician against the consequences of his/her culpable mistakes.<sup>592</sup>

94. Many hospitals, both public and privates, and medical practices have not developed adequate procedure designed to reduce or avoid the risk of injury.<sup>593</sup> While the theory of tort is to deter the negligent or incompetent practice of medicine, the practical effect of liability insurance is to protect physicians from the adverse financial consequences of such practice. It is argued that the current MM system is an instrument of medical discipline is entirely misguided. They are correct, however, inciting the tort law remedy as the only instrument, presently available to vindicate the rights of patients who have been hurt by a physician's negligence.<sup>594</sup>
95. This contradiction raises concern that insurance does not undermine the role of tort law and still promotes its role in protecting physicians from risks. In Europe, the desirability and feasibility of harmonisation of tort law have been done. It is said that real harmonisation of tort law is hard to achieve without taking into account other compensations systems such as private insurance and social systems. It is widely acknowledged that these systems are strongly interconnected. It seems undesirable to harmonise tort law and to overlook insurance law and social security.<sup>595</sup>

### 3.2. *Shortage of laws on medical malpractice liability insurance*

96. Another challenge of the current MMLI is caused by insufficient and lack of the independent laws of MMLI.<sup>596</sup> Understandingly, the medical profession is an occupation aimed at protecting, promoting, and restoring good health with a focus on

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<sup>592</sup> Frank, P., *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, Case Western Reserve Law Review, Vol. 36, 1986, p. 1064.

<sup>593</sup> Wilson, L. and Fulton, M., *Risk Management: How Doctors, Hospitals and MDOs Can Limit the Cost of Malpractice Litigation*, Medical Journal of Australia, Vo.172, 2000, p. 77.

<sup>594</sup> McNeely, M., *Illegality as a Factor in Liability Insurance*, Colum. L. Rev., Vol.41, 1941, p.31-33.

<sup>595</sup> DAM, C., *European Tort Law*, Oxford University Press, 2006, p. 161.

<sup>596</sup> Palmisano, D., *A Special Medical Liability Monitor Report: Examining Today's Malpractice Problem-The Controversial Search for Solutions*, Medical Liability Monitor, 2002, p. 6.

identifying, diagnosing, and treating illnesses using scientific and highly specialised knowledge.<sup>597</sup>

97. This career carries many risks, and there are difficult challenges. Unfortunately, there is no perfect solution to prevent or avoid the misstep that could lead to a malpractice claim. Following the best practices in medical care will provide optimal care and mitigate the likelihood of a breach of care. However, that strategy is not entirely infallible. There are always risks for healthcare professionals where they are least expected. Each year, hundreds of malpractice claims are made against medical professionals.<sup>598</sup> The critical point to note is that MMLI only indemnifies the insured with civil legal liability to a third party. This is the party that suffers loss or damage that results from physicians' negligence. As already observed, the legally recoverable loss of the third party claimant may exceed the loss recoverable under the MMLI.<sup>599</sup>
98. Because of such risks, the physicians need to be protected by the insurers. At this point, the insurance law and MMLI law that are the most essential tools to ensure the safety of the doctor as well as specific benefits of the insurer. Nevertheless, both of them confront insufficient and dependent provisions. Many countries, for instance, Belgium, France, England, and Vietnam in the scope of this research, they have no MMLI laws. Basically, MMLI is based on general rules of insurance laws and professional regulations in insurance laws. The general rules of insurance laws in the countries may not express the most accurate and necessary ways for the issues in the medical profession. A medical professional is entirely different from other areas because of its particularities. This may be a reason as to why physician and insurer are free to agree to terms in the contract,

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<sup>597</sup> *Definition of the Professional*, 2010;

[http://www.cgcom.es/noticias/2010/12/10\\_12\\_13\\_medical\\_professional](http://www.cgcom.es/noticias/2010/12/10_12_13_medical_professional)

<sup>598</sup> Ashleigh, S., *Risks for Health Care Professionals: What's at Stake*;

<http://locktonmedicalliabilityinsurance.com/risks-for-health-care-professionals/>

<sup>599</sup> *What is Professional Insurance?*

<https://www.markeluk.com/articles/what-is-professional-indemnity-insurance>

except for the basic terms required. Due to the peculiar nature of medical professional, it is, therefore, necessary to have sufficient and independent MMLI law.

99. The facts which are written in the insurance policy such as insurable interest, insured risk, insured premium, indemnity, third party, among others, they are the descriptions borrowed from general insurance law. They need to be guided by specific MMLI law to ensure that facts are accurate and reasonably applied. Besides, all the four countries, Belgium, France, England, and Vietnam are in a state of inadequate regulations to regulate MMLI.

### 3.3. *High cost of medical malpractice claims*

100. In the event of an allegation of negligence or a lawsuit, MMLI will cover expenses, including defence attorney fees, court costs, and any settlements or judgments. Without MMLI, physicians and healthcare providers have to pay for these expenses personally. They can also be held personally liable for any settlements or judgments resulting from a lawsuit.<sup>600</sup>
101. Firstly, the award of damages causes high cost. The reason for the high cost of damage is that the rules controlling awards for damages must be sufficiently general to cover losses of the injured. This necessity coupled with the numerous assumptions that underlie calculation of loss allowing attorneys and expert witnesses considerable discretion to cast the loss in favour of their clients.<sup>601</sup> Moreover, the award of damages for personal injuries have become unaffordable and unsustainable as the principal source of compensation for those injured through the fault of another.<sup>602</sup> Injuries of MM are divided into economic injury and non-economic injury which conclude different types. Compensation is complicated and costly.

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<sup>600</sup> *Medical Malpractice Insurance Complete Guide*;

<https://www.cunninghamgroupins.com/medical-malpractice-insurance-complete-guide/>

<sup>601</sup> Boyle, H., and George W., *Economic Evaluation of Neonatal Intensive Care of Very- Low-Birth-Weight Infants*, The New England Journal of Medicine, Vol. 308, 1983, p. 1130.

<sup>602</sup> Negligence Review Panel, *Commonwealth, Review of the Law Negligence – Final Report*, 2008.

102. Secondly, the difficulty that figures most prominently in all explanations of the insurers' problems is the "long tail" of malpractice claims. In contrast to some other forms of indemnity, the losses of MM cases may take time to investigate and conclude because of their complexities.<sup>603</sup>
103. Thirdly, the high costs of malpractice claims bring strong pressures on physicians to refuse to settle malpractice claim. Most physicians feel that any admission of malpractice will be a severe detriment to their careers. As a result, most MM contracts, unlike other insurance contracts, deny the insurer the right to make any settlement without the physician's permission. Many cases which could be settled quickly with low administrative, judicial, and legal costs are dragged through the courts because the physician is unwilling to accept a settlement. The physician's name and honour can be indicated only through litigation.<sup>604</sup>
104. Lastly, litigation costs are particularly expensive since lawyers spend three to four times longer for the cases compared to other injury claims. The litigation in covering can take up to a decade to complete the compensation.
105. A negligent lawsuit covers several kinds of expenses including defence attorney fees, court costs, and any settlements or judgments. The insurer who provides MMLI will spend high costs to compensate for damage, pay for defence's fees as well as attorney's fees.

#### ***3.4. Increasing medical malpractice insurance premium: physicians cannot afford***

106. Physicians have been forced to pay a high premium for the insurer. This problem comes for different reasons. Paying high premiums makes physicians confront financial difficulties, and it is possible for them to leave off their jobs. The insurer also struggles with the challenges of their MMLI's products.

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<sup>603</sup> Clen, O., *The Medical Malpractice Crisis of the 1970's: A Retrospective*, Law and Contemporary Problems, Vol. 24, 1986, p.8.

<sup>604</sup> Brant, J., *Medical Malpractice Insurance: The Disease and How to Cure It*, The Berkeley Electronics Press, Vol. 6, 1972, p.162.

107. Multiple factors have contributed to increase in MM insurance premium for physicians. However, the principal contributor has been the rapid growth in insurers' losses from claims. Claim losses include not only the settlements and judgments paid by carriers to the claimants on behalf of their insured physician but also most of the expenses incurred in defence of a claim.<sup>605</sup>
108. Also, MM insurers are forced to raise their premiums because of the increase in the number of claims for damages and compensation that will be paid by the insurer. The increase in MM claims cannot be ascribed to one single reason. Firstly, the rise in the value of MM claims could at least or in part ascribed to advances in medicine and technology. Advances in medicine enable people to live longer and increase their life expectancy which can be considered when calculating a number of damages in MM claims. Secondly, lawyers litigate for aggrieved patients who advertise to be represented as maltreated patients, and there have been suggested the possible reason to win the claims. Thirdly, patients are becoming more aware of their rights and are enforcing these rights through litigation. It has been pointed out that this is a proper development because it ensures aggrieved patients who have suffered harm as a result of the failure of the health care system, they are compensated.<sup>606</sup> Therefore, the insurers are forced to raise their premiums to cover their costs in the claims.<sup>607</sup>
109. One of the reasons for increasing premium is for the insurer to highly cover for the losses of doctors who work in areas with higher risks. About the different risk categories, the same applies: the higher the category, the more risk the medical activity entails and the higher the insurance premium will be.<sup>608</sup> Doctor specialists of the highest risk category

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<sup>605</sup> Charles, K., *Healthcare Professional Liability Insurance*, 2003;

<https://www.irmi.com/articles/expert-commentary/whats-causing-increased-medical-malpractice-premium-rates>

<sup>606</sup> Pienaar, L., *Investigating the Reasons behind the Increase in Medical Negligence Claims*, PER/PELJ, Vol. 19, 2016, p.6-7.

<sup>607</sup> Mello, M., Studdert, D., and Brennan, T., *The New Medical Malpractice Crisis*, New Engl J Med, Vol. 348, 2003, p. 2283.

<sup>608</sup> Baeyens, J., Cuypers, R. and Carolus., K., *et al., Zakboekje voor de ziekenhuisarts" (Pocket Book for the Hospital Doctor)*, Mechelen, Kluwer, 2016, 134-135.

can no longer pay their vast premiums, and many of them no longer find insurers because most large insurance companies have entirely left the market. The other insurers only provide cover for doctors who have not yet been charged with a medical error or just refuse to provide cover. The premiums of the insurance companies for doctors can also be high, especially for those who have already been charged several times.<sup>609</sup>

110. Consequently, if the cost of purchasing premium has risen dramatically, the physicians will leave the whole-time private practice of putting added pressure on the public system.<sup>610</sup> There is an alarm that some people will drop their cover completely. It seems to be more consensus that people will reduce their level of cover rather than dropping it because of the concern that people have the private health insurance.<sup>611</sup>
111. In the insurance business, costs drive premiums. The costs indicated here include the expenses which an insurer covers in MM claims.<sup>612</sup> The reasons for the costs to increase highly is the need to re-study and adjust the cost increase. Addressing the bottlenecks of costs is a way to control increasing premiums.

#### **4. Market for medical malpractice liability insurance**

112. MM insurance plays a big part in the insurance market as the market for property casualty insurance. This market is competitive but subject to a considerable amount of state regulation. In the MM insurance market, physicians and other health professionals are the consumers and MM insurers are the suppliers. Insurers decide which physician to ensure (whom to underwrite) and at what premium.<sup>613</sup>

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<sup>609</sup> Delphine, F., *De Medische Aansprakelijkheidsverzekering (The Medical Liability Insurance)*, 2013, *Master's Thesis of the Master of Law Program, Faculty of Law of Gent University*, p.129.

<sup>610</sup> Joint Committee on Health and Children, *Report on the Cost of Medical Indemnity Insurance*, House of the Oireachtas, 2015, p.13.

<sup>611</sup> *Increased Private Health Insurance Premiums Don't Mean Increased Value*, 2015;

<https://theconversation.com/increased-private-health-insurance-premiums-dont-mean-increased-value-727>

<sup>612</sup> Frech H., Hamm, W., and Wazzan, P., *Controlling Medical Malpractice Insurance Costs - Congressional Act or Voter Proposition*, *Indiana Health Law Review*, Vol. 3, 2006, p. 37

<sup>613</sup> Sloan, F. and Chepke, L., *Medical Malpractice*, 2008, The MIT Press, p.9.

113. Under the present system of tort recovery, MM insurance is no longer a precautionary device; it has become a necessity for medical professionals. At the same time, more insurance companies are abandoning the medical liability field or have been reducing their commitments in this area. The sum of these problems has created immediate concern about the availability of medical liability coverage for healthcare providers.<sup>614</sup>
114. Most MM insurance providers still have strong capital positions and low operating leverage. However, they have limited opportunities for business expansion due to lack of underwriting expertise in other markets. This is likely to encourage larger MM insurance companies to expand via acquisition rather than entering new markets via expansion. The acquisitions of MM insurance companies were relatively few in recent years, but merger activity in the broader property/casualty market rose in the first half of 2015.<sup>615</sup>
115. In Belgium, regarding MM, liability insurance has been stable, fluctuating from -5% TO +5%.<sup>616</sup> In France, the entrance of new insurers into the professional indemnity market has resulted in fierce competition, which has driven down rates for loss-free accounts. Comparing to MM liability insurance in Belgium, France, and England, the rates are more encouraging with the rate fluctuating from 0% to 10%.<sup>617</sup>

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<sup>614</sup> Student Symposium, *Medical Liability Insurance*, Mary's Law Journal, Vol. 7, 1976, p. 802.

<sup>615</sup> Matray, M., *No Crystal Ball: Soft Market Continues as Medical Malpractice Insurance Industry Faces Rapidly Changing Fundamentals*;

<https://www.cunninghamgroupins.com/no-crystal-ball-soft-market-continues-medical-malpractice-insurance-industry-faces-rapidly-changing-fundamentals/+&cd=1&hl=en&ct=clnk&gl=vn>

<sup>616</sup> Marsh Risk Management Research February, *Market Perspective: Europe, Middle East, and Africa Insurance Market Report*, 2015, p.7;

<http://www.oliverwyman.com/content/dam/marsh/Documents/PDF/USen/EMEA%20Insurance%20Market%20Report%202015-02-2015.pdf>

<sup>617</sup> Marsh Risk Management Research February, *Market Perspective: Europe, Middle East, and Africa Insurance Market Report*, 2015, p.13;

<http://www.oliverwyman.com/content/dam/marsh/Documents/PDF/USen/EMEA%20Insurance%20Market%20Report%202015-02-2015.pdf>

116. Meanwhile, Vietnam has just started the MMLI. It is regulated that all medical examination and treatment establishments must purchase MMLI, by December 31, 2017.<sup>618</sup> However, in reality, there are no official statistics about the progress of the law's application. Information available from the media <sup>619</sup> shows that the public hospitals are still depending on their limited compensation fund and the private health practitioners have shunned it because of high insurance premiums. Both of them indicated that this kind of insurance has many unconformities with the medical professionals. Moreover, the insurance companies have not been earnest to provide this product. Besides, many health providers are not excited about this insurance. The reason that the premium is very high and insurance policies are not clear for other reasons.<sup>620</sup> Importantly, the main reason is that the State has not seriously implemented the present regulations as well as guided the relevant parties on how to apply them. As a result, both the theory and practice of regulations have not been adequately realised.

## 5. Conclusion

117. In conclusion, the insurance laws of the four countries: Belgium, France, England, and Vietnam give freedom and protection for the parties to agree on the contracts. Nevertheless, the laws indicate the mandatory regulations to avoid nullification of the insurance contract, which must be permanently maintained in the insurance contract. Generally, the countries regulate MMLI (a kind of professional liability insurance) by most general regulations from the insurance contract codes (for example, insurable interest, insured risks, and insurance premium, etc.) although they also enacted additional laws for the MMLI.

118. While MMLI has historically existed and developed for an extended period in Belgium, France, and England. MMLI is an obligation, Vietnam has just begun to promote the

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<sup>618</sup> Decree No. 102/2011 / ND-CP on Medical Liability Insurance Stipulates, on the 31st of December 2015

<sup>619</sup> Kim Lan, *The Hospital is "Ambiguous" about Liability Insurance*, Dau Tu Chung Khoan, 2015;

<http://tinnhanhchungkhoan.vn/bao-hiem/benh-vien-van-mo-ho-ve-bao-hiem-trach-nhiem-133958.html>

<sup>620</sup> Hong Chi, *Doctor's Liability Insurance: Why the law is delayed to implement?*, Tai Chinh, 2013;

<http://thoibaotaichinhvietnam.vn/pages/tien-te-bao-hiem/2013-11-01/bao-hiem-trach-nhiem-bac-sy-co-luat-sao-cham-trien-khai-4941.aspx>

legislation. Vietnam does not have the necessary regulations on professional liability insurance in Law on Insurance Business as well as many gaps in the Decree on Liability Insurance in Medical Examination and Treatment.

119. Another difference is that Vietnam does not allow the third party direct claims for indemnification. Moreover, Vietnam lacks the necessary rules for protecting the third party' rights. The shortcoming makes Vietnam lag behind Belgium, France, and England.
120. Typically, there are three kinds of triggers of coverage including fact-occurrence, loss-occurrence, and claims-made. Among them, the fact occurrence or act-committed system is undoubtedly the most beneficial system for the physician-insured. The three policies have been recognised in Belgium, France, and England but not in Vietnam. Vietnam only admits claims-made policy. The main reason for this restriction is the limited legal capacity of the MMLI, which has not been developed as in other countries. As mentioned earlier, medical liability may take a considerable amount of time between the mistake, the discovery of the claim and the lodging of a claim. Apparently, for the physician, it is essential that, in the case of this system, the liability risk remains covered even after the insurance contract has been terminated.<sup>621</sup>
121. Admittedly, MMLI have faced many challenges. The conflicts between tort law and MMLI seem to undermine the role of tort law. The role of tort law is to find the fault for wrongdoing and deter the wrongdoer by compelling him to pay damages to the victim. In contrast, MMLI makes doctors more careless while performing their duties. Besides, all four countries of Belgium, France, England, and Vietnam are in a state of inadequate regulations to regulate MMLI. Regulations on MMLI are mostly based on general insurance law and rules created by the insurers. All caused difficulties in the management and implementation of MMLI. Moreover, MMLI is costly in situations where the insurer has to compensate for damage, pay for defence's fees as well as attorney's fees. As a result, many insurers fell into a loss and, therefore, do not want to provide MMLI anymore. To overcome the loss situation, the insurers must increase the

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<sup>621</sup> Vansweevelt, T, *De Beroepsaansprakelijkheidsverzekering van Artsen en Ziekenhuizen: een Vergelijkende Analyse (The Professional Liability Insurance of Doctors and Hospitals: A Comparative Analysis)*, Mys en Breesch, 1997, p.57.

premium. Like a vicious circle, physicians cannot pay high premiums which causes them to quit a job or refuse to provide health care services. Lastly, the role of the insurer in the standard of care determination seems forgotten while the insurer has to cover all kinds of fees of the claim. It is undoubtedly to admit their appearance. That helps the insurer to have more experience in writing policies, predicting specific risks in medicine and also ensuring his legitimate interests when he will do compensation for the third party.

122. Although the MMLI is a principal instrument for protecting healthcare practitioners and their patients, its development in the insurance market seems slow and quiet in Vietnam. Many medical establishments have refused or delayed the purchase of MMLI for a variety of reasons such as high premiums, short contract terms, and insufficient settlement of disputes. Meanwhile, the other markets of Belgium, France, and England have been relatively stable.

# CHAPTER 5: NO-FAULT COMPENSATION SYSTEMS

## 1. Introduction

1. As we know about MM, it begins with an injury or an adverse outcome to a patient occurring during medical care. Patients and families suffer from emotional and financial burdens arising from these adverse outcomes or injuries and seek compensation for the loss.
2. Most injuries in medicine, however, are due to either system errors or non-negligent reasons.<sup>622</sup> As an alternative to the tort or fault-based system, a no-fault compensation system has been viewed as having the potential to overcome problems inherent in the tort system. This is through the provision of fair, speedy, and adequate compensation for medically injured victims.<sup>623</sup> The form of the no-fault system is most likely to be adopted would be one that provides automatic compensation and not for all iatrogenic injuries.<sup>624</sup>
4. The implementation of a no-fault compensation system involves the shifting of responsibilities from the fault-bearer's individual responsibility to a wider collective responsibility through a "social insurance scheme," built upon the principle of distributive justice.<sup>625</sup> The social insurance scheme places the responsibility to

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<sup>622</sup>Sohn, D., *No-Fault Compensation Systems: Are there Benefits to not Assessing Blame?* AAOS Now, 2012, p.1.

<sup>623</sup> Kassim, P., *No-fault Compensation for Medical Injuries: Trends and Challenges*, Medicine and Law, 2014, p.21.

<sup>624</sup> Tancredi, L., *Designing a No-fault Alternative*, Health Law and Ethics, Vol.49, 1986, p.277.

<sup>625</sup> The concept of distributive justice as opposed to corrective justices; "distributive and corrective justice are the structure of ordering implicit in two different conceptions of interaction. In corrective justice, the interaction of the parties is immediate; in distributive justice it is mediated through a distributive arrangement...which activate a compensation scheme that shifts resources among members of a pool of contributors and recipients in accordance with a distributive criterion." (Weinrib, E., *Corrective Justice*, Oxford Legal Philosophy, 2012, p.415)

compensate the injured on the shoulders of the community at large or a group of people with common interest.<sup>626</sup>

## **2. Scheme of no-fault compensation**

5. A no-fault compensation system allows patients to be compensated without proof of a provider's fault or negligence. The deterrence objective is done differently in the system. Thus, instead of deterring physicians from substandard care, the system encourages physicians to collaborate with the system in detecting what causes the injuries. Although the application of a no-fault system differs slightly in each country, the basic idea is to eliminate fault or blame from the system of compensation to increase the fairness by making the claim process simple. Therefore, the patients with meritorious cases can access the system easily and be awarded for compensable injuries incurred during the medical treatment.<sup>627</sup>
6. Successful claims are paid in a uniform manner using a fixed benefits schedule and include compensation for both economic and non-economic (pain and suffering losses) without the necessity of proving negligence through a tort claim.<sup>628</sup>
7. A comprehensive no-fault system liability could use a wide range of recovery schemes. The most liberal models allow for recovery for all kinds of injuries with no regards for causation, but this would be expensive and impractical. Therefore, a no-fault system

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<sup>626</sup> Kassim, P., *No-fault Compensation for Medical Injuries: Trends and Challenges*, Medicine and Law, 2014, p.21.

<sup>627</sup> Health, Nutrition, and Population (HNP), *Medical Malpractice Systems around the Globe: Examples from the US-tort Liability System and the Sweden-No Fault System*, Document of the World Bank, 2013, p.5;

<https://openknowledge.worldbank.org/handle/10986/26120>

<sup>628</sup> David M., and Troyen, B., *No-fault Compensation for Medical Injuries: The Prospect for Error Prevention*, American Medical Association, Vol.286, 2001, p.220.

should only allow compensation for limited injuries. Furthermore, any possible no-fault system would also offer compensation based on the level of causation.<sup>629</sup>

8. No-fault systems share the same goal which is to compensate victims of injuries and deter substandard care. They apply different methods to increase effectiveness, the fairness of the system in compensating victims and deterring substandard medical care. They also control direct and indirect health care costs of the malpractice system.<sup>630</sup> In addition, they seek to improve upon the injury resolution of tort liability by replacing the existing fault remedy and liability insurance with a new no-fault alternative in whole or in part. Different reforms emphasise a different mix of the goals, reflecting reformers' perception of liability problems in the area addressed.<sup>631</sup>

### **3. The prospects of a no-fault system**

9. A no-fault can be seen as an alternative for a long-term prospect to the existing tort system of medical injury compensation. It looks optimistic for several reasons.<sup>632</sup> A no-fault compensation mechanism would be far more effective than the much maligned-fault compensation in achieving the twin goals that the tort system is supposed to serve with fair compensation and deterrence. A no-fault system would effectively and fairly compensate those whose injuries fall within this scope. The tort system is arguably inequitable in that its decision-making processes do not always yield consistent results in similar situations.<sup>633</sup> A no-fault system would also be more successful than the tort in preventing injuries through deterrence. Evidence showing iatrogenic illness is

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<sup>629</sup> Tappan, K., *Medical-Malpractice Reform: Is Enterprise Liability or No-Fault a Better Reform?* *Boston College Law Review*, Vol. 46, 2005, p.1109.

<sup>630</sup> Health, Nutrition, and Population (HNP), *Medical Malpractice Systems around the Globe: Examples from the US-tort Liability System and the Sweden-No Fault System*, Document of the World Bank, 2013, p.5;

<https://openknowledge.worldbank.org/handle/10986/26120>

<sup>631</sup> Bovbjerg, R. and Sloan, F., *No-fault for Medical Injury: Theory and Evidence*, University of Cincinnati Law review, Vol.67, 1988, p.65.

<sup>632</sup> Tancredi, L., *Designing A No-fault Alternative*, *Law and Contemporary Problems*, Vol. 49, 1986, p.277.

<sup>633</sup> Williams, P., *Abandoning Medical Malpractice*, *Journal Legal Medicine*, 1984, p. 549.

frighteningly common and frequently serious, especially in the hospital context,<sup>634</sup> which indicates that the tort system in its present form leaves many avoidable injuries uncompensated. Without fairly systematic compensation, it is likely that injuries are sub-optimally deterred confirming the fears of many that the tort system fails to deter even those injuries that would be compensable under its own restrictive rule.<sup>635</sup>

10. With the no-fault compensation system, claims are settled relatively fast with the result that patients know where they stand in a relatively short period. A second objection that is raised against the no-fault compensation system is that the system would reduce the damage preventive effect of liability law. In this view, the goal of liability law is not only to compensate for damage but also to prevent damage. However, this objection is not convincing because the damage- preventive effect of liability law in health care is of minor importance<sup>636</sup> and will at most play a role in certain sectors like high tech surgery. A third objection that raised against no-fault compensation system is that such a scheme does not provide for full compensation of the damage. It is correct, but that difficulty can be overcome when a no-fault compensation system is introduced while at the same time, the access to the courts is not blocked.<sup>637</sup>
11. Most no-fault schemes formulate some eligibility criteria within which compensation would be provided to victims. Victims are compensated only if the injury falls within

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<sup>634</sup> Barry R., *Iatrogenesis and Medical Error: The Case of Medical Malpractice Litigation*, Law, Medicine & Health Care, 1981, p.4.

<sup>635</sup> Tancredi, L., *Designing A No-fault Alternative*, *Law and Contemporary Problems*, Vol. 49, 1986, p.278.

<sup>636</sup> Jacobi, V. and Huberfeld, N., *Quality Control, Enterprise Liability, and Disintermediation in Managed Care*, *The Journal of Law, Medicine & Ethics*, Vol. 29, 2001, p. 305-322.

<sup>637</sup> Dute, J., *Medical Malpractice Liability: No Easy Solutions*, Martinus Nijhoff Publishers, 2003, p.89.

the designed parameter.<sup>638</sup> The following analysis of the four countries Belgium, France, England, and Vietnam are the frameworks of no-fault compensation schemes.

#### **4. No-fault compensation system in Belgium**

##### **4.1. Background**

12. Since the 1990s, in Belgium, the compensation system in medical incidents has been changed in the situations where general civil liability regime was not adequately concerning compensation to patients harmed by professional health providers as well as insurers.<sup>639</sup> These medical incidents were resolved in the court relying on tort and contractual liability laws. However, this system has been widely criticised for failing to realise its intended compensatory and preventive objectives. The vast majority of patients suffering medical incidents were left uncompensated, since awarding damages depended exclusively on fault liability, i.e., the assessment of a physician's fault, the harm suffered, and causation. Moreover, the patients are becoming increasingly empowered and expect top quality health care services. Hence, the growing number of claims against physicians. Consequently, physicians are unwillingly driven to practice defensive medicine to reduce their liability risk.<sup>640</sup> These crucial deficiencies prompted the legislative change and the establishment of the Fund of Medical Accidents (FMA) in Belgium. Since the FMA applies a no-fault rule in some instances, some victims of medical incidents can receive compensation even in the absence of a physician's fault.<sup>641</sup>

##### **4.2. No-fault compensation system**

13. In 2007, the Belgian legislature wished to meet the concerns of compensation for victims by introducing a system through a Fund covering both situations where there might have

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<sup>638</sup> Kassim, P., *No-fault Compensation for Medical Injuries: Trends and Challenges*, Medicine and Law, 2014, p.26.

<sup>639</sup> Fagnart, L., *Principes fondamentaux de la loi sur les accidents médicaux, Revue belge du dommage corporel et de médecine légale (Basic Principles of the Medical Accident Act)*, Belgian Review of Personal Injury and Forensic Pathology, 2011, p. 74-76.

<sup>640</sup> Vansweevelt, T., *Een no fault-systeem voor medische ongevallen in België: quo vadis? (A No-fault System for Medical Accidents in Belgium: Quo vadis ?)*Liber Amicorum Jean-Luc Fagnart, Anthemis, 2008, p.350-351.

<sup>641</sup> Vansweevelt, T. and Dewallens, F. (eds.), *Handboek Gezondheidsrecht (Health Code Handbook)*, Vol.I, 2014, p. 1579-1666.

been a fault or no fault. Hence, a no-fault system for damages resulting from health care was adopted with the laws of 15<sup>th</sup> May 2007.<sup>642</sup> Under this no-fault act, compensation could not be claimed in court anymore as civil liability was eliminated for medical injuries. Instead, a free administrative procedure would be introduced in which a fund applied a no-fault rule to compensate more patients.<sup>643</sup> Nevertheless, the law has never entered into force because of problems with the design and implementation, and the Law of March 2010 replaced it.<sup>644</sup>

14. The Law of 31<sup>st</sup> March 2010 (the *Law on Compensation of Victims of No-Fault Medical Accidents (the Act of 31<sup>st</sup> of March 2010)*) indicated a two-way compensation model. The law of 31<sup>st</sup> March 2010, on the indemnification of damages resulting from health care thus fully maintains - as French law - does the responsibility of health professionals. However, it adds a mechanism of compensation for the victim of the therapeutic hazard. In this regard, it establishes a Medical Accident Compensation Fund. By the law, a national solidarity mechanism intervenes to compensate a particular responsibility, while on the other hand, the injured party may choose a route other than that of judicial proceedings, where it suspects that a health care provider would be liable for damages resulting from the provision of healthcare.<sup>645</sup>
15. Similar to court proceedings, the Fund for Medical Accident (FMA) uses judicial and medical expert opinions to determine the nature of medical incidents although it claims to provide better support to patients during the resolution process. The FMA can even

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<sup>642</sup> Loi du 15 mai 2007 relative à l'indemnisation des dommages résultant de soins de santé et loi du 15 mai 2007 concernant le règlement des différends dans le cadre de la loi du 15 mai 2007 relative à l'indemnisation des dommages résultant de soins de santé.

(Law of 15 May 2007 on Compensation for Damage Resulting from Health Care and Law of 15 May 2007 on the Settlement of Disputes under the Law of 15 May 2007 on Compensation for Damage Resulting from Health Care.)

<sup>643</sup> Vandersteegen, T., Marneffe, W and Vandijck, D., *Physician Specialists' Perception of the Medical Malpractice System in Belgium*, European Journal of Health Law, 2015, p. 483.

<sup>644</sup> Loi du 31 mars 2010 relative à l'indemnisation des dommages résultant de soins de santé, M.B., 2 avril 2010 (Law of 31 March 2010 on Compensation for Damage Resulting from Health Care, M.B., 2 April 2010)

<sup>645</sup> Schamps, G., *Le Fonds des Accidents Médicaux et L'indemnisation des Dommages Résultant de Soins de Santé (The Medical Accident Fund and Compensation for Damage Resulting from Health Care Medical Liability)*, Responsabilité Médicale, 2014, p. 1-2.

award compensation to patients suffering from abnormal and severe injuries that occurred following a medical mishap, i.e., on a no-fault basis. Not all medical incidents will be subject to the no-fault rule though. Fault liability remains the primary compensation rule in all tracks; physicians remain liable for indemnifying the harmed patients who suffer in case of a medical error. According to some authors, the current Belgian compensation system for medical incidents is a not-only-fault system, rather than a right no-fault system.<sup>646</sup>

16. The missions of the Fund concluded in determining whether the damage incurred by the patient resulted from the caregiver's fault and to; evaluate the extent of the damage, verifying whether the caregiver is sufficiently ensured, compensating the victim if the caregiver was not at fault, and the conditions for compensation set forth by the Law are met, asking the insurance company to present an offer to the victim where the caregiver is at fault and organizing mediation at the request of the patient, his/her beneficiaries, the caregiver, or the insurance company. The Fund may eventually be a party to the mediation and giving an opinion as to whether the compensation amount proposed by the insurance company is sufficient as requested by the patient or his/her beneficiaries.<sup>647</sup>
  
17. The FMA claims to offer a simple, expeditious, and free alternative procedure for patients seeking compensation for medical incidents.<sup>648</sup> So far, each month, approximately 90 patients submitted a claim. These patients may benefit from the FMA's supporting role, possibly helping them with the burden of proving fault, harm, and causation. If these do not succeed in proving fault, they might still receive compensation on a no-fault basis provided that the harm suffered is considered severe and abnormal by the FMA. Severe injuries involve death, permanent disability of at least 25%, or a temporary incapacity for work of at least six months or those extremely

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<sup>646</sup> Vandersteegen, T., Marneffe, W and Vandijck, D., *Physician Specialists' Perception of the Medical Malpractice System in Belgium*, European Journal of Health Law, 2015, p.36.

<sup>647</sup> <http://www.droitbelge.be/>

<sup>648</sup> Vansweevelt, T., *La responsabilité des professionnels de la santé (The Responsibility of Health Professionals)*, Wolters Kluwer, Vol.4, 2015, p.7.

destabilising the patient's living conditions.<sup>649</sup> Even though the high severity rate of these criteria was criticised for being disadvantageous for patients, approximately half of the current FMA requests appear to comply with them.<sup>650</sup> Thus, only sufficient serious damage, within the meaning of the law, creates a claim against the Fund and confers upon the patient a personal right to compensation without the provider's fault being proven. According to the Federal Center for Health Care Expertise, this filter linked to the severity threshold will drastically reduce the number of claims that will actually be compensated by the Fund.<sup>651</sup>

18. In a compensation system that is primarily based on fault liability, most advantages for patients are inherently disadvantageous for physicians. First, the FMA's easy accessibility and the possibility of receiving damages on a no-fault basis may encourage patients to claim compensation. Even if no compensation is awarded, they can still obtain free advice about their injuries. As a result, an increasing number of physicians may be involved in medical incident claims, all potentially causing moral and reputational damage. Furthermore, they may suffer financially as well given a potentially ensuing increase in professional insurance premiums.<sup>652</sup> Secondly, physicians can still be sued following a medical incident, although the availability of the FMA procedure will probably reduce this threat. Moreover, decisions from the FMA are not legally binding and therefore, contestable in court. Thirdly, cooperation in FMA procedures is mandatory for physicians under penalty of financial sanctions. Fourthly, the FMA also acts as a gatekeeper to disciplinary proceedings since physicians can be referred to professional boards, e.g. the Order of Physicians, in serious cases. Therefore, their main advantage seems to be a reduced exposure to lawsuits. Even though more

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<sup>649</sup> Article 5 - The Law aims at compensating victims of no-fault medical accidents by creating a Medical Accident Compensation Fund (*Fonds des accidents médicaux*).

<sup>650</sup> Vandersteegen, T., Marneffe, W., and Vandijck, D., *Advantages and Disadvantages of the Belgian Not-only-fault System for Medical Incidents*, Acta Clinica Belgica, Vol.72, 2017, p. 37.

<sup>651</sup> On the basis of statistical projections, the Center thus comes to the conclusion that out of the 5,133 projects proposed 'eligible for compensation', the number of claims actually compensated by the Fund would be 801 (Federal Center for Health care, 'Compensation for health care damage - Phase V: budgetary impact of the transposition of the French system in Belgium', 2009, KCE reports 107, [www.kce.fgov.be](http://www.kce.fgov.be)).

<sup>652</sup> Vansweevelt, T., *De wet medische ongevallen (The Act on Medical Accidents)*, Tijdschrift voor gezondheidsrecht; 2010, p. 84–134.

physicians may be involved in claims, most of them are expected to be resolved via the FMA. Nevertheless, one should keep in mind that also prior to the reform, most medical incident claims were already resolved without any court interference.<sup>653</sup>

19. Besides, another gap of the Fund is stated that a wrong diagnosis cannot constitute a medical accident without liability even though it would entail abnormal damage to the patient.<sup>654</sup> This is explained by the fact that, in this hypothesis, there is no hazard since the damage does not result directly from a medical act, and the disease evolves on its own. Moreover, these criteria remain difficult to grasp concretely. The law does not specify what is meant by harm which should not have occurred in the light of the present state of science, the condition of the patient and its objectively predictable evolution.<sup>655</sup>
20. The reasoning in medical law is now entrusted to a college of specialised professionals and is no longer exclusively entrusted to magistrates. The members of the Fund have an important mission; their opinions, decisions and their "jurisprudence" will be essential in judging the effectiveness of the system.
21. However, it should be borne in mind that the procedure before the Fund is an amicable procedure, but the decision-making power will always come back to the judge when the parties cannot reach an agreement. Consequently, if the Fund adopts a policy which is too favourable to providers, victims will tend to refuse advice and offers of compensation from the Fund and will opt to challenge them systematically before the court. On the contrary, if the Fund develops a policy which is too favourable to victims about the jurisprudence of courts and tribunals, the doctors or their insurer will systematically opt for the judge.<sup>656</sup> The jurisprudence of courts and tribunals about

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<sup>653</sup> Vandersteegen, T., Marneffe, W., and Vandijck, D., *Advantages and Disadvantages of the Belgian Not-only-fault System for Medical Incidents*, Acta Clinica Belgica, Vol.72, 2017, p. 37.

<sup>654</sup> Muylaert, P., *The Law on Compensation of Health-related Damage*, Belgian Review of Personal Injury and Medicine Law, 2010, p. 89, in a reasoning which we hardly convince, tries to justify this exclusion. He considers that a diagnostic error is not abnormal in itself, it is the abnormal evolution or not. Diagnosed pathology that will justify or not from the application of the new law.

<sup>655</sup> Langenaken, E., *The Belgian Law of 31 March 2010 Concerning Compensation for Damages Resulting from Health Care: Still an Effort*, Responsabilité Médicale, 2011, p.5.

<sup>656</sup> Van Caeneghem, S., *The New Law of 31 March 2010 on Compensation for Damages Resulting from Health Care - Description of the New System*, Insurance Forum, Anthemis, 2010, no 107, p. 149.

medical liability and compensation for damage must therefore always guide the decisions of the Fund.<sup>657</sup>

## 5. No-fault system in France

### 5.1. *Background*

22. In France, the Patients' Rights Law of March 4, 2002 was adopted in a context of the *crisis of regulation* between the different actors involved in the previous compensation model based on fault liability and litigation. Firstly, the law reasserted the principle of fault liability for treatment injury and misdiagnosis as the sole basis for compensation by healthcare providers (doctors, clinics or public hospital). However, it simultaneously created a no-fault compensation scheme for victims who have suffered serious and unpredictable injuries without relation to their previous state of health and its foreseeable evolution. Compensation would be possible in case of the so-called *therapeutic alea* or medical hazard.<sup>658</sup> Secondly, the law of 4<sup>th</sup> March 2002 created an out-of-court settlement mechanism: an alternative for patients to suing through the courts or attempting a face-to-face negotiation with healthcare providers or their insurance companies (in France, most of these are private companies). The objectives were to limit the number of court proceedings against physicians and hospitals. They are to offer the victims a faster way to receive compensation, to reduce social inequalities by providing victims with free medical expertise, to restore public confidence within a context of strong criticism regarding the partiality, and the heterogeneity of the work carried out by judicial experts by introducing a new way of organising medical expertise.<sup>659</sup>

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<sup>657</sup> Langenaken, E., *The Belgian Law of 31 March 2010 Concerning Compensation for Damages Resulting from Health Care: Still an Effort*, Responsabilité Médicale, 2011, p.5.

<sup>658</sup> Helleringer, G., "Medical malpractice and compensation in France. Part II: Compensation based on national solidarity" in K. Oliphant and R. Wright (eds.), *Medical malpractice and Compensation in Global Perspective*, De Gruyter, 2013, p.164.

<sup>659</sup> Barbot, J., Parizot, I., and Winance, M., *No-fault Compensation for Victims of Medical Injuries: Ten Years of Implementing the French model*, Elsevier Ireland Ltd, 2013, p. 237.

## 5.2. *No-fault compensation system*

23. Since the Patients' Rights Law of March 4, 2002<sup>660</sup> (the Kouchner Act), all health professionals and health institutions are under an obligation to buy insurance against their own liability<sup>661</sup> except for public institutions, which are their own insurers.<sup>662</sup> In the case where the liable health professional is not covered (e.g., coverage elapsed or insurance limits are reached), or if the insurer's offer is insufficient, the victim can ask for compensation from the ONIAM (l'Office National d'Indemnification des Accidents Medicaux).<sup>663</sup> It should be emphasised that compensation through public welfare ("solidarité nationale") is subsidiary to compensation based on liability rules. Meaning that the ONIAM shall only compensate medical accidents when no health professional or institution may be held liable.<sup>664</sup> The scheme may, therefore, be characterised as one which is no-fault so far as the patient is concerned.<sup>665</sup>
24. The Act of March 4, 2002 intended to "clarify the rules governing medical liability: liability for negligence, the national solidarity for inherent therapeutic risks," and "to allow victims assistance and compensation." In short, the Kouchner Act produced three major innovations. First, it did not change the liability rules for medical accidents, but it consolidated them. Second, it created a new right to compensation by the National

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<sup>660</sup> Loi 2002-303 du 4 mars 2002 relative aux droits des maladies et à la qualité du système de santé, (2002), (Law 2002-303 of March, 2002 on Patient's Rights and Quality of the Health System), Journal Officiel de la République Française [J.O.] [Official Gazette of France], p.4118.

<sup>661</sup> CSP art. L. 1142-2. In 2002, a "Bureau central de tarification" (Central Bureau of Tariffs) was created, and it is in charge of determining the premiums for this compulsory insurance. Code Des Assurance (Insurance Code) [C. ass.] art. L. 252-1; see Laurent Leveneur, *L'intervention du Bureau central de tarification en matière d'assurance de responsabilité civile médicale* (The Intervention of the Central Bureau of Tarifs in Medical Liability Insurance), RDSS 59 (2010)

<sup>662</sup> Dupont, M., *Un Établissement de Santé est son Propre Sssureur: l'expérience de l'Assistance Publique-hôpitaux de Paris*, (A Health Institution or Own Insurer: The Experience of the Paris Public Hospitals), RDSS, 2010, p. 91.

<sup>663</sup> See CSP article L. 1142-21-1 (Concerning obstetricians, surgeons, and anesthetists); see also Cristina Corgas-Bernard, *L'assurance de responsabilité civile des professionnels libéraux de la santé* (The Liability Insurance of Private Health Practitioners), RDSS 2010, 75.

<sup>664</sup> See CSP art. L. 1142-1 para 1.

<sup>665</sup> Helleringer, G., *Medical Malpractice and Compensation in France. Part II: Compensation Based on National Solidarity* in Oliphant, K., and Wright, R. (eds.), *Medical Malpractice and Compensation in Global Perspective*, De Gruyter, 2013, p.174.

Office of Compensating Medical Accidents for certain inherent therapeutic risks. Third, it created a new procedure for settlement via three newly established bodies. The first of these bodies is the Regional Commission for Conciliation and Compensation of Medical Accidents, Iatrogenic Diseases, and Nosocomial Infections (CRCI or Conciliation Commissions), which facilitates the speedy resolution of serious accidents using Alternative Dispute Resolution (ADR). The second one is the National Office for Medical Accidents (ONIAM or Public Guarantee Fund), which fund victim compensation in the name of national solidarity when no-fault based liability exists. The third body is the National Damages Commission on Medical Damages, which establishes a list of experts to evaluate medical injuries and harmonises the practice of Conciliation Commissions to avoid disparities in the treatment claims.<sup>666</sup>

25. The scheme is intended to provide prompt compensation to the victim. Applicants submit their claim to a regional commission. The commission may reject an application at an initial filtering stage, where it decides that the claims fail to meet the requirement of seriousness. Experts will then draw up a report on each qualifying application, which will be followed by the full examination of the application before the commission.<sup>667</sup> Within six months of the original application, the commission is required to present a decision on the circumstances, the causes, the nature, extent of the damage and the compensation applicable.<sup>668</sup> Compensation must be then paid, either by the insurers in the case of a fault or by the state fund managed by ONIAM where there is no fault within a further four months.<sup>669</sup>

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<sup>666</sup> Thouvenin, D., *French Medical Malpractice Compensations since the Act of March 4, 2002: Liability Rules Combined with Indemnification Rules and Correlated with Several Kinds of Procedures*, Drexel Law Review, Vol. 4, 2011, p. 168.

<sup>667</sup> Article L.1142-16 - Public Health Code.

<sup>668</sup> Article. L. 1142. 8 para.2 - Public Health Code.

<sup>669</sup> Article. L.1142-14 (fault);

Article. L. 1142-17 (No-fault);

Taylor, S., *Medical Accident Liability and Redress in English and French Law*, Cambridge University Press, 2015, p. 56.

26. The scheme caters for situations where it proves difficult to obtain the cooperation of liability insurers. In cases where an insurer fails or refuses to make a compensation payment to the victim following the commission's decision, or where the insurance policy does not cover the loss, then ONIAM will compensate the victim and has the possibility of engaging a resource action through the courts to recover the sum from the insurer.<sup>670</sup> Also, if the patient feels that the offer from the insurer is too low, he can apply to the court for an assessment of the compensation due. Should the judge view the insurer's offer as "manifestly insufficient", the court can order the insurer to pay the full compensation to the victim, together with an additional penalty payment to ONIAM representing up to 15% of that sum.<sup>671</sup> The scheme in this way attempts to ensure that the insurers cooperate. Likewise, concerning no-fault accidents, the victim has the possibility of suing ONIAM when the victim finds the amount of compensation proposed by the organisation is insufficient.<sup>672</sup>
27. According to the legislation, the role of the state fund is subsidiary to that of the liability insurers. Where fault is established, it is the liability insurer who is liable. This ensures that the financial burden on the state is limited and that the accountability for a fault of medical service is retained.<sup>673</sup> However, a problem arises where the medical service provider is found to be only liable for loss of chance on the basis that he has provided inadequate information. In such cases, the *Cour de cassation* has decided that the compensation due to the liability insurers can be combined with payment from ONIAM where the accident that occurred qualifies as a medical accident.<sup>674</sup> The Conseil d'Etat

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<sup>670</sup> Article L. 1142.14 - Public Health Code.

<sup>671</sup> Article L. 1142.14 - Public Health Code.

<sup>672</sup> Article L. 1142.20 - Public Health Code.

<sup>673</sup> Jourdain, P., *L'indemnisation entre Responsabilité et Solidarité (Compensation between Liability and Solidarity)*, in Bacache, M. (ed.), *La loi du mars 2002 relative aux droits des malades (The law of March 2002 Relating to the Rights of the Sick)*, 2013, p. 207.

<sup>674</sup> Cass. Civ. (1), 11 March 2010, no. 09-11270, *Bull.* II, no. 63, D.2010, 1119, note M. Bacache.

has accepted a similar solution where the service provider is found liable for the loss of chance of a cure.<sup>675</sup>

28. In addition to its primary function concerning the compensation of medical accidents, ONIAM manages other compensation funds which have been established for specific categories of medical accident victims<sup>676</sup>, such as the compensation scheme for victims of HIV<sup>677</sup>, hepatitis C<sup>678</sup> from infected blood transmission, for victims of injuries following mandatory vaccines,<sup>679</sup> etc. Most of these funds operate on a different basis from the general medical accident scheme. This is because, unlike under the general scheme, responsibility for compensation is assumed by ONIAM for such accidents irrespective of whether there has been a fault on the part of the medical service provider. Where the victim chooses to apply for fund compensation rather than suing in the courts, an application in most cases is made directly to ONIAM without the involvement of the commission.<sup>680</sup>
29. The Law of March 4, 2002 has provided for a new procedure for the benefit of the victims, to promote simple and quick compensation. Today, the victims have two options: (1) they can bring their claim before a conciliation commission or (2) they can file a lawsuit against the health professional.<sup>681</sup>

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<sup>675</sup> CE, 20 March 2011, no. 327669, *RTD civ.* 2011, 550; Taylor, S., *Medical Accident Liability and Redress in English and French Law*, Cambridge University Press, 2015, p.59.

<sup>676</sup> Helleringer, G., *Medical malpractice and Compensation in France. Part II: Compensation Based on National Solidarity* in Oliphant, K., and Wright, R. (eds.), *Medical Malpractice and Compensation in Global Perspective*, De Gruyter, 2013, p. 166-168.

<sup>677</sup> Article L.3122 .1 - Public Health Code.

<sup>678</sup> Article L. 1221.14 - Public Health Code, introduced by Law no. 2008- 1330 of 17 December 2008.

<sup>679</sup> Article L.3111.9 - Public Health Code.

<sup>680</sup> Taylor, S., *Medical Accident Liability and Redress in English and French Law*, Cambridge University Press, 2015, p.60.

<sup>681</sup> *Patients' Rights Law of March 4, 2002*;

Helleringer, G., *Medical Malpractice and Compensation in France. Part II: Compensation based on National Solidarity* in Oliphant, K. and Wright, R. (eds.), *Medical Malpractice and Compensation in Global Perspective*, De Gruyter, 2013, p. 171-174.

**(1) Adjudication through Conciliation Commissions:** The Law of March 4, 2002 and the Law of December 30, 2002<sup>682</sup> provide for regional commissions of conciliation and compensation for medical accidents ("*Commission Régionale de Conciliation et d'Indemnisation des accidents médicaux, affections iatrogènes et infections nosocomiales*" [CRCI]) in each region.<sup>683</sup> This new organisation aims to provide new ways to solve disputes through amicable means and to help the victims obtain prompt compensation. CRCIs were created by the Decree of May 3, 2002<sup>684</sup> and are meant to be an alternative to courts. The mission of CRCIs is twofold. The first is to promote through conciliation and the resolution of disputes arising in connection with medical treatment. The second function of CRCIs is to solve disputes in order to facilitate compensation for the victims of medical accidents who suffer from serious injuries.<sup>685</sup>

**(2) Adjudication through Courts:** Victims are not obliged to enter into a conciliation procedure under the auspices of the Regional Commissions. They may also proceed against the liability insurer through direct action. Moreover, they can go to court if they are not satisfied with the opinion of the CRCI or with the compensation offer proposed by the insurer of the liable health professional or institution. A victim who has already started proceedings before a court may still bring the claim before the appropriate Regional Commission as long as the court and the Commission are informed.<sup>686</sup>

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<sup>682</sup> LOI n° 2002-1577 du 30 décembre 2002 relative à la responsabilité civile médicale (Law 2002- 1577 of December 30, 2002 on Medical Liability), *JO.*, Dec. 31, 2002, p. 22100

<sup>683</sup> CSP art. L. 1142-5.

<sup>684</sup> Décret 2002-886 du 3 mai 2002 relatif aux commissions régionales de conciliation et d'indemnisation des accidents médicaux, des affections iatrogènes et des infections nosocomiales prévues A l'article L 1142-5 du code de la santé publique (Decree 2002-886 of May 3, 2002 on the Regional Commissions of Conciliation and Compensation of Medical Accidents, iatrogenic, and Nosocomial Infections in Code of Public Health Art. L. 1142-5), *J.O.*, May 7, 2002, p. 9025.

<sup>685</sup> CSP art. L. 1142-5.

<sup>686</sup> Helleringer, G., *Medical Malpractice and Compensation in France. Part II: Compensation based on National Solidarity* in Oliphant, K. and Wright, R. (eds.), *Medical Malpractice and Compensation in Global Perspective*, De Gruyter, 2013, p.174. This aspect is explained by the fact that victims go to court only in cases where the practitioner's misconduct is obvious.

30. Unfortunately, despite the effort of reformers in 2002 to iron out discrepancies, differences remain between the civil and administrative jurisdiction.<sup>687</sup> This raises the question of why medical accident redress was not placed under a single jurisdiction.<sup>688</sup>

## **6. No-fault compensation in England**

### **6.1. Background**

31. At present, compensation for medical injuries can be sought through tort litigation with pay-outs made throughout of court settlements or through the courts.<sup>689</sup> In the 1970s, the English government acknowledged the shortcomings of their clinical negligence litigation system though its replacement by a no-fault scheme has been rejected ever since. To date, the NHS Redress Act 2006, adopting a compensation scheme without recourse to civil proceedings, has not been issued yet. Nonetheless, so-called pre-action protocols have been introduced to resolve clinical disputes without resort to legal action.<sup>690</sup>

### **6.2. No-fault compensation system**

32. In response to shortcomings of their clinical negligence litigation system, the Department of Health initiated a review of the system of handling claims for compensation and complaints, which resulted in a report by the Chief Medical Officer

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<sup>687</sup> Pierre, P., *La responsabilité Médicale à L'aune de la Loi Kouchner. Esquisse d'un Bilan D'étape* (Medical Responsibility in the Light of the Kouchner Law. Outline of a Progress Report), *Revue Lamy Droit Civil*, 2007, supplément 35, p. 22.

<sup>688</sup> Taylor, S., *Medical Accident Liability and Redress in English and French Law*, 2015, Cambridge University Press.

<https://www.cambridge.org/core/books/medical-accident-liability-and-redress-in-english-and-french-law/problems-posed-by-the-french-administrative-compensation-scheme/CB074291F66AE20FAB5BC3C6EE1E6248/core-reader>

<sup>689</sup> Dickson, K., Hinds, K., Chett, H., Brunton, G., Stansfield, G., and Thomas, J., *No-fault Compensation Schemes: A Rapid Realist Review to Develop a Context, Mechanism, Outcomes Framework*, The Department of Health Reviews Facility, 2016, p.16.

<https://eppi.ioe.ac.uk/CMS/Portals/0/PDF%20reviews%20and%20summaries/No%20Fault%20Comp%20Schemes%202016%20Dickson.pdf>

<sup>690</sup> Kessler, D., McClellan, M., *Do Doctors Practice Defensive Medicine?*, *The Quarterly Journal of Economics*, 1996, p. 353-390.

in 2003.<sup>691</sup> While rejecting a wide-ranging no-fault scheme for all types of injuries, primarily on the grounds of costs and the practicalities in framing it,<sup>692</sup> the Chief Medical Officer in his report, *Making Amends*, proposed that “a composite package of reform”<sup>693</sup> would apply to England only, and which involved a new system of providing redress for patients harmed “as a result of serious standard NHS hospital care” (The NHS Redress Scheme”).<sup>694</sup>

33. There would be four main elements to these arrangements: (1) an investigation of the incident that is alleged to have caused harm and the resulting harm; (2) provision of an explanation to the patient of what happened and why, and of the action proposed to prevent repetition; (3) the development and delivery of a package of care, providing remedial treatment, therapy, or continuing care where necessary; and (4) payments for pain and suffering, out of pocket expenses, and the cost of care treatment, which the NHS could not provide.<sup>695</sup>
34. The NHS Redress Scheme would also encompass a care and compensation package for seriously neurologically impaired babies, including those with cerebral palsy, where the impairment was related to or resulted from the birth. The overall goal of these proposed reforms was that they would be “fair both to individual patients and meet their needs as well as make care safer for all NHS patients. This has been subject to criticism because it has been pointed out that it is far from obvious that the litigation system needs to be changed “in order to make healthcare safer.”<sup>696</sup>

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<sup>691</sup> Department of Health, *Making Amends: A Consultation Paper Setting out Proposals for Reforming the Approach to Clinical Negligence in the NHS (June 2003)*, Chapter 15, p.113, para 15.

<sup>692</sup> *Ibid.*, p.113, para 15.

<sup>693</sup> *Ibid.*, p.113.

<sup>694</sup> Goldberg, R., *Medical Malpractice and Compensation in the UK*, Chicago-Kent Law Review, Vol. 87, 2011, p. 133.

<sup>695</sup> Department of Health, *Making Amends: A Consultation Paper Setting out Proposals for Reforming the Approach to Clinical Negligence in the NHS*, June 2003, Chapter 15, p.119.

<sup>696</sup> Goldberg, R., *Medical Malpractice and Compensation in the UK*, Chicago-Kent Law Review, Vol. 87, 2011, p. 134.

35. The NHS Redress Scheme will apply where a “qualifying liability in tort” arises in connection with the provisions, as part of the health service in England, of qualifying services by the Secretary of State, a Primary Care Trust, a designated Strategic Health Authority, and a body or other person providing services whose provision is the subject of arrangement with the Secretary of State, a Primary Care Trust or designated Strategic Health authority. A “qualifying liability in tort” is defined as a liability in tort owed:

*(1) in respect or consequence upon personal or loss arising out of or in connection with a breach of a duty of care owed to any person in connection with the diagnosis of illness or the care of treatment of any person, and*

*(2) in consequence of any act or omission by a healthcare professional.”<sup>697</sup>*

36. It is clear therefore that liability under the scheme is fault-based and is not a no-fault compensation.<sup>698</sup>

37. The NHS Redress Scheme does not apply to liability which has been the subject of civil proceedings.<sup>699</sup> It applies to services provided in a hospital, but the Secretary can extend the scheme by regulations.<sup>700</sup> However, the Scheme is inapplicable to primary dental service, primary medical service, general ophthalmic services, and pharmaceutical services.<sup>701</sup> While the claimant’s right to bring civil proceedings is not removed, civil proceedings and the NHS Redress Scheme will be mutually exclusive.<sup>702</sup>

38. Since the Regulations are yet to be issued, it is yet to be observed how the Act will operate in practice. It has been said that since it is intended that the scheme is overseen

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<sup>697</sup> NHS Redr/ess Act 2006, s.1 (4).

<sup>698</sup> M. Jones, *Medical negligence*, Sweet & Maxwell, 2008, p.57.

<sup>699</sup> NHS Redress Act 2006, s.2 (2).

<sup>700</sup> NHS Redress Act 2006, s.1 (5).

<sup>701</sup> NHS Redress Act 2006, s.1 (6).

<sup>702</sup>Goldberg, R., *Medical Malpractice and Compensation in the UK*, Chicago-Kent Law Review, Vol. 87, 2011, p. 9.

by the National Health Service Litigation Authority (NHSLA),<sup>703</sup> there may be a potential conflict of interest on the NHSLA of being a judge and jury in its own cause.<sup>704</sup> The proposed scheme has been further criticised on several grounds. It has been submitted that while it is likely to provide nominally greater access to justice for low value claims, it is generally unlikely to result in greater access to justice for injured patients, especially given its fault-based eligibility criteria. It lacks sufficient independence from the NHS regarding investigation procedures, and it fails to provide for the accountability of healthcare professionals.<sup>705</sup> To date, the Redress Scheme has not been fully implemented in England.<sup>706</sup>

39. In line with the government's expectation to establish no-fault compensation, this idea was also rejected as a reform option. Basically, four reasons were offered:

1. *A proper no-fault system would be significantly more expensive than the current approach;*
2. *Payment to patients would have to be substantially lower than at present to keep the cost within manageable boundaries;*
3. *Problems in differentiating between harm caused by the sub-standard care and that occasioned by the natural progression of disease would be considerable;*
4. *Such a scheme does not address broader systemic problems.*<sup>707</sup>

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<sup>703</sup> NHS Redress Act 2006, s.11 (1).

<sup>704</sup> Mason, J. and Laurie, G., *Mason and McColl Smith's Law and Medical Ethics*, OUP, Eighth Ed, 2010, p.128.

<sup>705</sup> Goldberg, R., *Medical Malpractice and Compensation in the UK*, Chicago-Kent Law Review, Vol. 87, 2011, p. 10.

<sup>706</sup> Farrell, A-M., Devaney, S. and Dar, A., *No-fault Compensation Schemes for Medical Injury: A Review*, Scottish Government Social Research, 2010, p.65.

<sup>707</sup> Mason & McCall Smith, *Law & Medical Ethics*, Oxford, 2016, p.131.

## 7. No-fault compensation in Vietnam

### 7.1. *Background*

40. One side, both the Civil Code and the Law on Medical Examination and Treatment (LMET) that the victims should not seek compensation without fault. In another side, the Civil Code admits no-fault compensation in the case of tort. Besides, the LMET also slightly mentions no-fault compensation. Also, there is an additional regulation allowing the victim to seek compensation without fault happens only in vaccination's incidents.

### 7.2. *No-fault system*

41. The no-fault system in Vietnam is strictly applied, mostly in a defective product. To win the claim, the claimant has to prove fault under the Civil Code. However, the Civil Code admits that the defendant has to pay a part of compensation in case of no-fault or compensation goes beyond to the defendant's financial ability. This recognition of Vietnam brings the difference to other countries. Evidently, the Civil Code states that "The person is liable for damage may be entitled to a reduction of the compensation if there is no fault or unintentional fault and the compensation is excessive about his or her economic ability."<sup>708</sup> This rule only appears in the tort liability. Thus, the remaining cases need to prove fault or set an agreement in the contract.
42. Under Vietnamese law, in the health sector, a physician can be exempted from the liability as the following rule. It says "*A practitioner may not take responsibility when a professional council determines that s/she was at the lack of technical means and was not specialised in examination and treatment that case.*"<sup>709</sup> According to this regulation, a patient cannot claim for damages if the incidents fall into the situation described in this article. For other incidents out of the regulation, the patient cannot seek compensation without fault. In this case, the only sources of compensation without fault are from the insurers (if the individuals or agents have been insured) or the pockets of health care practitioners under Article 76 of the LMET. Vietnam does not have Fund of the State for all kinds of no-fault compensation as Belgium and France. Currently,

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<sup>708</sup> Article 585.2 - Civil Code.

<sup>709</sup> Article 73.2.b - Determination of practitioners with or without professional and technical mistakes - the Law on Medical Examination and Treatment – No. 40/2009/QH12.

Vietnam has organised to pay for only the victim of vaccination's incidents without proving fault.

43. However, in practice, most hospitals (private and public) have their fund which is used to compensate the victims.<sup>710</sup> The hospitals' income saves this kind of fund but not from the Government. The author would like to emphasise that the amount of payment, in this case, is definitely different from the tort compensation. Tort aims to place the victim in the same condition as before the incident while the purpose of this fund is to partially "support and comfort" the victim without fully restoring them to the original condition. It is worth noting that the amount paid to support and comfort is always less than the required compensation amount. This work has not been guided by the state and has existed for years in Vietnam. Admittedly, this approach, although it is not a perfect way to protect the victims in the case of no-fault, can temporarily cover for some losses when waiting for a better solution.
44. In the author's point of view, no-fault registration under the LMET is a "polite" way to admit "fault." "Fault" here refers to a lack of equipment, facilities, practitioners, and professional regulations. In fact, these faults cannot occur in these cases because negligence causes the damage.<sup>711</sup> In other words, that is the shortcoming that should be admitted to by the State and medical agents.
45. Exceptionally, to face the crisis of vaccine-related incidents,<sup>712</sup> the Vietnamese Government enacted the Decree on Regulations on Vaccine Activity. According to the

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<sup>710</sup> The Court sentenced that the Hospital must pay compensation and relevant expenditures for the whole life for the patient after the staff caused malpractice (the doctors did a negligence in the kidney treatment and cut one of the victim's kidney);

<http://tuoitre.vn/tin/phap-luat/20170629/cat-nham-than-benh-vien-boi-thuong-suot-doi-cho-benh-nhan/1340662.html>

*Postoperative Complications Cause Blindness to the Patient,*

<http://laodong.com.vn/tu-van-phap-luat/luat-su-noi-gi-ve-vu-doi-benh-vien-y-duoc-boi-thuong-236-ti-dong-623809.bld>

<sup>711</sup> Article 73.2.b - Law on Medical Examination and Treatment – No. 40/2009/QH12.

<sup>712</sup> 16 Children Died from Vaccination in 2015 (5 cases of TB vaccine, 8 cases of Quinvaxem 8, 3 cases of hepatitis B);

Decree, if severe complications occur and they severely affect health or cause damage to the lives of the people vaccinated,<sup>713</sup> the State is responsible for the compensation of the victims. The State compensation occurs when the vaccination leads to disability or death. Regarding “serious complications,” the Government has not had any extra explanation or standard to guide it.

46. It should be remembered that compensation is only made when the patient uses the suffer damage from the “the national vaccination program, vaccination against the epidemic seriously affect the health and life of the people vaccinated.”<sup>714</sup> Therefore, in all remaining cases, to be compensated, the patient must prove the fault of the person causing the damage.

47. The Decree also indicates the damage, scope, and level of compensation as follows:

1. *The damage caused by the sequelae resulting in the disability shall be compensated for 30 months<sup>715</sup> of base salary and the expenses;*
2. *Damage to life is supported as follows:*
  - a. *Expenses specified before death;*
  - b. *The funeral expenses shall be equal to 10 months of base salary prescribed by the State; (equal to 1000 Euro - 1500 Euro<sup>716</sup>)*
  - c. *Expenses for making up for mental suffering of VND 100,000,000 (equal to 4000 euro) for relatives of the affected/harmed persons;*
  - d. *Expenses due to lost or reduced incomes.<sup>717</sup>*

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<http://www.baogiaothong.vn/16-tre-em-tu-vong-do-tiem-vac-xin-nam-2015-d134347.html>

<sup>713</sup> Article 3.4 - Decree on Regulations on Vaccine Activity – No. 104/2016/NĐ-CP.

<sup>714</sup> Article 15 - Decree on Regulations on Vaccine Activity – No. 104/2016/NĐ-CP.

<sup>715</sup> Every month is equal 100 Euro - Decree on Basic Salary for the Regions in 2017 – No. 153/2016/ND-CP.

<sup>716</sup> Decree on Basic Salary for the Regions in 2017 - No. 153/2016/ND-CP.

<sup>717</sup> Article 16 - Decree on Regulations on Vaccine Activity - No. 104/2016/NĐ-CP.

48. The compensation is calculated to fit. It is quite contrary to the regulation in compensation of the Civil Code. It says that "how much a patient suffers from damage, how much compensation is made." The spirit of Vietnamese law regarding no-fault compensation differs from Belgium, France, and England. If the three countries apply this system to restore the patient's condition before suffering damage, Vietnam only aims to recover some of the damage partly.
49. The victim or relatives who think that they are eligible for state compensation must prepare and submit a dossier to the Department of Health Records.<sup>718</sup> Understandably, compensation under this Regulation appears to be a unilateral imposition of power on the part of the State. Victims are not dealt with as well as not protected by any specialised organisation when they suffer damage. In cases where the compensation is not satisfactory, the victim also has no right to make a complaint when this Regulation does not contain the provisions relating to the complainant's rights. The regional Department of Health will be liable for compensation without enforcement. There is no intermediary agency for a fair and objective assessment of damage for victims. Moreover, while the three countries, Belgium, France, and England have courts as an alternative way to support the victims if they are not satisfied with the compensation, Vietnam's courts are isolated from these cases. Patients cannot find other support, regardless of the decision made by the regional Department of Health.
50. Indemnity for damage in without fault is very limited in Vietnam. There are separate terms in Civil Code and LMET. Notably, the no-fault system is regulated to compensate only the incidents of "the national vaccination program, vaccination against the epidemic seriously affect people's health and life.

## **8. Conclusion**

51. As mentioned, a no-fault compensation system has been viewed as having the potential to overcome problems inherent in the tort system by providing fair, speedy, and adequate compensation to victims of MM. Several countries have adopted it or are on the way to

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<sup>718</sup> Article 17 - Article 16 - Decree on Regulations on Vaccine Activity - No. 104/2016/NĐ-CP.

adapt with an aim to achieve its benefits. However, they have not completed the no-fault system.

52. In Belgium, despite some inconsistencies, the implementation of the Law of 31<sup>st</sup> March 2010 undoubtedly has improved the situation of victims of health care damage.<sup>719</sup> The patients would enjoy the benefits brought by the no-fault system. The patients do not only need to prove fault but can also avoid a lengthy and expensive procedure. In addition, the physicians can avoid losing reputation and conflict between them and their patients, etc.<sup>720</sup>
53. Since the Law of 4th March 2002 was adopted in France, the model has reasserted its belief in the utility of fault as a tool for improving the quality of care and protecting the interests of private insurance companies. Under this Law, within out-court dispute settlement mechanism, victims obtain an initial decision faster than by going through the courts. While the overall number of favourable compensation decisions varies very little, there are differences in the manner of defining boundaries between the admissibility and non-admissibility of applications (depending on where plaintiffs' make their applications, they will not have the same access to free medical expertise) and differences between fault and no-fault compensation schemes. These differences in practice might be the magistrates have different attitudes towards the mechanism.<sup>721</sup>
54. No-fault compensation has been debated for decades but has never got off the ground in England. The NHS Redress Act 2006 was an attempt to set up a framework for a fast and low-cost administrative scheme to the tort system. The plan was that the health service would carry out the investigation and, if the NHS body was deemed to be at fault, make an offer of amends to the patient, who would receive independent free legal

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<sup>719</sup> Muylaert, K., *The Law on the Compensation of Damage Due to Health Care*, Belgian Review of Personal Injury and Forensic Pathology, 2010, p. 93.

<sup>720</sup> Vansweevelt, T., *A No-fault System for Medical Accidents in Belgium*;  
[www.ophtalmologia.be/downloads/BOG/4.Vansweevelt.pdf](http://www.ophtalmologia.be/downloads/BOG/4.Vansweevelt.pdf)

<sup>721</sup> Barbot, J., Parizot, I., and Winance, M., *No-fault Compensation for Victims of Medical Injuries: Ten Years of Implementing the French Model*, Elsevier Ireland Ltd, 2013, p.244.

advice before deciding whether to accept the offer or not. However, the act has not been brought into force in England, and there are no active plans to implement it.<sup>722</sup>

55. Currently, different from Belgium and France, Vietnam applies for no-fault compensation in a restricted way (for vaccine incidents only). Moreover, Vietnam has not yet proposed any project for this system as the way England has done. Perhaps, there are few rules in some legal documents to temporarily prevent a crisis of medical incidents. Vietnam has tried to provide the necessary benefits for patients. However, evidently, these current regulations have maintained unreasonable gaps and small rules.
56. Although the four systems of Belgium, France, England, and Vietnam seek to improve upon the injury resolution of tort liability by replacing a no-fault alternative, in whole or in part, they also need to bridge the existing gaps beside having illogical regulations purged as presented above.

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<sup>722</sup> Dyer, C., *Fault Lines: Resolving Clinical Negligence Claims*, BMJ Publishing Group Ltd, 2013, p.13-14.

# CHAPTER 6: STATUS OF PATIENTS' RIGHTS PROTECTION IN SOME PROVINCES OF MEKONG DELTA UNDER VIETNAMESE LAW

## 1. Introduction

1. In the past decade, a violation of patients' rights in Vietnam has come to the attention of the society.<sup>723</sup> The violation of patients' rights leads to severe physical and mental consequences/anguish.
2. The problem seems more pronounced in the Mekong Delta (Vietnam) compared to the rest of the country because of its particularities, such as lower economic growth, educational development, health investigation from the State, patients' limited awareness of their rights, and poor law enforcement. In particular, the patient's limited knowledge about their rights, limited enforcement of patients' rights regulations, and weak laws and regulations have restricted patients from enjoying their rights.
3. So far, there has not been any comprehensive research on the status of protection of patients' rights in Mekong Delta to point out the factors that lead to the violation of patients' rights and to look out for suitable solutions.

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<sup>723</sup> *The Patient's Right to Confidentiality was Infringed;*

<http://suckhoedoisong.vn/quyen-duoc-giu-bi-mat-cua-benh-nhan-n15076.html>

*The Doctor Refused to Give Emergency Care to the Patient;*

<http://baodatviet.vn/chinh-tri-xa-hoi/tin-tuc-thoi-su/thong-tin-moi-vu-bac-sy-tu-choi-cap-cuu-benh-nhan-3309680/>

4. Hence, it is necessary to research the protection of patients' rights in the selected provinces. These include Can Tho, Vinh Long, Soc Trang, and Kien Giang. These provinces have similar characteristics regarding the level of economic growth, culture, education, health, and especially health care development which can represent Mekong Delta.
5. From this survey, a thousand patients residing in Can Tho, Vinh Long, Soc Trang, and Kien Giang were randomly selected and orally interviewed at public and private hospitals. Two hundred and fifty respondents were selected per province. These one thousand patients directly answered the questions which were designed in the questionnaires. Suitably, one thousand questionnaires were collected back.
6. Currently, the LMET is being implemented, protecting patients' rights. Also, common civil rights under the Civil Code are applied where the LMET does not apply. In this research, the author emphasises on patients' rights under the LMET. The author derived some patients' rights that have not been regulated by the LMET from European Charter of Patients' Rights. The purpose is to indicate the importance of adding more legislation on patients' rights. In the survey, the author paid particular attention to patients who are insured under the SHI. Since there have been negative experiences<sup>724</sup> by patients covered by the SHI, there is, therefore, a need for fairness and equality in medical examination and treatment.

## **2. Characteristics of Mekong Delta**

7. Mekong Delta region covers the provinces of Long An, Tien Giang, Ben Tre, Vinh Long, Tra Vinh, Can Tho, SocTrang, Bac Lieu, Ca Mau, Kien

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<sup>724</sup>*The negative reflections were discussed in Chapter 5.*

Giang, An Giang, Dong Thap, and Hau Giang. Mekong Delta is located in the southern part of the country and southeast of the South China Sea. It borders Cambodia, the East Sea, and the west and it is adjacent to the Gulf of Thailand. The total area of the region is 39,763 square kilometers and its population by the end of 2015, was over 17 million people.<sup>725</sup> Mekong Delta is the largest food producer in the country and has more favourable conditions for the development of large-scale farming compared to the other parts of the country.<sup>726</sup>

8. The average income has reached 39 million VND (2000USD) per person annually, approximately the national average.<sup>727</sup> The educational level of the Mekong Delta is the lowest in the country. A recent survey showed that Mekong Delta severely lacks qualified human resources in the health sector. The situation is very dire that some of the provinces lack doctors.<sup>728</sup>

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<sup>725</sup>Ministry of Natural Resources and Environment, *Mekong Delta Forum 2015: Focusing on the Vision of Sustainable Livelihood Development*, 2015;

<http://dwrn.gov.vn/index.php?language=vi&nv=news&op=Hop-tac-quoc-te/Die-n-da-n-Do-ng-ba-ng-song-Cu-u-Long-2015-Ta-p-trung-tha-o-lua-n-ta-m-nhi-n-ve-pha-t-trie-n-sinh-ke-be-n-vu-ng-4020>

<sup>726</sup> Ngoc Thien, *Mekong Delta Strives to Export Goods to 15 Billion USD*, CAFEF. Accessed on January 16<sup>th</sup>, 2017.

<http://cafef.vn/dong-bang-song-cuu-long-phan-dau-xuat-khau-hang-hoa-dat-15-ty-usd-2017011520222965.chn>

<sup>727</sup>Anh Phuong, *In 2017, GDP growth is Estimated at 6.7%*, 2017;

<http://www.sggp.org.vn/nam-2017-tang-truong-gdp-uoc-dat-67-474952.html>

<sup>728</sup>*Shortage of medical resources in the Mekong Delta: There Should be Policies and Appropriate Measures*, Bao Moi, 2017,

<https://baomoi.com/truc-loi-trong-linh-vuc-y-te-nguyen-nhan-do-dau/c/22586815.epi>

### **3. Application of patients' rights regulations in Europe and Vietnam**

9. Before going to the research on the status of protection of patients' rights in the four provinces in Mekong Delta, it is necessary to have an overview of the patients' rights legislation in Europe and Vietnam. Identifying the differences between Vietnamese and European patients' rights legislation would help in establishing what needs to be done to protect Vietnamese patient's rights in the future. Being a part of Vietnam, Mekong Delta will also benefit.
10. Formalized in 1948, the Universal Declaration of Human Rights recognises "the inherent dignity" and the "equal and inalienable rights of all members of the human family." It is by this concept of the person, the fundamental dignity, and equality of all human beings, that the notion of patient rights was developed. In other words, what is owed to the patient as a human being, by physicians, and by the state shaped a great part and acknowledged this understanding of the fundamental rights of the patients?<sup>729</sup>
11. In Europe, the patients' rights are a reflection of human rights. The human rights movement has gathered importance in the world since 1945. The Universal Declaration of Human Rights was adopted on 10<sup>th</sup> December 1948. This was followed by the signing of the European Convention on Human Rights in 4<sup>th</sup> November 1950. Patients' rights became recognised as specific human rights throughout the European region. Of particular importance was the European Consultation on the

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<sup>729</sup> *Patients' Rights*;

<http://www.who.int/>

Rights of Patients that was held in Amsterdam on 28<sup>th</sup> - 30<sup>th</sup> March 1994 under the auspices of the WHO Regional Office for Europe (WHO-EURO). It was hosted by the Government of Netherlands, which was attended by 60 representatives from 36 Member States.<sup>730</sup>

12. Moreover, another significant event supporting patients' rights is the Human Rights Act of 1998. The Human Rights Act of 1998 (also known as the Act or the HRA) came into force in the United Kingdom in October 2000.<sup>731</sup> The HRA was passed to give "further effect" to the European Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") in domestic law.<sup>732</sup> The Act incorporates most of the Convention. The Act has already made a substantial impact on medical law and will have a continuing effect on health care practice.<sup>733</sup> In this Act, "the Convention on human rights" means the rights and fundamental freedoms set out in Articles 2 to 12 and 14 of the Convention.<sup>734</sup>

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<sup>730</sup> *Patients' Rights in Europe;*

<http://home.broadpark.no/>

<sup>731</sup> *The Human Rights Act;*

<http://www.equalityhumanrights.com/>

<sup>732</sup> *The Human Rights Act;*

<https://www.liberty-human-rights.org.uk/>

<sup>733</sup> Samanta, A., *The Human Rights Act 1998 - Why it should Matter for Medical Malpractice?*, Journal of The Royal Society of Medicine, Vol. 98, 2005, p.404.

<sup>734</sup> *Human Rights Act 1998;*

<http://www.guernseylegalresources.gg/article/95287/Human-Rights-Bailiwick-of-Guernsey-Law-2000>

13. The Articles of the Convention that have had a major impact on health care are Article 2 (Right to life), Article 3 (Prohibition on torture and inhuman, degrading treatment), Article 5 (Right to liberty and security), and Article 8 (Right to respect for private life and family life). None of these rights is absolute. However, Article 4 represents an absolute prohibition and cannot be interfered with by the State under any circumstance (s). Article 2 and 5 are subject to limited exceptions. Article 8 is a qualified obligation that requires a balance to be struck between the interests of the individual and the wider interests of society. Any limitation or constraint imposed by a public body must be justified as being “proportionate to the legitimate aim pursued.”<sup>735</sup> In most cases, these rights are qualified by a “margin of appreciation” which invites courts to engage in a proportionality test to determine whether there has been a breach of the provision in a particular case.<sup>736</sup>
  
14. So far, European countries have also started acknowledging patients’ rights by adopting the Declaration on the Promotion of Patients’ Rights endorsed by Amsterdam Consultation in 1994,<sup>737</sup> the Convention on

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<sup>735</sup> Samanta, A., *The Human Rights Act 1998 - Why it should Matter for Medical Malpractice?*, Journal of The Royal Society of Medicine, Vol. 98, 2005, p.404.

<sup>736</sup>Markesinis, B. and Deakin, S., *Tort Law*, Oxford University of Press, Seventh Ed, 2013, p.350.

<sup>737</sup> *World Health Organization*, 1994.

Human Rights and Biomedicine,<sup>738</sup> and the European Charter of Patients' Rights.<sup>739</sup>

15. Among them, the Charter of Fundamental Rights is the basis of the declaration of the fourteen concrete patients' rights currently at risk. These include the right to preventive measures, access, information, consent, free choice, privacy and confidentiality, respect of patients' time, observance of quality standards, safety, innovation, avoidance of unnecessary suffering and pain, personalised treatment, and the right to complain and to receive compensation.<sup>740</sup>
16. These rights are also linked to several international declarations and recommendations issued by both the WTO and the Council of Europe. They regard organisational standards, technical parameters as well as professional patterns and behaviour. This Charter can reinforce the degree of protection of patients/citizens' rights in different national contexts and can also be a tool for the harmonisation of national health systems that favour citizens' and patients' rights.<sup>741</sup>
17. The Charter of Fundamental Rights which will represent the first "brick" in the European constitution is the main reference point of the present

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<sup>738</sup> Council of Europe, European Treaty Series - No. 164;

<sup>739</sup>The European Charter of Patients' Rights was drafted in 2002 by Active Citizenship Network in collaboration with 12 citizens' organizations from different EU countries. The European Charter of Patients' Rights states 14 patients' rights that together aim to guarantee a "high level of human health protection" (Article 35 of the Charter of fundamental rights of the European Union) and to assure the high quality of services provided by the various national health services in Europe

<sup>740</sup> O'Mathúna, D., Scott, A., McAuley, A., Walsh-Daneshmandi, A., Brenda, D., *Care Rights and Responsibilities: A Review of the European Charter of Patients' Rights*, Irish Patients' Association, 2005, p.16.

<sup>741</sup> Active Citizen Network, *European Charter of Patients' Rights*, 2002, p.1;

Charter. It affirms a series of inalienable universal rights which EU organs and Member States cannot limit and individuals cannot waive. These rights transcend citizenship attaching to such a person. They exist even when national laws do not provide for their protection. The general articulation of these rights is enough to empower persons to claim that they are translated into concrete procedures and guarantees. According to Article 51, national laws will have to conform to the Charter. However, this shall not override national constitutions which will be applied when they guarantee a higher level of protection (Article 53). In conclusion, the particular rights outlined in the Charter are to be interpreted extensively so that an appeal to the related general principles may cover any gaps in the individual provisions. Article 35 of the Charter provides for a right to health protection as the “*right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.*” Article 35 specifies that the Union must guarantee “*a high level of protection of human health,*” meaning health for an individual and social good as well as health care. This formula sets a guiding standard for national governments does not stop at the floor of the “minimum guaranteed standards” but aim for the highest level notwithstanding differences in the capacity of the various systems to provide services.<sup>742</sup>

18. In addition to Article 35, the Charter of Fundamental Rights contains many provisions that refer either directly or indirectly to patients’ rights and are worth recalling: the inviolability of human dignity (article 1) and

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<http://www.activecitizenship.net/patients-rights/projects/29-european-charter-of-patients-rights.html>

<sup>742</sup>*European Charter of Patients’ Rights;*

[http://ec.europa.eu/health/ph\\_overview/co\\_operation/mobility/docs/health\\_services\\_co108\\_en.pdf](http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf)

the right to life (article 2); the right to the integrity of the person(article 3); the right to security (article 6); the right to the protection of personal data (article 8); the right to non-discrimination (article 21); the right to cultural, religious and linguistic diversity (article22); the rights of the child (article 24); the rights of the elderly (article 25); the right to fair and just working conditions (article 31); the right to social security and social assistance (article 34); the right to environmental protection (article 37); the right to consumer protection (article 38); the freedom of movement and of residence (article 45).<sup>743</sup>

19. Vietnam is a State party to several human rights instruments including the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Racial Discrimination; the Convention on the Elimination of all Forms of Discrimination against Women, the Convention on the Rights of the Child, and the Convention against Torture (CAT). Vietnam is a member of the UN Human Rights Council (2014-16). It has also undergone the UN's Universal Periodic Review (UPR) in 2009 and 2014 and has accepted over 270 recommendations from other countries, but the implementation is superficial which draws criticism.<sup>744</sup>
20. Regarding patients' rights, Vietnam has not yet implemented any international patients' rights law. Vietnam applies the domestic law (the

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<sup>743</sup> Cotturri, G., Inglese, S., Moro, G., Roffiaen. C. and Scattolon, C., *European Charter of Patients' Rights*, 2002, p.1-2;

[http://ec.europa.eu/health/ph\\_overview/co\\_operation/mobility/docs/health\\_services\\_co108\\_en.pdf](http://ec.europa.eu/health/ph_overview/co_operation/mobility/docs/health_services_co108_en.pdf).

<sup>744</sup> *Human Rights in Vietnam*, 2016;

<https://www.civilrightsdefenders.org/>

LMET) to regulate several issues in the medical sector. In this Law, seven patients' rights are described in Articles 7 to 13. They are:

*Article 7. Right to medical examination and treatment with quality suitable to actual conditions*

1. To be given counselling and explanations about their health status, treatment methods and medical examination, and treatment services suitable to their diseases;
2. To receive treatment with safe, appropriate, and effective methods according to professional and technical regulations.

*Article 8. Right to respect for privacy*

1. To have their health status and private information given in their case history dossiers kept confidentially;
2. The information referred to in Clause 1 of this Article may be disclosed only when so agreed by patients or for an exchange of information and experience between practitioners directly treating the patients to improve the quality of diagnosis, care, and treatment of patients or in other cases provided by law.

*Article 9. Right to respect for honour and protection of health in medical examination and treatment*

1. To be subject to no discrimination in medical examination and treatment or forced medical examination and treatment;
2. To be respected regarding age, gender, ethnicity, and belief;
3. To be subject to no discrimination based on their financial and social status.

*Article 10. Right to free choice in medical examination and treatment*

1. To fully receive information, explanations, and counselling about their health status, results, and possible risks to choose diagnosis and treatment methods;
2. To accept or refuse to participate in biopsy and medical research in medical examination and treatment;
3. To nominate representatives to perform and protect their rights and obligations in medical examination and treatment.

*Article 11. Right to obtain information on case history dossiers and medical examination and treatment expenses*

1. To receive brief information on their case history dossiers when so requested in writing unless otherwise provided by law.
2. To be provided with information on charges for medical examination and treatment services and detailed explanations about expenses indicated in invoices for medical examination and treatment services.

*Article 12. Right to the refusal of medical treatment and discharge from medical examination and treatment establishments*

1. To refuse to test, use of drugs, and application of treatment techniques or methods but to make a written commitment to personal responsibility for such refusal;
2. To leave medical examination and treatment establishments when treatment is not completed but to make written commitment to take personal responsibility for such leaving which is contrary to practitioners advice.

*Article 13. Rights of patients losing civil act capacity, or without civil act capacity or with restricted civil act capacity, or being juveniles aged between full six years and under full 18 years*

1. Lawful representatives of patients losing civil act capacity, or without civil act capacity or with restricted civil act capacity, or being juveniles aged between full six years and under full 18 years may decide on medical examination and treatment for the patients;
2. In cases of emergency, to protect the life and health of a patient, the head of a medical examination and treatment establishment may decide on medical examination and treatment for the patient when his/her lawful representative is absent.

In comparison to European Charter of Patients' Rights, there are some rights which are not admitted to the LMET. For example, the missing articles are:

*Article 1: Right to preventive measures*

Every individual has the right to a proper service to prevent illness. The health services have the duty to pursue this end by raising people's awareness, guaranteeing health procedures at regular intervals free of charge for various groups of the population at risk, and making the results of scientific research and technological innovation available to all.

*Article 5. Right to free choice of treatment procedures and providers*

Each has the right to freely choose from among different treatment procedures and providers with adequate information. The patient has the right to decide which diagnostic exams and therapies to

undergo, and which primary care doctor, specialist, or hospital to use. The health services have the duty to guarantee this right, providing patients with information on the various centres and doctors able to provide a particular treatment, and on the results of their activity. They must remove any obstacle limiting the exercise of this right. A patient who does not have trust in his or her doctor has the right to designate another one.

*Article 7. Right to respect for patients' time*

Each individual has the right to receive necessary treatment within a short and predetermined period.

This right applies to each phase of the treatment. The health services have the duty to fix waiting times within which specific services must be provided on the basis of specific standards and depending on the degree of urgency of the case. The health services must guarantee each access to services, ensuring immediate sign-up in the case of waiting lists.

Every individual who so requests have the right to consult the waiting lists within the bounds of respect for established privacy norms. Whenever the health services are unable to provide services within the predetermined maximum times, the possibility to seek alternative services of comparable quality must be guaranteed, and any costs borne by the patient must be reimbursed within a reasonable time. Doctors must devote adequate time to their patients, including the time dedicated to providing information.

*Article 8. Right to the observance of quality standards*

Each individual has the right of access to high-quality health services by the specification and observance of precise standards.

The right to quality health services requires that health care institutions and professionals provide satisfactory levels of technical performance, comfort, and human relations. This implies the specification and the observance of precise quality standards, fixed using a public and consultative procedure and periodically reviewed and assessed.

*Article 9. Right to safety*

Each individual has the right to be free from harm caused by the poor functioning of health services, medical malpractice and errors, and the right of access to health services and treatments that meet high safety standards.

To guarantee this right, hospitals and health services must continuously monitor risk factors and ensure that electronic medical devices are properly maintained, and operators are properly trained. All health professionals must be fully responsible for the safety of all phases and elements of medical treatment. Medical doctors must be able to prevent the risk of errors by monitoring precedents and receiving continuous training.

Healthcare staff that reports existing risks to their superiors and/or peers must be protected from possible adverse consequences.

*Article 10. Right to innovation*

Each individual has the right of access to innovative procedures, including diagnostic procedures, according to international

standards and independently of economic or financial considerations. The health services have the duty to promote and sustain research in the biomedical field, paying particular attention to rare diseases. Research results must be adequately disseminated.

*Article 11. Right to avoid unnecessary suffering and pain*

Each individual has the right to avoid as much suffering and pain as possible in each phase of his or her illness.

The health services must commit themselves to taking all measures used to this end, such as providing palliative treatments and simplifying patients' access to them.

*Article 12. Right to personalised treatment*

Each individual has the right to diagnostic or therapeutic programs tailored as much as possible to his or her personal needs.

The health services must guarantee, to this end, flexible programs, oriented as much as possible to the individual, making sure that the criterion of economic sustainability does not prevail over the right to health care

21. Apparently, as mentioned above, several basic and essential rules of patients' rights are not paid attention and implemented in Vietnam. Consequently, the lack of necessary and important regulations leads to patients' rights protection that is not fully implemented. Compared to Europe, lack of these regulations in Vietnam is a significant drawback in improving as well as protecting the rights of patients. Supplementing the missed articles should be studied and taken seriously.

#### 4. Data processing method

22. The collected data was entered and stored in Epidata 3.1 software. STATA 10 software was used to process the data. Descriptive statistics method was then used to analyse the characteristics of the researched objects. Normality of data was assessed using a Shapiro-Wilk test. Non-normal continuous data were transformed to normality using the Inskew0 command in Stata. Non-parametric tests were used for severe departure from standard distribution variables. All analyses were carried out with a significance level of 5 %, and all tests were two-sided.

#### 5. Status of protection of patients' rights protection in some provinces of Mekong Delta under the Vietnamese Law

##### 5.1. General characteristics of the investigated sample

**Table 1: General characteristics of the studied sample**

General information	Male		Female		Total	
	Gender n (%)	488	49.34	501	50.66	989
Age mean ±SD	487	40.33±13.79	500	38.69±13.82	993	39.51±13.81
<b>Ethnic group</b>						
Kinh	444	90.98	426	84.19	870	87.53
Hoa	9	1.84	7	1.38	16	1.61
Khmer	35	7.17	70	13.83	105	10.56
Other	0	0.00	3	0.59	3	0.30
<b>Religion</b>						
Buddhism	120	24.64	151	30.38	273	27.58
HoaHao Buddhism	15	3.08	24	4.83	39	3.94
Catholicism	43	8.83	61	12.27	104	10.51
Protestantism	4	0.82	4	0.80	8	0.81
Caodaism	5	1.03	2	0.40	7	0.71

None	242	49.69	242	48.69	487	49.19
Other	58	11.91	13	2.62	72	7.27
<b>Education level (%)</b>						
Illiteracy	30	6.16	18	3.64	49	4.96
Grade I	106	21.77	115	23.23	223	22.57
Grade II	144	29.57	152	30.71	299	30.26
Grade III	112	23.00	84	16.97	196	19.84
Intermediate level	32	6.57	43	8.69	75	7.59
College	42	8.62	53	10.71	95	9.62
University	8	1.64	9	1.82	17	1.72
Other	13	2.67	21	4.24	34	3.44
<b>Occupation</b>						
Farmer	215	44.15	130	26.26	348	35.22
Worker	81	16.63	44	8.89	125	12.65
Officer	58	11.91	57	11.52	115	11.64
Self-business	42	8.62	44	8.89	88	8.91
Homemaker	4	0.82	119	24.04	124	12.55
Unemployment	25	5.13	24	4.85	49	4.96
Other	62	12.73	77	15.56	139	14.07
<b>Residence</b>						
Urban region	339	70.92	336	68.99	681	70.13
Rural region	139	29.08	151	31.01	290	29.87

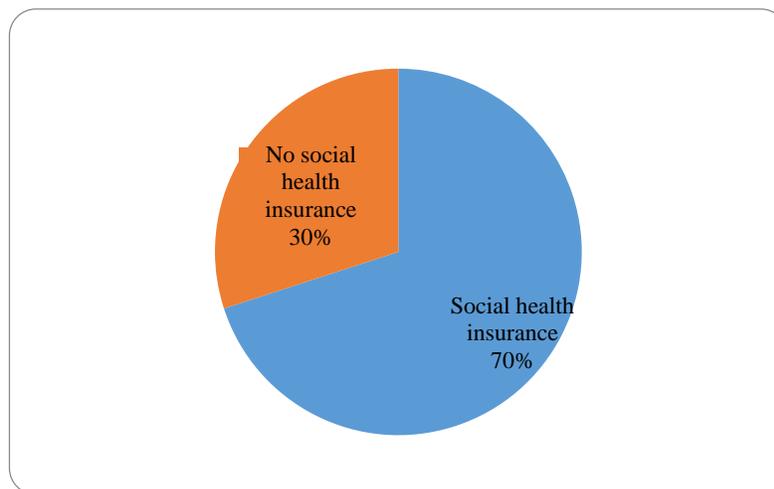
23. From Table 1, there was a general gender balance in the sample size. Males accounted for 49.34% of the sample while female participants accounted for 50.66%. The average age of the participants was  $39.51 \pm 13.81$ . Majority of the participants were the Kinh people, accounting for 87.53%, followed by Khmer ethnic group at 10.56% while the minority was Hoa (Chinese) ethnic group at 1.61%.
24. Those who reported their highest level of education as grade II were 30.26%, followed by grade I (22.57%), grade III (19.84%) and the ones who reported as being illiterate was 4.95%. Among them, there were

9.62% of patients with a college diploma and 1.72% with a bachelor's degree.

25. Most women and men in the survey were farmers (the rates of male and female farmers were 44.15% and 26.26% respectively). Female homemakers were 24.04% while very few men were homemakers in the sample.
26. Most participants in the survey were from the urban regions (70.13%) compared to those from the rural region (29.87%). The distribution of gender in the regional groups was even.

## 5.2. *The status of protection of patients' rights among the insured versus the uninsured patients*

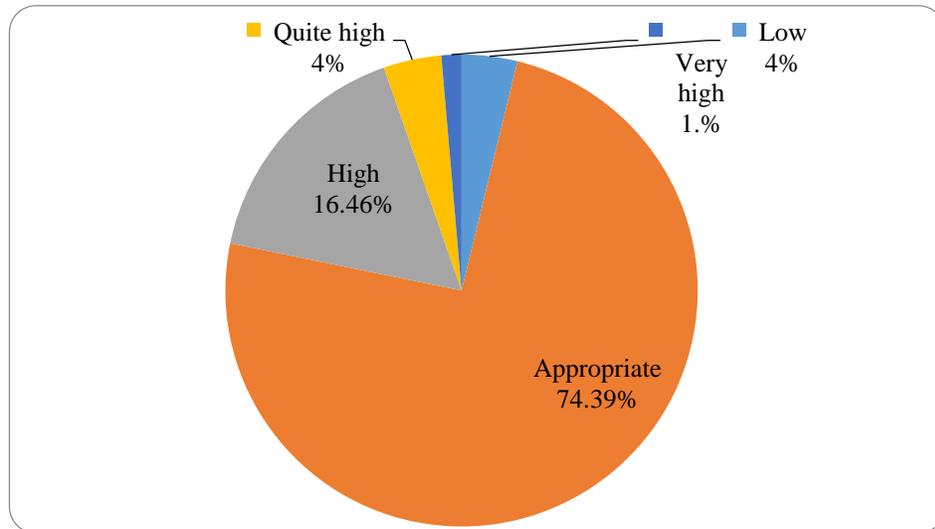
### 5.2.1. **Purchase of social health insurance**



***Figure 1: The percentage of insured versus uninsured patients.***

27. The percentage of the insured patients was more than double (70%) the uninsured ones (30%).

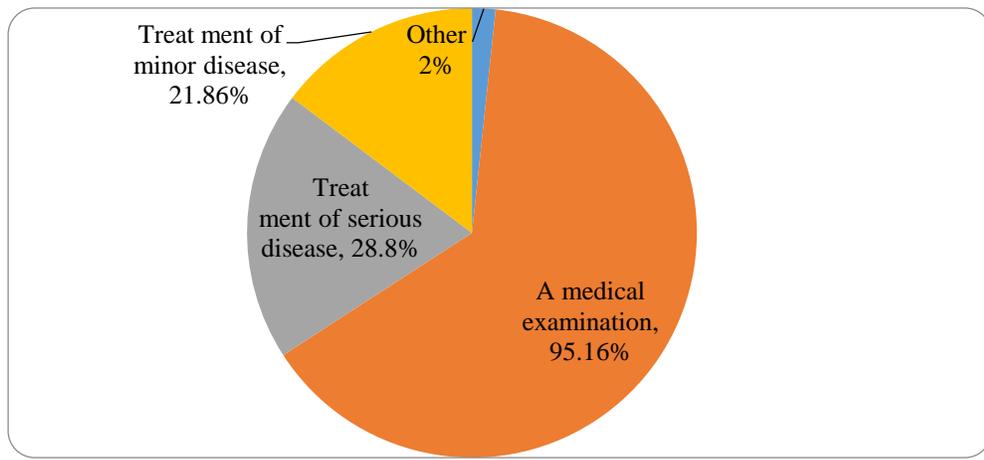
### 5.2.2. Opinions from the patients about insurance premium compared to their incomes



***Figure 2: Opinions from the participants about the insurance premium compared to their incomes***

28. Figure 2 showed the majority of the people (74.39%) with SHI thought that the insurance premium they paid was appropriate according to their income. However, the rate 16.46% of patients said that the premium was higher than their incomes. The percentage of people who said the insurance premium was quite high was the same as the percentage of those who said that it was low (4%). There was only 1% of the insured who said the insurance premium was high.

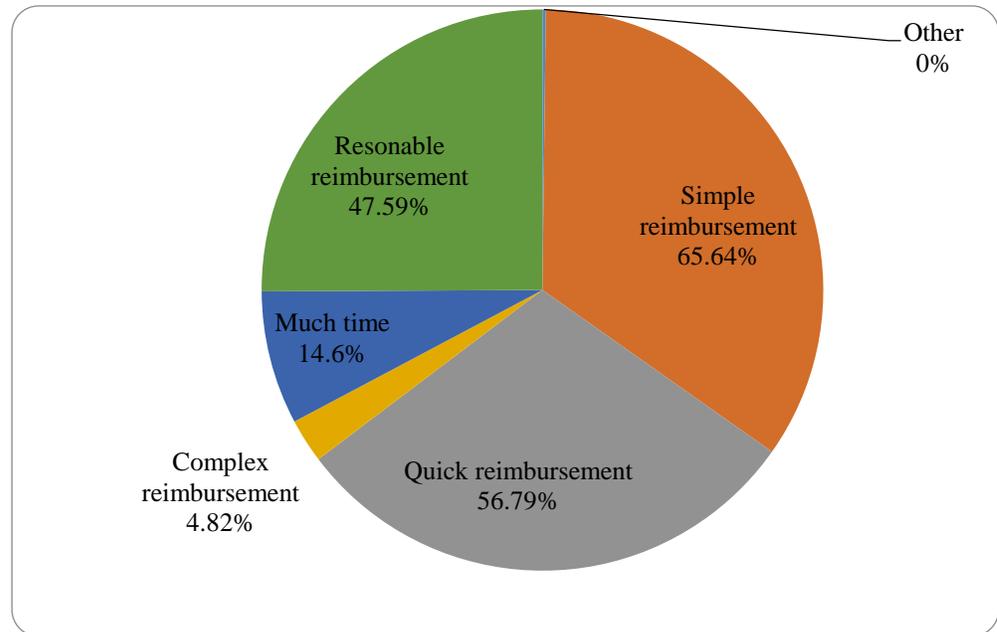
### 5.2.3. Reasons for purchasing social health insurance



**Figure 3: Reasons for purchasing medical social insurance**

29. Among the interviewed people who were insured, 95.16% of them reported that SHI was mostly used for medical examination, 21.8% for the treatment of minor illnesses, and 28.8% for the treatment of serious illnesses. A few individuals reported the use of SHI for purchasing medicine and claiming refunds after giving birth.

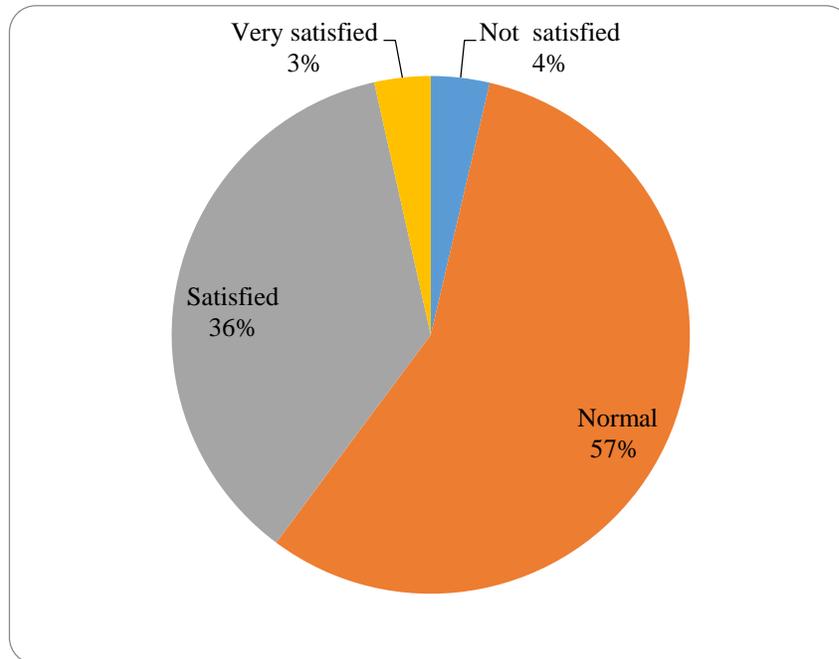
#### 5.2.4. Procedure for social health insurance reimbursement



*Figure 4: Procedure of social health insurance reimbursement*

30. The patients gave comments about the procedure for reimbursement with the following rates: simple (65.64%), quick (56.79%), and reasonable (47.59%). However, (14.6%) among them said that it took time to receive reimbursement while the others (4.82%) reported that the payment procedure was complicated.

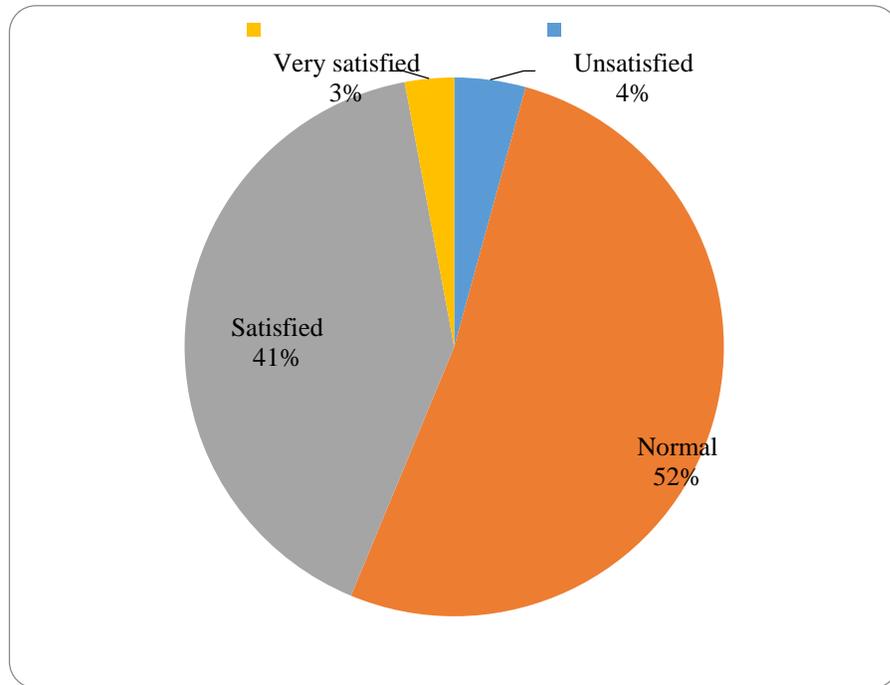
**5.2.5. Comments from the insured patients about the indicated medical examination and treatment agents**



***Figure 5: Comments from the insured patients about the indicated medical examination and treatment agents***

31. Concerning the use of indicated agents, 57% of the insured patients stated that they had no objection to using indicated medical examination and treatment agents. Yet, there were 36% of them who felt satisfied. While those who said that they were not satisfied and very satisfied were quite low (3% and 4% respectively).

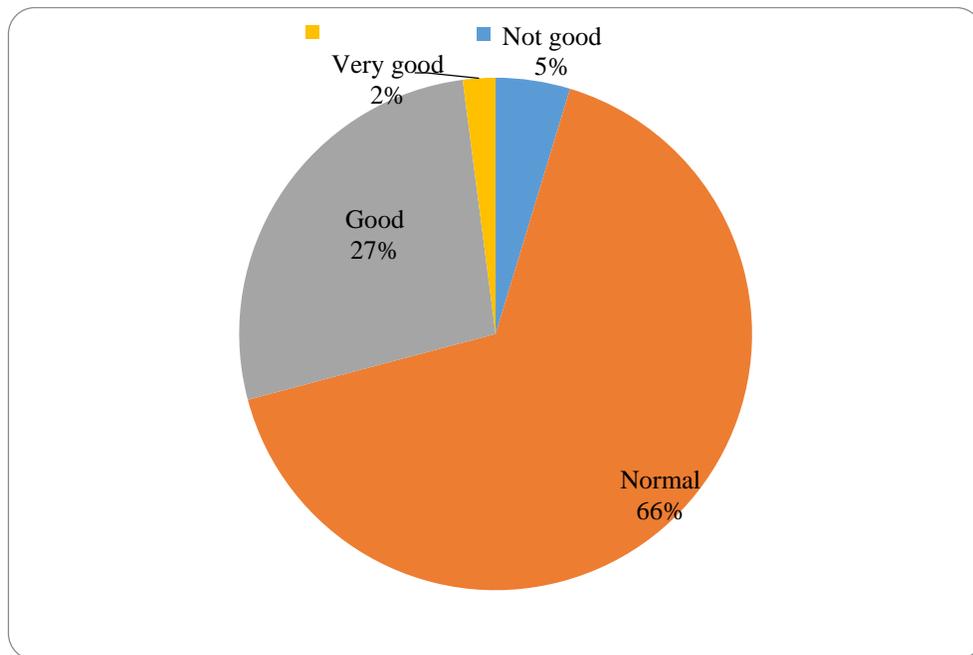
**5.2.6. Patients' comments about the health services covered by social health insurance**



***Figure 6: Patients' comments about the health services covered by social health insurance.***

32. Patients who rated the health services covered by SHI to be normal were 52%. Those who said that the services were satisfactory were 41% followed by those who were not be satisfied (4%) and very satisfied (3%).

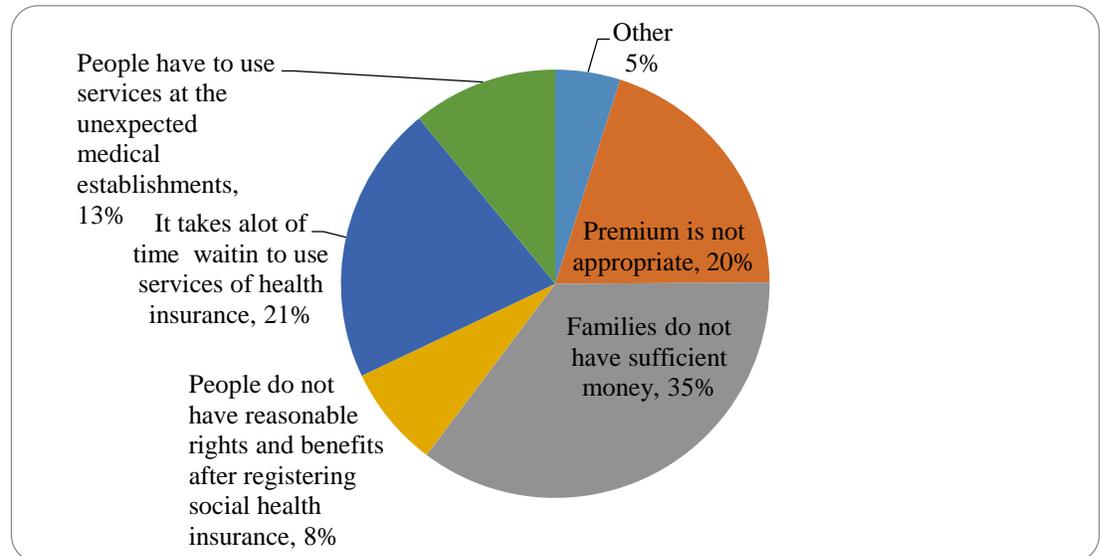
### 5.2.7. Medical practitioners' behaviour towards the health-insured



***Figure 7: Medical practitioners' behaviour towards the health-insured***

33. Most of the insured felt that they were typically treated 66% with those who believed they were treated well accounted for 27%. There were a few participants who felt that the treatment was perfect (2%) and those who felt that the treatment was not properly accounting for 5%.

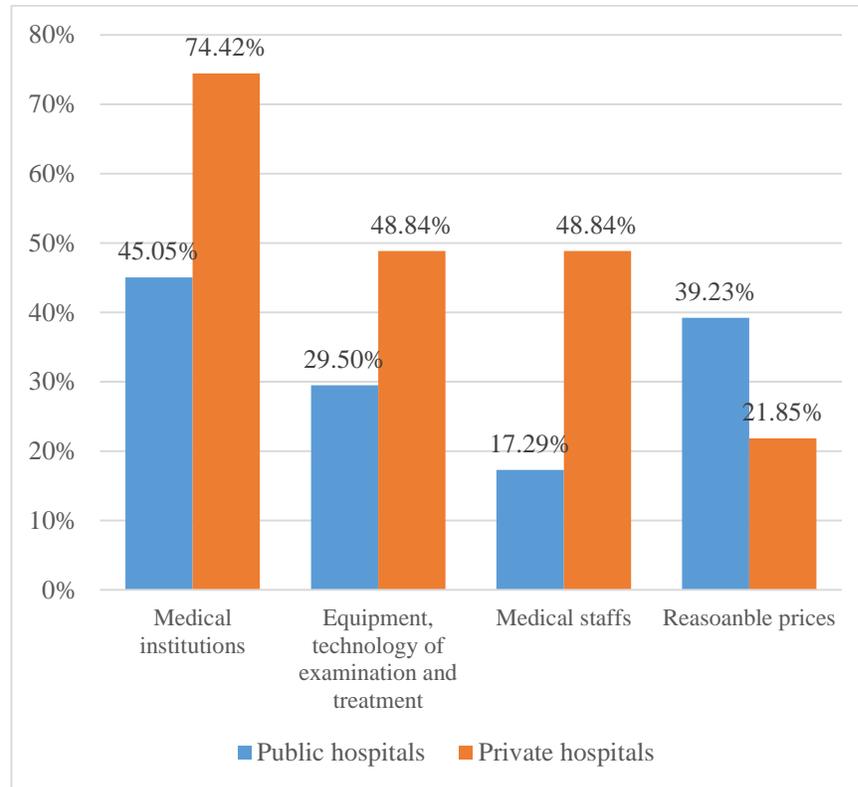
**5.2.8. Reasons for patients failing to purchase social health insurance**



**Figure 8: Reasons why the participants fail to purchase social health insurance.**

34. When asked for the reasons for failure to buy SHI, the participants said that their families did not have sufficient income (35%), the premiums were inappropriate (20%), and it took time waiting to use health insurance services (21%). Other reasons included using the services at the unexpected medical examination and treatment establishments (13%) and that people lacked reasonable rights and benefits when they enrol for health insurance (8%).
35. Other participants reported that they failed to register because they found insurance unnecessary in their lives, they did not meet the conditions for purchasing insurance (for example, could not show their permanent residence), their employers failed to offer them insurance, and they did not like going to public hospitals.

**5.2.9. The uninsured participants' reasons for the choices of medical examination and treatment agents**



***Figure 9: Uninsured participants' reasons for the choice of medical examination and treatment agents***

36. The majority of participants without SHI who would choose public health services was 45.05% less than those who would opt for private ones (74.42%). The uninsured people who sought health services in public hospitals because of proper equipment and technology was 29.50% who were less than those who sought treatment in private hospitals at 48.84%. However, 48.8% of the uninsured patients preferred having medical examination and treatment in private hospitals because of their qualified staff which was significantly higher than in public hospitals (17.29%). Public hospitals offered a reasonable price for

services and hence attracted more uninsured people (39.23%) while private hospitals attracted 21.85% of uninsured patients.

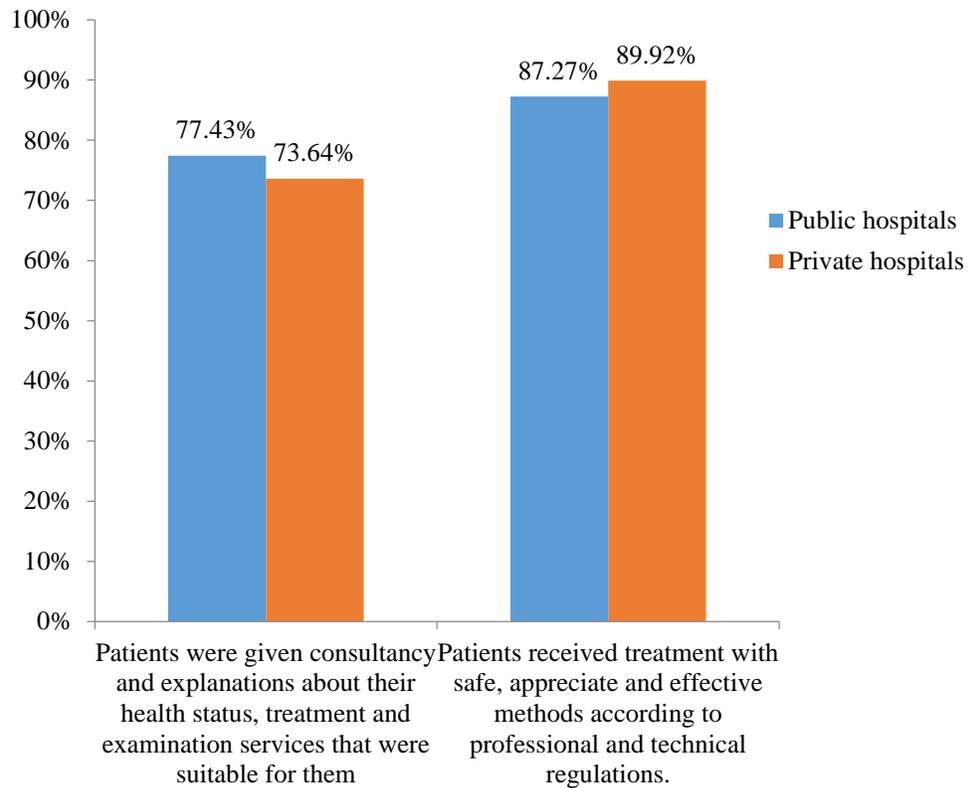
37. Amazingly, no one thought that the decision to choose public or private medical services depended on the prompt and the convenient services.

### ***5.3. The status of protection of patients' rights under regulations and in practice***

#### ***5.3.1. The trend of access to health services***

38. One thousand patients (regardless of having or not having SHI) who were interviewed said they all used both public and private hospitals depending on their health situations. However, when they were told to indicate one of the systems that they frequently used in the last six months, the rates were equal between the public hospitals and private hospitals (52.2% vs. 47.8%).
39. The interviewed patients had to indicate the public or the private healthcare facility they attended. The following questions were asked based on the chosen system.

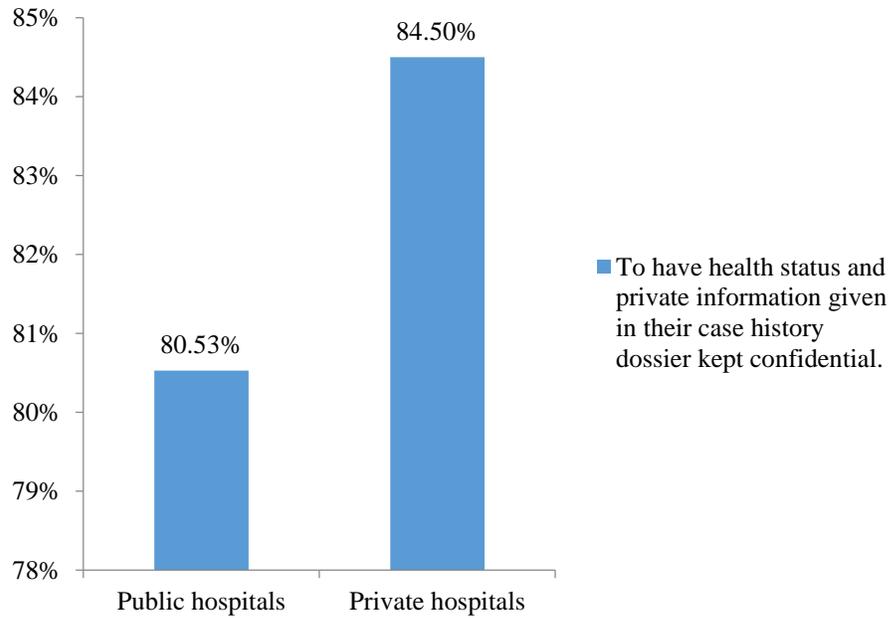
**5.3.2. Respect for the right to medical examination and treatment which comply with the patients' conditions**



**Figure 10: Respect for the right to medical examination and treatment which comply with the patients' conditions**

40. The survey showed that the satisfaction level for consultancy and explanations about their health status, treatment, and examination services were not much different in both public and private hospitals, (73.43% and 73.64% respectively).
41. It was realised that majority of patients in public hospitals (87.27%) and private hospitals (89.92%) were treated with safe, appropriate and effective methods according to professional and technical regulations.

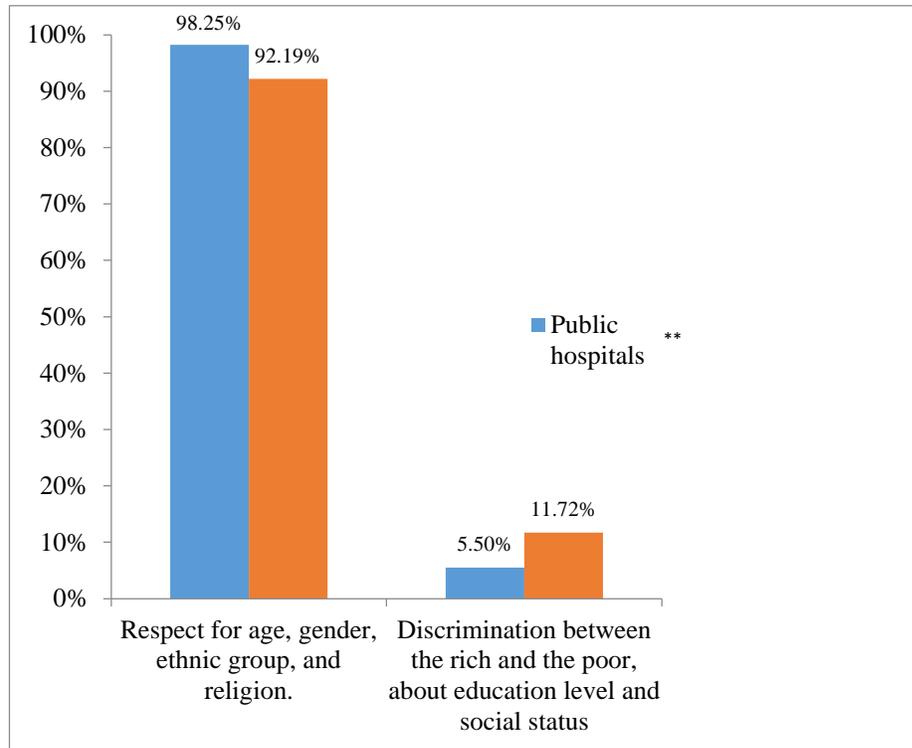
### 5.3.3. Respect for the right to privacy



***Figure 11: Respect for the right to privacy***

42. The participants who admitted that their right to privacy was respected in public hospitals were 80.53% compared to 84.50% in private hospitals.

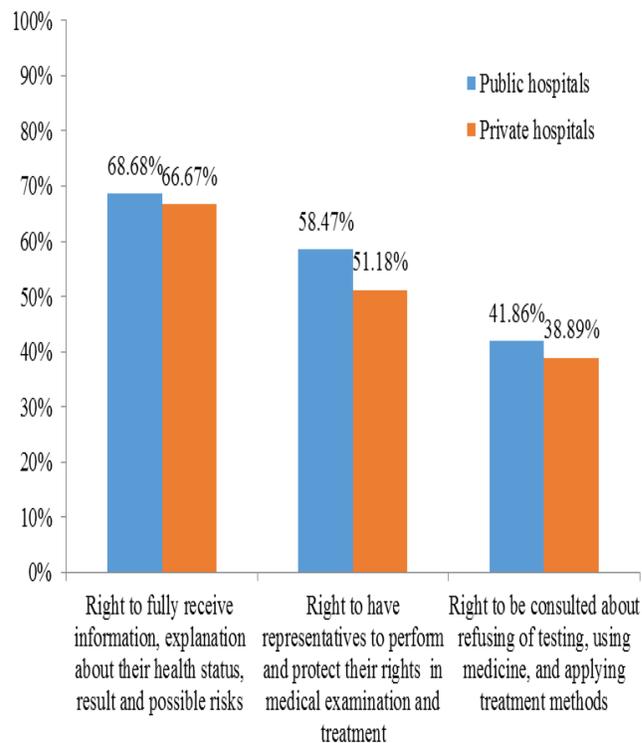
### 5.3.4. Right to being respected regardless of age, gender, educational level, social status.



**Figure 12. Right to being respected regardless of age, gender, educational, social status**

43. The figure shows that people were more respected regardless of their age, gender, ethnic group and religion in private hospitals than in public hospitals (98.25% vs. 92.19%).
44. However, the rate of discrimination between the rich and the poor and discrimination according to the level of education and social status was higher in private hospitals than in public hospitals (11.72% vs. 5.50%).

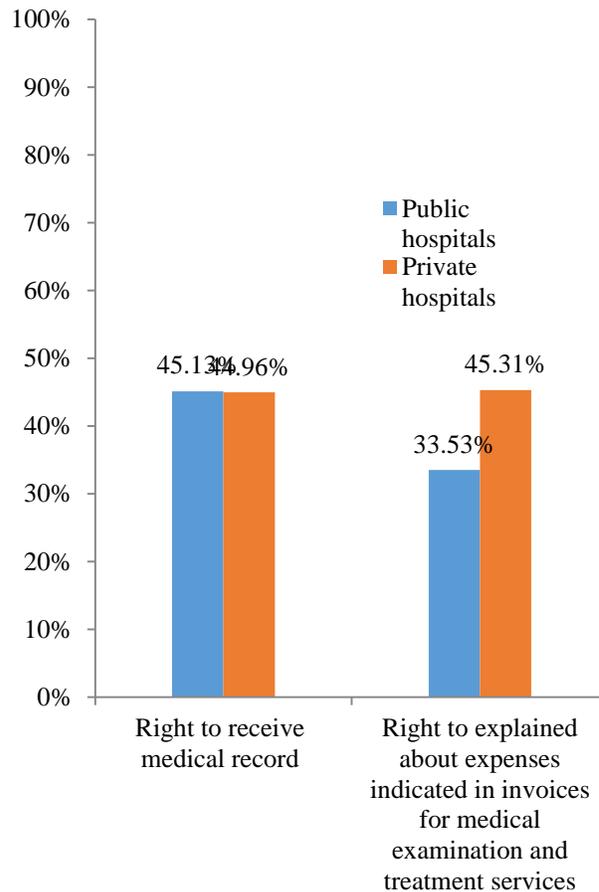
### 5.3.5. Right to choice in medical examination and treatment



**Figure 13: Right to choice in medical examination and treatment**

45. The survey indicated the rate at which the patients' rights fully receive information and explanation about their health status, result and possible risks were not as expected in both public and private hospitals (68.68% and 66.67% respectively).
46. The percentage of patients who were denied the right to choose a representative to perform and protect their rights in both public and private hospitals was high. (58.4% and 51.18% respectively).
47. The patients also mentioned that they were not consulted about the right to refuse to test, using medicine, and applying treatment methods (58.14% in public hospitals and 61.11% in private hospitals).

### 5.3.6. Right to being given medical records and explained medical expenses

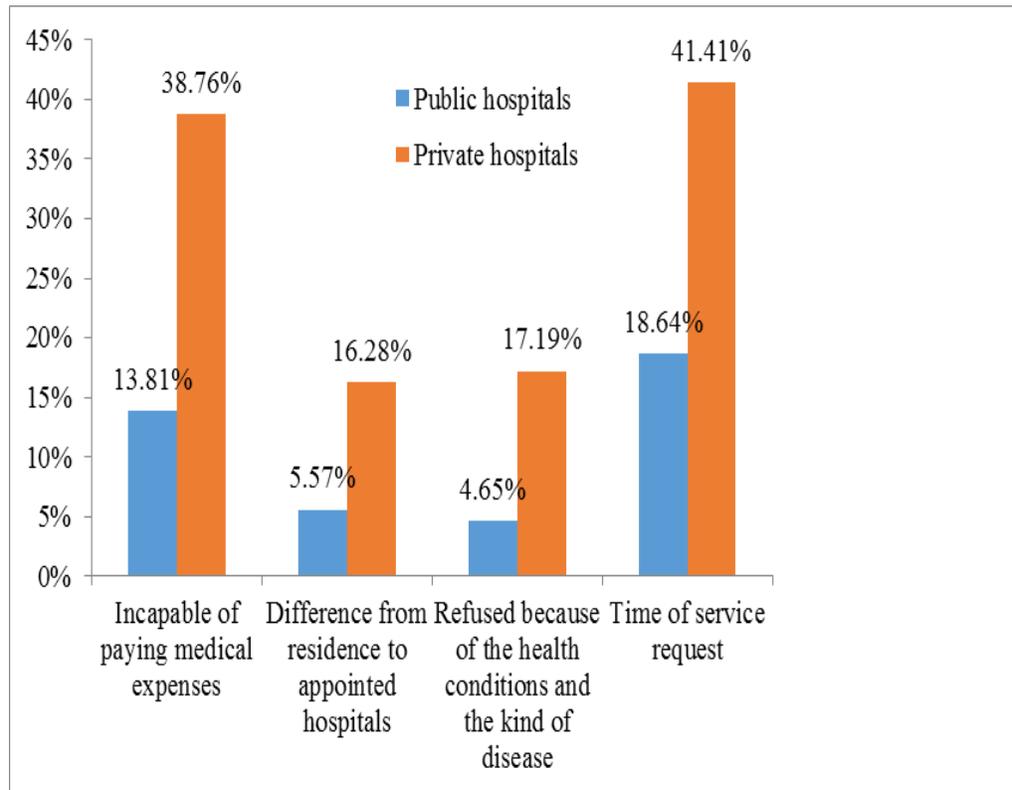


**Figure 14: Right to obtain information on case history dossiers and examination and treatment**

48. The rates were not high in both systems of health care. It was noted that patients were given medical records when they requested both in public hospitals (45.13%) and private hospitals (49.96%).
49. The figure also showed that the right to be explained about medical expenses was not respected. That disappointment happened more

seriously in the public hospitals compared to private hospitals (33.53% and 45.31% respectively).

### 5.3.7. Right to access medical examination and treatment



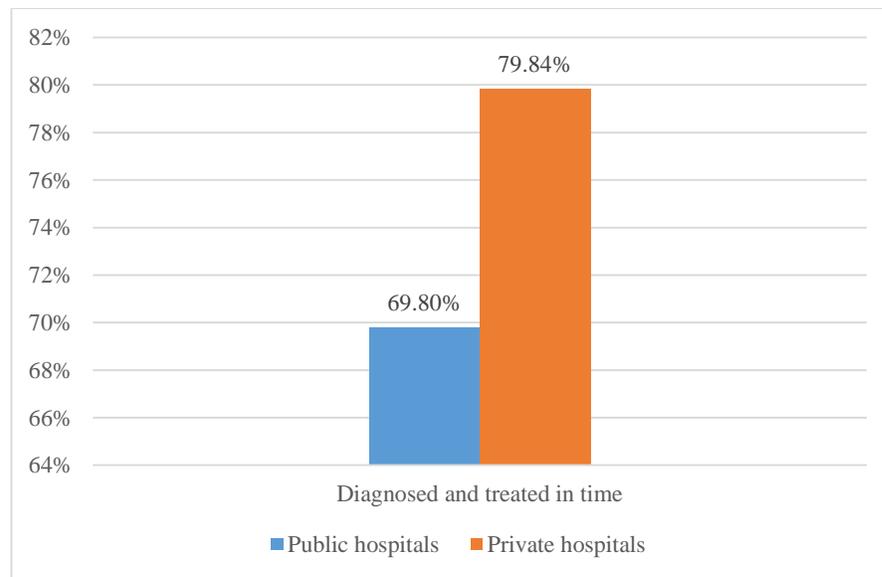
**Figure 15: Right to access medical examination and treatment**

50. In the survey, the patients reported that they were denied the right to medical services because of inability to pay at private hospitals (38.76%) and public hospitals (13.81%). The portion of the patients who were denied in the private hospitals when they were unable to pay for the health services was more than threefold the patients in the public hospitals.
51. They were also denied the services due to the difference in residence, appointed medical examination and treatment facility in both public and

private hospitals. The number was higher in private hospitals (16.28%) compared to 5.57% in public hospitals.

52. 4.65% of the patients said they were denied medical services due to their health conditions and kind of disease they suffered from in public hospitals compared to private establishments 17.19%.
53. The time of service request was also mentioned as a reason for denial in both healthcare systems. It happened significantly in the private hospitals (41.41%) compared to the public hospitals (18.64%).

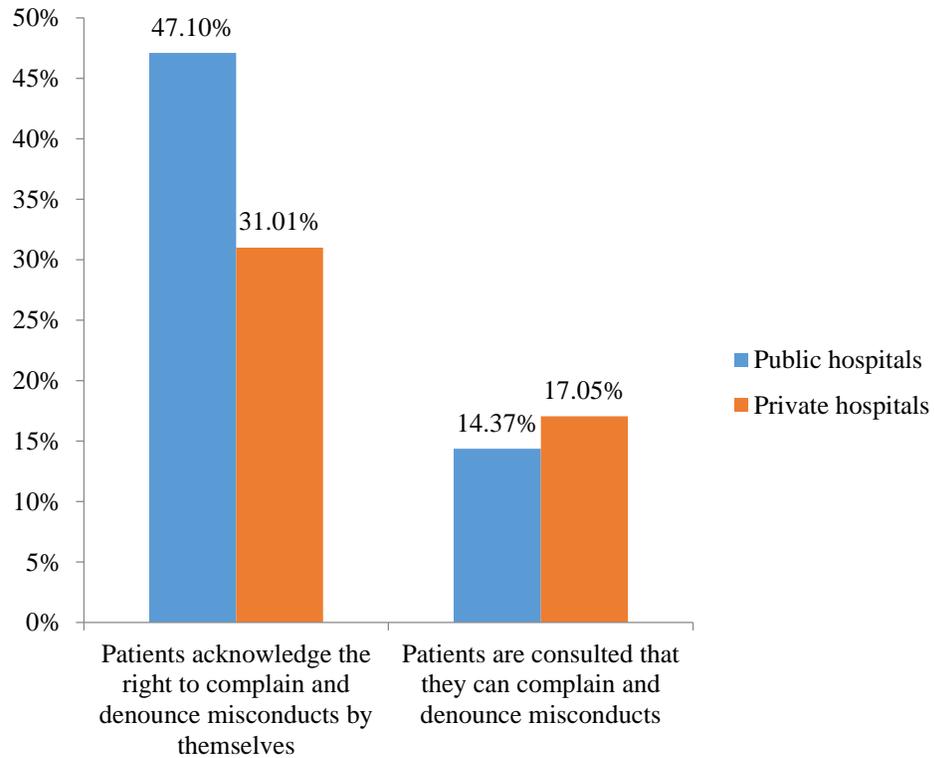
#### 5.3.8. Right to be diagnosed and treated in time



**Figure 16: Right to be diagnosed and treated in time**

54. The percentage of patients who were diagnosed and treated in time in private hospitals was higher than in public hospitals (69.80% vs.79.84 %).

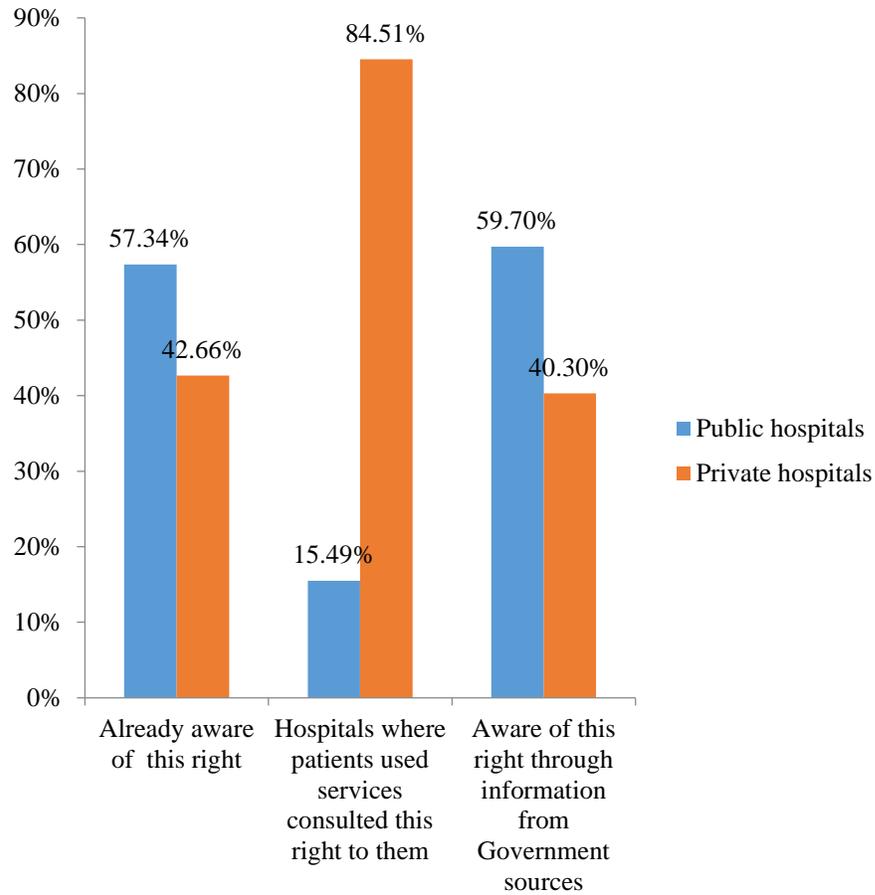
### 5.3.9. Right to complain



**Figure 17: Right to complain**

55. During the survey, the patients who reported to be aware of their right to complain and denounce misconduct experienced when using health services were higher in public hospitals than in private hospitals (47.10% and 31% respectively). Surprisingly, a quarter of them in both systems knew of this right (14.37% vs.17.5%).
56. In both public and private systems, the rates showed the patients who were consulted to know the right to complain and denounce misconduct counted rather low. Only 14.37% and 17.05% respectively.

### 5.3.10. Right to compensation



**Figure 18: Right to compensation**

57. The survey indicates that patients in public hospitals were much more aware of the right to compensation compared to patients in private hospitals (57.34% and 42.66% respectively).
58. Astonishingly, there were 84.51% of patients consulted of this right by private hospitals while public hospitals consulted only 15.49%.

59. Also, more patients in the public hospitals realised this right through information from Government sources with the rate higher than in the private ones. The disproportions were 59.70% and 40.30%.

## **6. Discussion**

### ***6.1. The status of patients' rights protection to the insured and the uninsured patients***

60. Generally, the patients in the four provinces in Mekong Delta could access health services covered by SHI and private ones funded by themselves.
61. The research indicated that majority of the patients (70%) in the four provinces purchased SHI. The rest did not have SHI. The number of the insured corresponded with the national statistics. The rest of the patients (30%) had not purchased SHI for various reasons. The main reason was that they could not afford the fee (42.43%). The rate meant that these uninsured patients were exposed to many risks. They could not access timely medical health services, and they may incur medical expenses that would not be covered by SHI.
62. There were various reasons as to why the patients purchased the SHI. The majority of them said they used the insurance for medical examination (95.16 %) while others said it was for the treatment of minor diseases (21.86%) and treatment of severe disease (28.8%).
63. However, some of the insured patients mentioned that they did not want to use the health services covered by the SHI although they paid the premium. Logically, the insured patients who did not use the health services covered by the SHI might seek health services in other ways. For example, they could use services in higher level public hospitals

where they believed that the services were better visited private hospitals or travelled abroad. As a result, they would spend out-of-pocket for those mentioned services. The result showed that the SHI does not correctly serve its purpose.

64. It is not a good impression for the public hospitals and a lot needs to be done to win everyone's trust. The uninsured patients put more trust in public services than private ones. The patients who did not have SHI preferred to go to public hospitals (45.05%) compared to private hospitals (74.42%).
65. The reasons they gave for their choice to use health services in the private hospitals compared to public hospitals were good infrastructure and technology (48.84% vs. 29.50%) and also qualified staff (48.84% vs. 19.29%). Exceptionally, the public hospital's charges for health services were less than in the private ones (39.23% vs. 21.85%). It meant that a significant part of the population in the four provinces in Mekong Delta region do not thoroughly enjoy either public hospitals or private hospitals. They, therefore, choose the better option depending on their situations.

#### ***6.2. The status of patients' rights protection under regulations and practice***

66. The survey indicated that a significant portion of the sample in the public hospitals (77.43%) and the private hospitals (73.64%) was consulted and explained their health conditions, treatment, and examination services. The majority also reported that there were safe, appropriate, and effective treatment methods under professional regulations of technology (87.27% in the public hospitals and 89.92% in the private hospitals). Some people admitted that their health condition and personal information in medical

records were kept confidential in public and private hospitals (80.53% and 84.50% respectively). These indications proved that most of the patients were satisfied with the confidentiality offered by both public and private hospitals. The conclusion reflected positive reforms in the health sector.

67. Nevertheless, there were several indications that patients' rights were violated. Some patients (11.72% in public hospitals and 5.50% in private hospitals) were discriminated against by being either rich or poor as well as their level of education and social status. Although the rates were not significant, they proved that there were cases of inequality in the use of medical services.
68. The rates at which patients were not supplied with information, explained and consulted about their, health conditions, results, and risks to decide the diagnosis and treatment methods were high both in the public hospitals (68.68%) and the private hospitals (66.67%). The rates of not being consulted about the right to refuse to test use medicine and apply treatment methods were high in private hospitals (38.89%) and public hospitals (41.86%). Patients also complained that they were not provided with medical records if requested in public hospitals (58.47%) and private hospitals (51.18%). In other words, more or less half of the patients who used medical services in both public and private hospitals had this right violated. Indeed, these results cannot escape the attention of the State and the society.
69. The violations of the right to receive medical records and to be explained about medical expenses were very significant. Evidently, less than half of the patients were provided with medical records when they asked for them (45.13% in the public hospitals and 44.96% in the private ones). In

addition, over a half of the patients in both public and private hospitals were not explained about the medical expenses. However, the private hospitals protected this right better than in the public ones (45.31% vs 33.53%).

70. The patients who were denied medical services because of their inability to pay in public hospitals were 13.81% and 38.76% in the private hospitals. Although the LMET and other relevant regulations do not protect the patients who cannot afford medical fees, medical ethics should not be ignored. In fact, this shows the shortfall of State policies on patients' rights and life protection.
71. In both public and private systems, the rates of consultancy for the patients were meager. Evidently, the patients who were consulted about their right to complain and denounce misconduct were 14.37% in the public hospitals and 17.05% in the private ones. Additionally, there were 47.10% of patients in the public hospitals and 31% of the patients in private hospitals who were aware of their right to complain about physical and mental damage, resulting from medical misconduct. For both public and private medical systems, the rates at which patients were consulted about this right by medical establishments were rather low at (14.37% in the public hospitals and 17.05% in the private hospitals).
72. The results also showed that a significant portion of the patients was aware of their right to seek for compensation; 57.34% in the public hospitals and 42.66% in the private ones. This right was significantly infringed in the public hospitals where only 15.49% of the patients were consulted while it accounted to 84.51% in the private ones. Besides that, the State lacks effective strategies to inform patients about their rights despite that, the law on complaint and compensation does exist.

Approximately 60% of patients from public hospitals and 40.30% of patients from private hospitals knew this right from the Government.

## **7. Conclusion**

73. The survey was carried in four provinces in the Mekong Delta: Can Tho, Vinh Long, Soc Trang, and Kien Trang by randomly interviewing a thousand patients. The number of patients interviewed was equally divided for the four provinces. STATA 10 software was used to process the data. Descriptive statistics method was used to analyse the characteristics of the researched objects. The results found in this research included the status of patients' rights protection to the insured and the uninsured patients as well as the status of patients' rights protection under regulations and practice.
74. As for patients' rights protection to the insured and the uninsured patients, there are 30% of the population in four provinces in the Mekong Delta that has not covered by the SHI. Most of them are unable to pay the insurance premium. Many of them do not believe in the quality of healthcare services covered by SHI. The results showed that the patients did not place complete trust in any hospital system. Paradoxically, the insured even refused to use health care services covered by SHI because of lack of trust. They chose the public hospitals or the private hospitals depending on their health status, economic conditions, and quality of services provided by the hospital systems. As a result, patients had to face the risk of illness and paid their medical fees.
75. The research also explored the status of patients' rights protection in four provinces of the Mekong Delta. The results showed that a part of patients enjoyed their rights when using medical health services. Nevertheless, a

number of patients both insured and uninsured faced obstacles when using medical services in both systems.

76. A significant portion of all interviewed patients had experienced a violation of patients' rights. For example, most of them said that they were denied the right to access and obtain information freely, and the right to choose medical examination technology. Also, the majority of the patients were unaware of their right to complain and to be compensated when they suffered damage after medical misconduct.
77. In conclusion, patients' rights in the four provinces in the Mekong Delta region were not well protected. The current laws did not play effective roles in the protection of patients' rights. Obviously, based on the findings of this research, high rates of patients' rights were infringed (for example, right to choice in medical examination and treatment, right to obtain information on medical records, examination treatment, and right to complain, etc.).
78. Moreover, compared to some countries in Europe, Vietnamese patients have been ignored when there are many essential patients' rights still missing. As such, the protection of patients' rights in Vietnam is not only far below expectations, but the rights are also far from the acceptable international standards.
79. From doing the survey and learning from other countries of patients' rights can be lessons for Vietnam to improve the status of protection of patients' rights. Vietnam should rebuild patients' rights to remove the current restrictions on the protection of patients' rights.

## **CHAPTER 7: SUGGESTIONS FOR THE FRAMEWORK OF REFORMING THE MEDICAL MALPRACTICE LAW IN VIETNAM**

1. There are many issues discussed in the author's study concerned with the medical law in Belgium, France, England, and Vietnam. These issues are healthcare systems, MM laws, MMLI, no-fault compensation, patients' rights. The primary purpose of this study is to answer three questions:
  1. What are the gaps in MM law in Vietnam?
  2. Which necessary MM provisions of Belgium, France, and England should Vietnam adopt?
  3. Which other MM provisions and other related factors that Vietnam should change, supplement, and modify to fit Vietnam' context?
2. These questions have been answered. MM law in Vietnam has had a number of gaps which needs to be improved by adopting the provisions of Belgium, France, and England. Besides adopting the provisions of the three countries, Vietnam also needs to change, modify, and supplement some related legal factors to complete MM law.

Here, the author answers the three research questions.

### **1. The gaps in MM law in Vietnam**

1. The research findings indicate that Vietnamese medical legislation has contained a number of gaps. Firstly, the patients in Vietnam are not granted fair and safe health services and are not covered sufficiently by

the health insurance system.<sup>745</sup> Hence, Vietnam has to come up with solutions to make Vietnamese people benefit more from its health care services and ensure the SHI covers the highest population possible.

2. Secondly, this study found out that the MM law in Vietnam has a number of deficiencies which directly affect its implementation and enforcement.<sup>746</sup> This circumstance has inhibited the development of the country as well as MM law in particular. Hence, health care providers have no reliable basis to carry out their practice, and patients lack a stable legal basis to seek redress whenever health providers' errors negligently harm them.
3. Thirdly, there is a worrying fact that Vietnam is in a crisis of MM incidents. It should be firmly established that MMLI should be taken into practice to take over doctors' liability when they cause harm.<sup>747</sup> Unfortunately, the current legislation is imperfect and insufficient. It is recommended that the legislation should be changed and developed with an aim to increase the role of MM law.
4. Fourthly, along with reforms in the aspects related to MM law, Vietnam should adopt the no-fault system. As the research has established, this system has been viewed as having the potential to overcome problems inherent in the tort system by providing fair, speedy, and adequate compensation for medically injured victims.<sup>748</sup>

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<sup>745</sup> See Chapter 1.

<sup>746</sup> See Chapter 2.

<sup>747</sup> See Chapter 4.

<sup>748</sup> See Chapter 5.

5. Finally, Vietnam should seriously recognise the weakness and shortcomings in patients' rights protection, primarily by paying more attention to the Mekong Delta provinces.<sup>749</sup> Enforcing the existing laws, adding the necessary regulations, and supervising law enforcement are what Vietnam should focus.
6. Based on the results of the research, the author will present legal recommendations to ameliorate MM law in Vietnam. Most of the recommendations focus on MM legislation as well as social strategies which can be included as part of the reforms.

## **2. The necessary MM provisions of Belgium, France, and England Vietnam should adopt**

### ***2.1 Reforming the healthcare system by allowing the insured to have a free choice in using health services***

7. A free choice in using health services is highly appreciated in Belgium, France, and England. The reason for patients' ability to use this choice freely comes from the fact that these countries have a health sector system that has high qualified healthcare providers and modern health facilities. At the same time, the Health Social Insurance policy does not distinguish between reimbursements of health care fees among levels of health establishments and between public and private hospitals like Vietnam. Vietnam should allow patients to freely choose wherever they want to use health care services as this is one of the essential needs and advantages a patient should have. Although this acknowledgment is a challenge in Vietnam due to the limitations of the healthcare sector, Vietnam should have a suitable plan and realise it step by step. According

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<sup>749</sup> See Chapter 6.

to the findings of this research, Vietnam should restructure the levels of the examination and treatment system.

8. As mentioned earlier, Vietnam has four levels of primary examination and treatment. They are community level, (family doctors, ward clinics, ward commune), district level, public district general hospitals, private district general hospitals (ranked into level III and IV<sup>750</sup>), district health centers, district general clinics, and specialized district hospitals), provincial level (public city general hospitals , provincial general hospitals (ranked into level I and II), central level hospitals (central general hospitals and specialized central hospitals and institutes). Insured members can only register for primary examination and treatment at the levels of commune and district hospitals.<sup>751</sup> Patients must accept to use health services from the medical establishments indicated on the Health Insurance Card.<sup>752</sup>
9. The research posits that this regulation is definitely irrational when Vietnam cannot offer quality services in the said medical establishments. One more unreasonable condition is that patient must register for primary examination and treatment in an establishment even if it is a specialist establishment because the establishment is domiciled in their area of residence. There are instances where the nearest hospital in someone's area of residence is a specialist hospital. For example, a Heart Hospital

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<sup>750</sup> The ranks of hospital levels based on the standard of the hospital such as number of beds, facility technology and human resource of the hospital under the Circular on Guiding Classification of Hospitals, No. 03/2004/TT-BY, Health Ministry of Vietnam

<sup>751</sup>Article 8: Circular on Primary Medical Examination and Treatment covered by Health Insurance and transfer to other levels for Health Examination and Treatment covered by Health Insurance, No. 40/2015/TT-BYT, Health Ministry of Vietnam.

<sup>752</sup>Decision on Establishing the Codes Written on Health Insurance Card, No. 1071/QĐ-BHXH, Social Health Insurance of Vietnam.

or Cancer Hospital. As a matter of policy, one is expected to register in such a hospital for primary examination due to its proximity to his/her area of residence even if it does not resonate with patients' needs.

10. Instead of continuing to use four levels as the situation, currently, Vietnam can refer to the following model in line with modern trends and the State should abolish the four existing levels of hospitals. This division can be applied according to primary health care and secondary health care needs.

### **1. Primary health care**

11. Primary health care can be provided by a family doctor and general private clinics (mostly private clinics in Vietnam). In Vietnam, the private clinic system is robust in ensuring human resources and medical equipment for primary health care. In cases where patients need specialised treatment, GPs / private healthcare clinics will refer patients if need be to a specialised medical facility for treatment.

### **2. Secondary healthcare**

12. In cases where patients need specialised treatment, family doctors/ private primary health care clinics will advise their patients to visit secondary medical care establishments for treatment at the provincial level or another health establishment best suited for the patients' condition in the whole country. In addition, the State needs to invest more to develop specialised hospitals to meet the needs of patients while ensuring a suitable connection between primary health care and secondary health care to avoid primary health care facing difficulties when referring their patients to secondary healthcare facilities. This kind of restructuring needs to be coordinated with other relevant agencies such as the Ministry of Education in guiding GPs training, Ministry of

Health in regulating SHI and Ministry of Finance in ensuring consistent payment for medical services rendered.

13. This change would probably ensure the envisioned benefits to patients. At the same time, the State can also tackle the health problem of overcrowding of patients in hospitals ineffective utilisation of human healthcare resources and medical equipment.

## **2.2. Reforming medical malpractice law**

### **2.2.1. Construct standard of care**

14. Up to now, Vietnam has had no regulations on a standard of care and has not enacted the National Clinic Guideline (temporarily named) which is the reference to the standard of care. The lack of merits causes difficulties in determining the responsibility of the doctor. The determination of the legal responsibility of the physician is made only on the basis of feeble regulations and otherwise groundless/baseless reasons. Hence, the compensation is only supportive and unsatisfactory. To solve these problems, it is necessary to redefine the meaning of a standard of care and redefine the national standard of care by establishing the Central Clinical Authority (temporarily named and will be presented in detail in 3.3) with specialists to develop a National Clinical Guideline (temporarily named).
15. The first goal is to redefine the meaning of the standard of care to suit Vietnam's context. Drawing from the definitions from Belgium, France, and England, the standard of care should be defined to be suitable in Vietnam. The researcher suggests that *“The standard of care is that a health practitioner offers a patient medical help conscientiously and attentively. That health practitioner must offer the health services in*

*conformity with the data. Advances in medical science in the sense that the level of scientific progress should be taken into account when providing health services. In another word, it is a practice accepted as a responsible body of medical men skilled in that particular art.”*

16. Regarding the definition of the standard of care, the criteria to evaluate conscientiousness and attention in the definition should be combined with the physician’s responsibilities, regulated in the LMET. For instance, to ensure equality, fairness and non-discrimination for patients; to respect patients' rights; to keep confidential information on the health status and privacy of patients indicated in their case history dossiers; to promptly and adequately observe professional and technical regulations; to prioritise medical examination and treatment in cases of emergency; under-6 children, sufferers of severe disabilities, people aged 80 or older; people with contributions to the revolution and pregnant women)<sup>753</sup> and the relevant regulations such as professional ethics, behaviours, etc.
  
17. In line with Belgium and France,<sup>754</sup> the definition of standard of care should be understood as an obligation *not to cure* the patient but to offer him medical help conscientiously and attentively, in conformity with the data and advances of medical science in the sense that the level of scientific progress should be taken into account. This definition should be applied in both tort and contract in Vietnam. This research realised that currently, according to Vietnam’s Civil Law, a contract between a physician and his patient, a particular result which must be achieved most of the time appear in the contract as an obligation of the physician. This existence seems unrealistic when the medical sector is a particular sector

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<sup>753</sup> Law on Medical Examination and Treatment.

<sup>754</sup> Mercier, Civ., 20<sup>th</sup> May 1936, DP 1936, 1.88.

whose result depends on many factors: patient's health status, "skilled person", and medical science, etc.

18. In addition, the concept of the status of medical science in the sense of the level of scientific progress should also be clarified. The state of medical science should be understood at the level of development in Vietnam. Besides, the State may identify the medical science in the internal scope which Vietnam has adopted and applied. Therefore, the acceptable practice will be built based on both national and international levels.
19. Moreover, it is essential to indicate the targets of a "skilled person". The author would like to give recommendations concerning this point. Firstly, to work as legal health care providers, medical practitioners should attain a stipulated minimum level of professional training (university or college) and spend a period practising in accredited medical establishments. After meeting the prerequisite requirements and upon being evaluated to determine whether they are qualified or not, it is when they would be granted licenses to practice.<sup>755</sup> Secondly, the standard of care should not be based on common skilled professional requirements, but it should depend on rules written and enacted by the legislature, which must be up to date (the so-called procedure of care). Consequently, Vietnam has not responded quickly to modern and advanced medical developments characteristic of developed countries. To eliminate these obstacles, Vietnam should recognise the concept of "skilled person."<sup>756</sup> The first task in filling this gap is to establish an

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<sup>755</sup> Article 18 - Law on Medical Examination and Treatment.

<sup>756</sup> See *Breach a duty of care in the country of Belgium (No.2.2.3)*, *France (No.3.2.3)*, *England (No.4.2.3)* and *Vietnam (No.5.2.3)* in Chapter 3.

independent agency that comprises of specialists in different medical fields to evaluate health care providers to establish whether they are qualified to be termed as “skilled persons.”

20. The second target is to bolster the national standard of care in the examination and treatment of all kinds of health problems. This national standard of care should be standardised and popularised in the medical education system- public and private, workshops, and the mass media, etc. to create awareness for both providers and other people. All of these solutions are designed to ensure that all physicians are aware of the standard of care expected in each of the areas in which they are practising.
21. As we know, a standard of care can also refer to informal or formal guidelines that are generally accepted in the medical community for treatment of a disease or condition. It may be developed by a specialist society or organisation and the title of a standard of care awarded at their discretion. It can be a clinical practice guideline a formal diagnostic and treatment process a doctor must follow for a patient with a specific set of symptoms or a specific illness. That standard will follow guidelines and protocols that experts would agree with as most appropriate also called "best practice." Standards of care are developed in some ways. Sometimes they are merely developed over time and in other cases, they are the result of clinical trial findings. A national authority collates clinical practice guidelines. Thus, there is no valid concept of standard of care. The inconsistency allows the physicians to stay with their standard of care belong to their specialisation. A standard of care in one community will not necessarily be the same standard in another. Further,

one doctor's standard can vary from another doctor's, hence the need for a universally accepted standard of care.<sup>757</sup>

22. Based on this argument, Vietnam should establish a Central Clinical Authority (temporarily named) with specialists to develop a National Clinical Guideline (temporarily named) to serve as a basis to determine the standard of care. Depending on the development conditions of each city, the Government should set up the City Clinical Authorities (temporarily named will be detailed presented in 3.3) that have specialists who are knowledgeable on the National Clinical Guideline to contribute to determining the standard of care in each city when MM cases occur.
23. Redefining the meaning of a standard of care and building up the national standard of care by establishing the Central Clinical Authority (temporarily named) with specialists to develop a National Clinical Guideline can be a remedy to give a practical solution to investigate the responsibility of the doctor.

### ***2.2.2. Legalize “Loss of a chance”<sup>758</sup> as a part of the compensation system***

24. The theory of the loss of a chance has never been clarified in Vietnam like it is in Belgium, France, and England. Due to lack of the same, the legitimate rights and interests of the patient are ignored. Drawing from these countries, Vietnam should apply the theory of loss of chance by

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<sup>757</sup> Torrey, T., *Standard of Care*, Verywellhealth, 2018;

<https://www.verywell.com/standard-of-care-2615208>

<sup>758</sup> See “Causation” in Belgium (No.2.2.5), France (No.3.2.5), England (No.4.2.5), and Vietnam (No.5.2.5) in Chapter 3.

constructing the meaning of the loss of chance, apply the theory of but-for-test, and propose a suitable rate of damage to be compensated.

25. The researcher reiterates that the “but for” test is to be used as the standard for establishing causation in most MM cases. The general but not conclusive test for causation is the “but for” test which requires the plaintiff to show that the injury would not have occurred but for the negligence of the defendant.”<sup>759</sup> Although the “but-for-test is not perfect, it can be a good solution for Vietnam to the legal system. Particularly, in action for delayed medical diagnosis and treatment, a plaintiff is obliged to provide on a balance of probabilities that the delay caused or contributed to the unfavourable outcome. In other words, the plaintiff must prove that the unfavourable outcome would have been avoided with prompt diagnosis and treatment. It is not sufficient to prove that a timely and adequate diagnosis would have afforded a chance of avoiding the unfavourable outcome unless the chance surpasses the threshold of “more likely than not”.<sup>760</sup>
26. In the context of Vietnam, the concept of loss of a chance should be defined as “*Loss of a chance is to lose the opportunity to have a better outcome which is reduced or lost by the health providers’ negligence.*” This definition sounds similar to the ones of Belgium, France, and England. Belgium says that the loss of chance is to lose the opportunity

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<sup>759</sup> *Athey v. Leonati* (1996), 140 D.L.R. (4<sup>th</sup>) at para. 32. [1996] 3 S.C.R. 458. [1997] 1 W.W.R. 97.

<sup>760</sup> *General Principles of Medical Malpractice Litigation*, p.20.

<http://webcache.googleusercontent.com/search?q=cache:Jl2GiGX9OoEJ:www.lerners.ca/wp-content/uploads/2006/03/General-Principles-of-Medical-Malpractice-Litigation.pdf+&cd=10&hl=en&ct=clnk&gl=vn>

to see a situation improving or not to see a situation deteriorating.<sup>761</sup> In France, if the patient was not thoroughly informed, he or she should be compensated only for the loss of a chance to escape the risk. Moreover, compensation is granted for loss of chance when the patient would have benefited from earlier or better treatment.<sup>762</sup> Similarly, England states that “the loss of a chance,” i.e., where it is alleged that by the defendant’s failure to diagnose or treat or both, the patient has lost the opportunity to avoid an adverse outcome. Although Belgium, France, and England have similar definitions for the loss of chance, Belgium and France do not mention whether the patient can claim for compensation if physician’s wrong diagnosis caused the loss of the chance. Vietnam should allow the patient to seek compensation for both diagnosis and treatment.<sup>763</sup> In practice, the physician’s wrong diagnosis deprives the patient of a chance to recover or have a better outcome.<sup>764</sup>

27. The researcher posits that the application of the ‘but-for test’ could be tried in Vietnam to prove that without the negligence of the defendant, the patient would not have lost the hope to obtain advantage (patrimonial or physical).

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<sup>761</sup> Winiger, B., Koziol, H., Koch, B. and Zimmermann, R., *Digest of European Tort*, Springer, Wien -New York, Vol. 1, 2007, p. 557.

<sup>762</sup> G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, Chicago-Kent Law Review, Vol. 86,2011, p.1114.

<sup>763</sup> G'Sell-Macrez, F., *Medical Malpractice and Compensation in France: Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002*, Chicago-Kent Law Review, Vol. 86,2011, p.1114.

<sup>764</sup> Tran, B.T., *May Forgive the Wrong Diagnosis but not Wrong Surgery*, Tuoi Tre. Accessed on November 26<sup>th</sup>, 2016.

<https://tuoitre.vn/chan-sai-cho-phep-mo-nham-thi-khong-1225813.htm>

28. Moreover, the author suggests that, research should be carried out to determine the rate (50% or 51% as applied in other countries) at which to compensate and in which cases loss of a chance should be applied. In Vietnam, the overall development in the medical sector (e.g., the quality of physicians and medical equipment) has been lower than the other countries referred to for purposes of this research, namely (Belgium, France, and England). Hence, to indicate an appreciation rate, these conditions of the medical sector's situation should be considered. The researcher recommends, at the first trial, the rate should be around 60%-65%. The researcher proposes that this rate is applied in Vietnam because if applied to other countries, the boundary between compensation and non-compensation is too fragile (50%-50% or 51%-49%) while the degree of applicability of judicial authorities in the health sector is not as high as in other countries.
29. Applying the theory of loss of a chance in determining the responsibility of the doctor caused damage to the patient is necessary to reduce the doctors' errors and patients' interests. To apply this theory, the priority should be constructing the meaning of chance, admitting 'but- for' test and proposing the rate of determination.

***2.2.3. Organize an independent agent to evaluate health care providers' malpractice***

30. MM incidents in Vietnam are very high. Although there are no specific statistics on medical complications, the medical occupation incident rate is 7%. It is estimated that 67,000 patients suffer from medical complications annually, 15,300 suffer from permanent disabilities and 5% of deaths are due to medical complications emanating from MM

every year.<sup>765</sup> However, Vietnam does not have a permanent organisation to determine those incidents but only has a temporarily professional council constituted as per need basis whenever there is a request for settlement of disputes on medical examination and treatment when MM accidents occur to patients.<sup>766</sup>

31. According to the law,<sup>767</sup> the composition of the professional council includes experts in the same professional fields and experts of other specialities related to incidents in medical examination and treatment. Typically, a lawyer or person specialised in law. To establish the council, there is a stringent procedure that must be followed.
32. There are several illogical issues in this rule when it is applied in practice. Firstly, the experts mentioned in the rule, most of the times, come from the same medical agents where the incident occurs. The law does not restrict where the experts come from. Hence, the evaluation of errors might not be objective. Secondly, the people expected to conclude might not be skilled enough. The tension might lead to inaccurate conclusions. Also, Vietnam has very few lawyers, and people specialised in medical law. Hence, any lawyer or person who graduates from law school can be a member of the council. As a result, again, the conclusions of the council could be wrong. Thirdly, the council is usually dissolved after it settles the agreement between the wrongdoer and the patient while it takes much time and a complicated process to establish it as required by the law.

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<sup>765</sup> *How to Limit Medical Incidents in Vietnam?*, Kien Thuc, 2015;

<http://kienthuc.net.vn/tai-bien-y-khoa/giao-luu-truc-tuyen-lam-the-nao-han-che-tai-bien-y-khoa-o-viet-nam-606904.html>

<sup>766</sup> Article 74 - Law on Medical Examination and Treatment.

<sup>767</sup> Article 75 - Law on Medical Examination and Treatment.

33. To solve these problems, Vietnam should have a Central Clinical Authority and City Clinical Authorities (as mentioned in 3.2) and with qualified/skilled experts and people specialised in medical law. So that, whenever incidents occur, they can respond on time. Also, if the Government admits an agent, the so-called “Central Clinical Authority”, it should empower the agent with special independent rights. For example, the Central Clinical Authority may develop its own working rules which will be recognised by the State. The Central Clinical Authority should be empowered to enact “standard of care” of a particular illness without following the Procedures for promulgation of documents as prescribed by the State. The allowance will allow the agency to respond promptly.
34. After that, the Central Clinical Authority will transfer and guide the knowledge of the National Clinical Guideline (as mentioned in 3.2) to City Clinical Authorities (as mentioned in 3.2). Moreover, these Authorities themselves will directly participate in determining whether the doctors’ actions amount to MM. The conclusions of the Authorities may be appealed to the “Central Clinical Authority.” Combined with the findings of the Authorities, the courts can, therefore, make rulings.
35. The establishment of the Central Clinical Authority, the City Clinical Authorities and the development of the National Clinical Guideline is an urgent need for determining the physician's liability. The authorities should have independent powers in exercising their functions without being governed by the judicial system of the State to ensure objectivity, professionalism, and fairness.

#### *2.2.4. Establish States' medical malpractice fund*

36. As of now, Vietnam does not have a budget for cases of MM. There are only funds created by each hospital, and they are used to pay patients who suffer damage induced by their professional health providers.
37. There are some inherent weaknesses when there is no State-run MM fund. To solve the problem of lacking a State-run fund, the hospitals extract hospitals' funds to make compensation. Firstly, the regulations which hospitals apply to budget and to pay for compensation on behalf of health professionals are enforced by the hospitals. Hence, the application will be inconsistent among the hospitals. The consequence of the lack of consistency in the compensation is that there might be inconsistency in abiding by the law and unfairness to patients. Secondly, in some cases, compensation cannot be made because several hospitals do not have sufficient funds to pay. Once the hospital does not have enough funds to pay compensation, the liability will go directly to the doctor who causes damage to the patient. Hence, the economic pressure piles up because the individual doctor is unlikely to be eligible for compensation, especially in cases of significant mental and physical harm.
38. Because of these problems, it is necessary to establish a State-run MM Fund to ensure patients' benefit when they suffer from health care providers' errors. As for the establishment and applicability of the state-run MM fund, the researcher suggests that the fund should be used to compensate for all health establishments (including the public and private healthcare systems). In case of any wrongdoing, the Fund will pay compensation directly to the patients.

39. Regarding the Fund, the private health practitioners should contribute a specific pre-determined amount to the Fund as a necessary statutory condition to practice. Upon meeting this condition, they would be included in the fund to be assisted when they have to pay compensation.
40. The procedure for compensation from the State fund should comply with the civil code. It means that the procedure should follow the regulations of the time, damage evaluation, and compensation method, etc. The parties involved (a representative of the State Fund and patient) should be non-partisan in negotiation or a court.
41. Establishing the State-run Fund is a way to ease the financial burdens of the hospital as well as the physicians. Also, it ensures reasonable payment for the patient's damages. The compensation procedure in the Civil Code should be the basis for the Fund's compliance to ensure consistency in the implementation of the law.

#### ***2.2.5. Establish a no-fault compensation system***

42. As discussed, as an alternative to the tort or fault-based system, a no-fault compensation system has been viewed as having the potential to overcome problems inherent in the tort system by providing fair, speedy, and adequate compensation for MM victims.<sup>768</sup>
43. According to the research findings, realising this system is very important to transform the health sector of Vietnam. Evidently, Vietnam's healthcare sector is facing four key challenges; including increasing disease burden, insufficient healthcare infrastructure, insufficient health financing and investment, and lack of IT application.

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<sup>768</sup> Kassim, P., *No-fault Compensation for Medical Injuries: Trends and Challenges, Medicine and Law*, 2014, p.21.

Besides, tertiary hospitals are overcrowded. Bed occupancy rates are high especially at the central level hospitals, which was 112.5% on average while the sustainable rate as recommended by WHO is 80%.<sup>769</sup> Lack of skilled doctors is also a significant problem.<sup>770</sup> With such a situation, some patients cannot easily prove the errors made by the health professionals. These patients will be not granted any compensation even if they suffer MM damage.

44. Vietnam, at the moment, accepts to compensate without proving fault for patients in cases of incidents that emanate from vaccination. The author would suggest that learning from other countries. The State should extend the compensation in other areas such as contraception and contaminated transfusions (HIV and hepatitis). Hence, no-fault compensation should be applied in more cases. However, it is necessary to issue legal provisions for the application of this system. Moreover, the State should establish a no-fault compensation fund by combining with the Fund of fault compensation. The State could budget this fund and it will be managed by the Department of Social Health Insurance.
45. A no-fault compensation system has been viewed as having the potential to overcome problems inherent in the tort system by providing fair, speedy, and adequate compensation for medically harmed victims. Proponents of the suggested no-fault compensation system have argued that this system is more efficient regarding time and money as well as in

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<sup>769</sup> Biinform, D., *Vietnam Healthcare Sector Preview*, 2016;

<https://biinform.com/Reports/195-vietnam-healthcare-sector-preview-2016-4530.html>

<sup>770</sup> *Emerging Opportunities in Vietnam Healthcare's Landscape*, Solidiance, 2015, p.18;

<http://www.solidiance.com/whitepaper/vietnams-healthcare-opportunities-beyond-hanoi-and-ho-chi-minh-city.pdf>

making the circumstances in which compensation is paid much clearer. However, the arguments against no-fault compensation systems are mainly on issues of funding difficulties, accountability, and deterrence, particularly, once a fault is taken out of the equation.<sup>771</sup> When establishing the no-fault compensation in Vietnam, the State should also take into account the factors mentioned above. The following recommendations should be included in Vietnam's no-fault compensation system:

46. Firstly, the concept of a no-fault compensation system should be redefined. Among the three countries: Belgium, France, and England, only Belgium defines no-fault compensation. While France prescribes the scope for the patient to receive compensation without proving fault in the case of the so-called therapeutic alea or medical hazard.<sup>772</sup> Moreover, England has not yet approved “no-fault system.”<sup>773</sup>
47. Although it is not easy to give a complete concept, it should contain the main factors: (1) a no-fault medical accident occurring during medical or health care activities, (2) must be of a physical nature,<sup>774</sup> does not result from the patient's health condition, (3) and gives rise to abnormal damage. Damage is deemed abnormal if it should not have occurred due

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<sup>771</sup> Kassim, P., *No-fault Compensation System for Medical Injuries: Trends and Challenges*, Medical Law, 2014, p.1.

<sup>772</sup> Helleringer, G., *Medical Malpractice and Compensation in France. Part II: Compensation based on National Solidarity* in K. Oliphant, K. and Wright, R (eds.), *Medical Malpractice and Compensation in Global Perspective*, De Gruyter, 2013, p.164.

<sup>773</sup> Mason & McCall Smith, *Law & Medical Ethics*, Oxford, 2016, p.131.

<sup>774</sup> Document of the World Bank, *Medical Malpractice System around the Globe Examples from the US-Tort Liability System and Sweden No-fault System*, p.8;

[siteresources.worldbank.org/.../Resources/Malpractice\\_Systems\\_eng.pdf](http://siteresources.worldbank.org/.../Resources/Malpractice_Systems_eng.pdf)

to the present state of science, the patient's health condition and the objective and foreseeable evolution of his/her condition.<sup>775</sup>

48. According to the findings of this research, a no-fault medical accident occurring during medical or healthcare activities should include the activity of diagnosis. This idea is derived from French law. When the injury results from acts of prevention, diagnosis, or treatment, and when such injury is abnormal with respect to the patient's previous health and its likely evolution, the victim's claim may be brought before the National Fund for Compensation of Medical Accidents (*Office National d'Indemnisation des Accidents Médicaux* [ONIAM]).<sup>776</sup> Elsewhere, in Belgium, a wrong diagnosis cannot constitute a medical accident without liability even though it would entail abnormal damage to the patient.<sup>777</sup>
49. Getting the right diagnosis is a crucial aspect of healthcare - it explains a patient's health problem and informs subsequent health care decisions. The diagnostic process is a complex collaborative activity that involves clinical reasoning and information gathering to determine a patient's health problem. According to *Improving Diagnosis in Health Care*, diagnostic errors-inaccurate or delayed diagnoses-persist throughout all settings of care and continue to harm an unacceptable number of patients.

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<sup>775</sup> *Belgium: New Law on Compensation of Victims of No-Fault Medical Accidents*;

<http://www.loc.gov/law/foreign-news/article/belgium-new-law-on-compensation-of-victims-of-no-fault-medical-accidents/>

<sup>776</sup> Helleringer, G., *Medical Malpractice and Compensation in France. Part II: Compensation based on National Solidarity*, Vol. 86, Chi.-Kent L. 2011, p. 1127.

<sup>777</sup> Muylaert, P., *The Law on Compensation of Health-related Damage, Belgian Review of Personal Injury and Medicine Law*, 2010, p. 89, in a reasoning which we hardly convince, tries to justify this exclusion. He considers that a diagnostic error is not abnormal in itself, it is the abnormal evolution or not. Diagnosed pathology that will justify or not from the application of the new law.

It is likely that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences. Diagnostic errors may cause harm to patients by preventing or delaying appropriate treatment, providing unnecessary or harmful treatment, or resulting in psychological or financial repercussions.<sup>778</sup>

50. It is also necessary to specify what is meant by harm which should not have occurred in the light of the present state of science, the condition of the patient, and its objectively predictable evolution.<sup>779</sup> Notably, in the context of Vietnam, the development of medical science has lagged behind compared to developed countries and specifically the countries in this comparative study. (Belgium, France, and England). It is necessary to identify the ordinary standard of medical science to whether it is abnormal or not based on the presence of science.
51. Secondly, the state should use experts' evidence/opinion to investigate some questions: the duty of the physician, the causation link between the omission and damage, the patient's damage (invalidity), and the procedure to seek for compensation, etc. The reasons which support

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<sup>778</sup> Balogh, E., Miller, B., and Ball, J., *Improving Diagnosis in Health Care*, The National Academic Press, 2015, p.1.

Thouvenin, D., *French Medical Malpractice Compensations since the Act of March 4, 2002: Liability Rules Combined with Indemnification Rules and Correlated with Several Kinds of Procedures*, Drexel Law Review, Vol. 4, 2011, p. 168.

<sup>779</sup>Langenaken, E., *The Belgian Law of 31 March 2010 Concerning Compensation for Damages Resulting from Health Care: Still an Effort*, Responsabilité Médicale, 2011, p.5.

*See:* Law of 31 March 2010 on compensation for damages arising from healthcare and the law of 25 February 1991 concerning liability in relation to defective products by proving the vaccine defect and the link between the damage suffered and the defect.

these recommendations are relevant for the agent to evaluate health care's provider's malpractice liability.<sup>780</sup>

52. Thirdly, Vietnam should apply for the no-fault compensation in several incidents, such as vaccination, blood transfusion (HIV, hepatitis B, C), and contraception, etc. Belgium<sup>781</sup>, France,<sup>782</sup> and England<sup>783</sup> are some of the countries that compensate without proving fault when patients suffer from the activities of vaccinations and blood transfusion. After that, the scope of application can be extended.
53. Fourthly, to apply for the no-fault compensation system, the claimant should satisfy one of the following conditions:

- 1. Damage is deemed grave if the patient has a developed a permanent disability:**

Some countries indicate the rates of disability. For example, in Belgium, 25% of disability that allows the patient to seek

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<sup>780</sup> See 3.3. Organization an independent agent to evaluate health care's provider's malpractice, No. 37 – 40.

<sup>781</sup> See: Law of 31 March 2010 on compensation for damages arising from healthcare, and the law of 25 February 1991 concerning liability in relation to defective products by proving the vaccine defect and the link between the damage suffered and the defect in Belgian Advisory Committee on Bioethics, Opinion No. 64 of 14 December 2015 on the Ethical Aspects of Mandatory Vaccination, 2015, p. 32;

[https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth\\_theme\\_file/opinion\\_64\\_obligation\\_de\\_vacc\\_0.pdf](https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/opinion_64_obligation_de_vacc_0.pdf).

<sup>782</sup> Article L.3122-1 - Public Health Code;

Article L.1221.14 - Public Health Code.

<sup>783</sup> See The MacFarlane and the Eileen Trust for HIV infection through blood transfusion, the Skipton Fund for Hepatitis C infection through blood transfusion in Taylor, S., *Medical Accident Liability and Redress in English and French Law*, Cambridge University Press, 2015, p. 64.

compensation. France says that compensation would be possible in case of the so-called therapeutic area or medical hazard<sup>784</sup> while England has not yet adopted the system in its entirety. However, in the context of Vietnam, a specific suitable rate should be researched and determined when Vietnam has never adopted the system of a no-fault system. According to the author's idea, the proper rate should be from 30% to 40%. This rate cannot be the same as Belgium (25%) because the medical development between the countries is slightly different. Vietnam is still in the rear of developed countries like Belgium.

Setting a proper rate which allows the patients to claim for compensation in the first place may help Vietnam step by step to adapt to the no-fault system. After a legally stipulated time, once the patient suffers any form of deviance from good health, he or she can claim for compensation. Therefore, after that, once damage occurs, the patient can seek compensation. In addition, the patient can also seek compensation if he or she suffers from a three to six-month temporary invalidity, suffered particularly severe perturbations (including economic) in his living conditions, or is deceased;

## **2. If the insurer pays insufficient**

Notably, MMLI in Vietnam has been facing challenges. Few physicians/medical establishments can afford this liability

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<sup>784</sup> Helleringer, G., *Medical Malpractice and Compensation in France. Part II: Compensation Based on National Solidarity* in Oliphant, K. and Wright, R (eds), *Medical Malpractice and Compensation in Global Perspective*, De Gruyter, 2013, p.164.

insurance because the insurance's premium is high compared to their income. If they can afford the insurance, the indemnification may not be sufficient for the patients' damage. Therefore, it is indispensable to allow the patients to claim for compensation from the Fund if the insurer does not provide sufficient compensation.

### **3. If the physician (and/or the place where he works for) cannot manage enough to offer sufficient compensation**

As mentioned, few physicians/medical establishments can afford medical liability insurance. If the physicians and medical establishments who do not have MMLI cause harm to the patients, they have to take care of the compensation by themselves. In most of the cases, the physicians' income and medical establishments' fund are not sufficient to cover the compensation for their income and funds are insufficient.<sup>785</sup>

### **4. If the court totally rejects the claim**

According to Civil law, a patient is allowed to claim for compensation if he/she can prove that he/she suffered damage from a physician's fault. Probably, the court will reject the claim in this case. Hence, a no-fault compensation system creates a resource for the patient.

54. Moreover, for the procedure, the claimant may choose either to launch a compensation claim through the Court or a no-fault compensation system

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<sup>785</sup> See: *Reduce Work Pressure and Raise Income for Health providers*, Chapter 7, No. 2.3

See: *Establish State's Medical Malpractice Fund*, Chapter 7, No. 3.4.

directly. In other words, if the patient has concerns about the expert evidence, s/he will be free to follow the most suitable procedure based on the prevailing circumstances. However, if the patient is not satisfied with the compensation from either procedure, s/he can go back to the one that seems to have a more favourable offer. Hence, the patient would benefit by saving time, reducing the cost of the procedure, and receiving the most suitable compensation.

55. For these reasons, Vietnam should soon recognise a no-fault compensation system. This compensation system can overcome the weaknesses of the tort compensation system. Some points to note when building a no-fault compensation system to suit Vietnam's circumstances are redefining of the concept, pilot applying in some cases (vaccination and blood transfusion) and extension of the scope after that, and set up conditions that would apply for compensation, etc.

#### ***2.2.6. Add more types of pecuniary and non-pecuniary damage***

56. Admittedly, there are two kinds of damages in Vietnam: economic damage and non-economic damage.<sup>786</sup> However, these classifications may not be sufficient to restore the patients to the position they were in before suffering damage.
57. For economic damage, Vietnam's law does not consider the damage of future earning capacity or a chance to get a promotion. These kinds of damages are recognised in Belgium, France, and England. For example, in France, loss of future earning is generally the main item of a financial loss suit. The judge has to contrast the position before and after the accident and estimate the difference. A future loss of earning claim may

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<sup>786</sup> See: *Damage (No.5.1.4) in Vietnam* in Chapter 3.

be spread over many years and will almost certainly attract varying rates of loss. Such a loss of earnings may be total or partial, and for a limited period or permanently. Besides, Belgium acknowledges that loss of a chance of promotion is also compensated. The jurisprudence had already indemnified one who was physically injured for the loss of a chance to receive a professional promotion when that promotion seemed relatively uncertain. Without this consideration in compensation, the patient is disadvantaged when receiving compensation.<sup>787</sup>

58. As for the non-economic loss, currently, Vietnam has not legally set guidelines for or clarified the types of non-economic damage. Hence, the law in Vietnam does not mention the kinds of the non-economic loss such as loss of enjoyment and ability to have sex. Indeed, the State should promptly set a base for determining this damage. This is informed by the fact that the non-economic damage itself exists in various forms such as the injury itself, disfigurement, and loss of enjoyment of life among others as the laws of Belgium, France, and England<sup>788</sup> regulate.
59. Another suggestion is that Vietnam should not impose and/or limit the amount of non-economic compensation based on basic salary without distinction of what kind of non-economic loss and how much the patient suffered from the damage. The compensation should be based on the actual losses.
60. The classification of losses in Vietnam is not complete. The addition of future earning capacity or a chance to get a promotion (economic

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<sup>787</sup> Bussani, M and Palmer, V., *Pure Economic Loss in Europe*, Cambridge University Press, 2003, p.209.

<sup>788</sup> See *Damage in Belgium* (No.2.2.4), France (No.3.2.4), and England (N.4.2.4) in Chapter 3.

damage), and loss of enjoyment and ability to have sex (non-economic damage) to ensure the restoration of patients to the position they were in before suffering the damage.

### ***2.3. Reforming medical malpractice liability insurance by allowing the third party to claim for compensation***

61. Although the Law on Business insurance mentions the third party, it does not allow the third party to claim for indemnification directly.<sup>789</sup> The law does not specify any exceptions for the third party to claim directly. Liability of the insurer arises if the third party claims an insured person for indemnity of loss or damage caused by the insured's fault during the duration of the insurance.<sup>790</sup> Apparently, the third party's rights are not sufficiently taken care.
62. There are two systems that are focused on in this research. The systems are applied in Belgium and France, and they recognise the right of the third party to claim the damage with the insurer directly. In England, this applies when the insured party has become insolvent.<sup>791</sup>
63. Of the two systems, the Belgian and the French models seem more appropriate. The author posits that whenever the patients' benefits are sufficiently insured, the patients can directly claim for compensation from the insurers. This research finds the law related to default questionable, a fact which may have a negative effect on patients' interests if Vietnam adopted the system used in England.

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<sup>789</sup>Article 53.2 - Vietnamese Law on Insurance Business.

<sup>790</sup> Article 53.1 - Vietnamese Law on Insurance Business.

<sup>791</sup> See Third party (No.2.7) in Chapter 4.

64. The third party is an essential subject in MMLI because he is the one who will directly receive the compensation. Therefore, Vietnam should recognise the third party's rights, particularly the right to participate in claims where they are not adequately compensated directly.

#### *2.4. Supplementing more regulations on patients' rights*

65. As discussed in Chapter 6, compared to other countries in Europe,<sup>792</sup> the Vietnamese government has paid little attention to patients' rights while many important patients' rights have been largely ignored.
66. For the patient's rights to be protected and enhanced as a development policy, Vietnam should adopt and apply the patients' rights which are recognised in Europe but lacking under Vietnam's law such as:
1. *Right to preventive measures*
  2. *Right to free choice of treatment procedures and providers*
  3. *Right to respect for patients' time*
  4. *Right to the observance of quality standards*
  5. *Right to safety*
  6. *Right to innovation*
  7. *Right to avoid unnecessary suffering and pain*
  8. *Right to personalised treatment*

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<sup>792</sup>See: *Application of patients' rights regulations in Europe and Vietnam (No.3) in Chapter 6.*

The details of these rights may be drawn more from Belgium, France, and England. At the same time, they should be modified to suit Vietnam's conditions.

67. Besides that, the State should add more patients' rights:

9. *Right not to be declined service due to inability to pay.*

Article 16 of Vietnam's LMET states that patients have to pay the required fee for health examination and treatment as an obligation. If the patient cannot afford the fee, he/she will be refused treatment because paying the fee is his/her obligation. When a doctor fails to carry out his duty to the person who cannot afford the fee, s/he does not violate the law. Inability to pay for medical health services usually falls into the groups of the poor, the uninsured, and those who are dejected after lengthy treatment. The rule seems unethical for the noblest duty of health professionals is to save lives. Hence, this Article should be struck out. The researcher opines that the Government should create a fund or any unique financial support mechanism for the cases of patients who actually cannot afford health expenses, or/and, the Government can settle on some method for deferred payment.

68. In fact, for these rights to be applied, Vietnam should work comprehensively to improve other fields as discussed above. For example, to apply the right to free choice to treatment procedures, the health care law should also broaden the choice of the insured to use both public and private services as the patients wish. The same should encapsulate the right to the observance of quality standards. MM law has to define the standard of care too. Optimistically, the status of patients' rights protection will be nationally improved upon legislation and adoption of the extra rights as recommended.

69. Moreover, proposing national research on patients' rights protection is also a way for Vietnam to supplement the necessary rights which are not covered in the categories of Vietnamese patients' rights. Moreover, Vietnam should be a signatory to international human rights (including patients' rights) and patients' rights organisations to be updated on how patients should/may be protected.
70. Vietnam has up to now lacked the rules protecting the rights of patients. Alongside that, patients also do not realise that they are not adequately protected. Therefore, the enactment of a full set of patient rights is a requirement that the State should pay particular attention. To complete it, the State should refer to recognised patient rights systems as the case is in Belgium, France, and England in addition to existing regulations. This research found out that the rights listed above have not been recognised in Vietnam yet they are indispensable and need to be implemented.

### **3. The other medical malpractice provisions and related factors that Vietnam should change, supplement, and modify to be fit Vietnam' context**

#### ***3.1. Reforming the healthcare system***

##### ***3.1.1. Advanced medical human resources***

71. To train and have qualified health professionals, the State should design a uniform medical education system. In the whole country, there are very few universities which meet international standards in educating and training medical professionals while the demand is rather high.<sup>793</sup> It is

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<sup>793</sup> *Top 12 Best Medical Universities in Vietnam, 2017;*

also necessary to have exchange programs for human resources in this field with practitioners going abroad to learn and advance their knowledge and skills.

72. Moreover, the State needs to monitor the training establishments strictly to make sure that the medical education programs are meeting the stipulated standards. On the other hand, the State needs to design a training program with more chances for health practitioners to practice and realise their professional skills.
73. At the moment, Vietnam does not have any organisation to evaluate the proficiency of health care practitioners to determine whether they are qualified to start their careers or not. Currently, medical professionals, only need to complete the practising duration in medical examination and treatment establishments, but specialists do not professionally evaluate them.<sup>794</sup> Hence, establishing a board of quality assessment for health care providers is necessary.
74. As a matter of fact, many medical education establishments do not have their hospitals. The circumstance shows that their staff and students have nowhere to practice and they end up focusing a lot on the theoretical aspect of their training. Consequently, as mentioned above, many universities/colleges focus on theory, yet practical training is also vital

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<http://toplist.vn/top-list/truong-dao-tao-y-duoc-tot-nhat-o-viet-nam-16273.htm>

<sup>794</sup> Article 24.3 - Law on Examination and Treatment - No. 40/2009/QH12;

Persons who have diplomas related to medical profession, granted or recognized in Vietnam, must pass the practicing duration at the following medical examination and treatment establishments before being granted the practicing certificates:

- a) 18 months practicing in hospitals or research institutes (hereinafter referred collectively to as hospitals) for doctors;
- b) 12 months of practice in the hospital for the doctor;

for medical professionals. Having a well-equipped hospital should be a compulsory pre-condition to opening a medical education establishment (university/college).

### ***3.1.2. Stabilize the quality of public and private hospitals***

75. The differences in the quality of services between public hospitals and private hospitals have an enormous impact on the choice and use of services by patients. When faced with a health problem, the patient must consider where he or she might access qualified doctors and modern equipment to ensure that his/her case is handled correctly. As a result of the lack of quality as well as uniform standards of service in Vietnam, patients sometimes have to travel abroad in search of better health care services which is costlier compared to Vietnam. Moreover, in case of emergencies, this lack of reliable facilities can cause serious health complications and even fatalities of patients. Therefore, the State should come up with a uniform policy for constructing medical establishments that cut across the entire country. To achieve this, the State, of course, has to prioritise the financing of the health sector to provide enough health professionals and medical facilities.

### ***3.1.3. Invest more in medical equipment and technicians***

76. The Government and the hospitals should develop plans to invest in equipment that meet professional needs. Many hospitals in Vietnam, especially the hospitals in remote areas and level I and level II hospitals (explained in Chapter 1) lack medical equipment. The available medical equipment is of low quality or outdated and does not meet the requirements for treatment of patients.

77. Most level I and II hospitals meet 20% of medical equipment requirements. Around 30% -50% of equipment of level III and IV hospitals meet the standards. The deficiency focuses on surgical lights, ultrasound machines, haematology instruments, and respirators among others.<sup>795</sup>
78. For instance, every day, Radiology Department of K Hospital must conduct radiation therapy to more than 1,000 patients, and due to insufficient machinery, the treatment must be divided into three shifts: morning, afternoon, and night. Each shift must work continuously from eight to ten hours to treat more than 300 people, which is six times higher than the standard of operation specified by the manufacturer.<sup>796</sup>
79. Moreover, training technicians to explore all functions of new and modern equipment is also essential. Failure to do so would be harsh to avoid a situation whereby costly equipment is available, and it is not being used effectively. In recent years, with financing sourced from various sources, including State capital preferential loans from the World Bank, ADB, ODA, and aid from international organisations such as WHO, UNICEF etc. Medical equipment at health facilities has been raised both regarding quantity and quality. The raise has made an essential contribution to improving the quality of medical examination

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<sup>795</sup> *District Hospitals Lack of Medical Equipment*, 2015;

<https://tuoitre.vn/benh-vien-tuyen-huyen-con-thieu-thiet-bi-y-te-997303.htm>

<sup>796</sup> *Cancer Patients must be Treated at Night in Hospital K deal to Lack of Facilities*, 2017;

<http://vtv.vn/trong-nuoc/benh-vien-k-thieu-trang-thiet-bi-y-te-benh-nhan-ung-thu-phai-dieu-tri-vao-ban-dem-2017121718420047.htm>

and treatment and contributed to the reduction of overcrowding in higher level hospitals.<sup>797</sup>

#### ***3.1.4. Reduce work pressure and raise income for health providers***

80. In Vietnam, overcrowding in provincial and central hospitals has been severe. A doctor must examine about 70-80 patients a day. On average, every three minutes, a doctor must finish the examination, treatment, and prescribe for a patient. Instead of working for eight hours at a time, their work hours can stretch up to 10-16 hours per day.<sup>798</sup> Also, it is somewhat typical for a doctor to have more than fifteen operations a day. According to the doctors, they have to work five times more than the recommended limit of exertion.<sup>799</sup>
81. As a result, the doctors end up exhausted, and they have no time to upgrade their professional knowledge. Moreover, the overexertion and related fatigue strain their relationship with patients and in some instances leads to medical incidents/accidents. Hence, it is time for the state to restructure working hours to reduce the workload of doctors and at the same time increase their income. Consequently, the doctors are left

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<sup>797</sup> Thanh Hang, *Inadequate Skilled Technicians, Modern Medical Equipment Lost Value*, CNN, 2015;

<http://cand.com.vn/y-te/Khong-du-trinh-do-su-dung-thiet-bi-y-te-hien-dai-cung-mat-gia-tri-371556/>

<sup>798</sup> Nguyen, T. C., *Pressures on Doctors*, VNExpress, 2015;

<http://suckhoe.vnexpress.net/tin-tuc/suc-khoe/tu-su-cua-bac-si-cap-cuu-ve-ap-luc-voi-thay-thuoc-vn-3176759.html>

<sup>799</sup> *Doctors of Central General Hospital Exhausted because of Overwork*, Dan Tri, 2005

<http://dantri.com.vn/xa-hoi/bac-si-benh-vien-trung-uong-kiet-suc-vi-qua-tai-1119524061.htm>

with sufficient time to improve and upgrade their professional knowledge and skills.

82. The State should consult other countries such as Belgium, France, and England where a total number of hours worked by a healthcare practitioner is capped at maximum 48-hours per week.<sup>800</sup> The Law should also regulate appropriate workload. For example, some examinations, treatments, and surgeries per day for a physician should be determined.
83. The defined goal must be a reduction in working hours and workload for all doctors at all levels in the hospital services to a level sustainable for a healthy work-life balance for staff and safe care for patients. Tired, inexperienced, and poorly supervised junior doctors make more mistakes than both those who are more rested and adequately supervised.<sup>801</sup> Therefore, reconstructing the health care system is essential. Some of the factors that should be paid more attention to in reforming the health sector are that the State should ensure availability of enough health care providers, health establishments, and medical equipment. These things, of course, are not easy to avail/achieve, but they cannot be wished away in the quest to improve quality in the healthcare system of Vietnam.
84. Despite all this strain, doctors' incomes are rather low compared to what they give regarding professional person-hours. On average, a graduate doctor working in a public hospital earns less than two hundred euros per

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<sup>800</sup> Temple, J., *Resident Duty Hours around the Global: Where Are We Now?* Vol. 14, BMC Medical Education, 2014, p.1.

<sup>801</sup> Temple, J., *Resident Duty Hours around the Global: Where Are We Now?* Vol. 14, BMC Medical Education, 2014, p.1.P.5.

month.<sup>802</sup> Extra income may be gotten through other means such as working overtime and performing more operations. To make more money, they have to look for extra opportunities such as working in private clinics or opening private practices.

85. Increasing the minimum basic salary and giving special financial support should form part of the government's plan for comprehensive improvement of the health sector. Belgium, France, and England are a typical example of countries that pay their physicians well.<sup>803</sup> Although better pay for physicians in these countries may be attributed to the vibrancy of their economies, they deserve to be well-paid because they exam, treat, and promote health for people. They also conduct research, improve or develop concepts, theories, and operational methods to advance evidence-based healthcare.<sup>804</sup> Therefore, Vietnam has no reason to be indifferent to the role of healthcare professionals in falling to make them have a stable and commensurate income. Once physicians are more specialised in their work, they spend more time in researching and developing their skills hence contributing to the reduction of the crisis of MM claims.

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<sup>802</sup> Lam Phong, *How much Doctor Paid?*, 2016;

<http://news.zing.vn/luong-cua-bac-si-la-bao-nhieu-post660758.html>

<sup>803</sup> Sabin, S., *The 10 Highest Paid Countries in the World for Doctors*, 2016;

<https://medicfootprints.org/10-highest-paid-countries-world-doctors/>

<sup>804</sup> *Transforming and Scaling Up Health Professionals' Education and Training: World Health Organization Guidelines*, 2013;

<https://www.ncbi.nlm.nih.gov/books/NBK298950/>

### 3.1.5. *Strengthen social health insurance*

86. It was confirmed that in 2016, the current national health insurance scheme covers an estimated 71% of the population.<sup>805</sup> It means that 29% of the population (more than 27 million people) in Vietnam has not been insured. The uninsured people can be divided into two groups.
87. The first group of uninsured people is the poor who cannot afford insurance premiums. This situation has put the uninsured people at financial risk in the event of the health services' fees increasing threefold compared to the status quo.<sup>806</sup> Therefore, to solve this problem, the Government needs to react quickly so that the uninsured segment of the population can have health insurance soon. The author contends that it is possible to classify uninsured groups depending on their incomes. It would be prudent to allow them insurance at a lower cost than the general base and also let them make payments in instalments. Besides, people who have no stable/predictable income (including children, the elderly, and the unemployed) should get free SHI or pay a nominal amount.
88. Secondly, among those who do not have SHI, there are those who are not aware of the role of SHI. So, the Government should disseminate information on the benefits of SHI and SHI's policies and laws. Dissemination of information (civic education) should pay particular attention to the lowly educated, poor people, and or those who live in remote and isolated areas. Based on the fact that these people do not

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<sup>805</sup> Rousseau, T., *Vietnam: Social health Insurance*, Project Collaborator COOPAMI, 2010, p.13;

<sup>806</sup> Circular No. 02/2017 / TT-BYT, from 1 June 2017, public health facilities will officially apply new hospital fees to more than 1,900 health services for the target group.

understand the benefits of having SHI and cannot easily access it, the Government should find out and use the best means to help these people access SHI. For example, means such as information exchange between SHI professionals and the mass media, use of flyers, posters, banners, and brochures, etc.

89. In addition, for the whole country, the Government should have a universal solution to maintain the number of the insured and attract the uninsured. The Government should raise the quality of medical examination and treatment to ensure the benefits for the insured by further consolidating and perfecting the system of medical examination and treatment establishments from four levels (commune level, district level, provincial level, and central level). Health care providers need to enhance their qualifications regularly. Concurrently, there is a need to ensure that the medical establishments have necessary facilities for primary medical examination and treatment. These should be the top priority conditions for the medical establishment to be licensed.
90. Along with that the health care practitioners and providers should continue to review the mode and attitude of serving patients. In Vietnam, especially in the public hospital system, the mechanism of “asking for or giving away” is still quite common. The situation makes patients feel insecure and anxious when they go to the public hospitals. That is why they avoid using health care services paid for by the SHI, even when they have SHI. Hence, they have to pay for private medical care to feel secure and comfortable.
91. Also, the Government should pay more attention to reforming the administrative procedures, enhancing the application of information technology in medical examination and treatment, etc. This proposal is

because patients using SHI have to wait quite long when there is a need for medical examination and treatment, due to a large number of patients but the service teams are not enough. Besides, some hospitals have not applied information technology in the management of patients' information but still rely a lot on paperwork.

### ***3.1.6. Realize the model of family doctor model***

92. Realizing the model of family doctor is a priority for the health sector in Vietnam. Yardstick models, for instance, Belgium, France, and England need to be studied regarding their relevance to Vietnam's developmental conditions. There are three core issues in the development of a family physician model in Vietnam today. These include taking the direction of educating family doctors, acknowledging their practice as being legal and patients' approaching this model. In Vietnam, the research uncovered three differences from Belgium, France, and England which are also Vietnam's challenges.
93. Admittedly, to become a GP in Belgium, France, and England, GPs have to undergo advanced study and training. At the same time, the GPs in these countries have been built over a long time and have definite plans and directions for their existence and development to ensure the promotion of the role of GPs in the healthcare sector.
94. In Belgium, a General practitioner (GP), or a family doctor is a physician specialised in general practice. To be certified as a family doctor, GPs must have completed medical studies, including specialized training and an internship and have attended different seminars for in total at least 40 hours each year. To become accredited, doctors need to enrol for continuing medical education, participate in a local quality circle and

have more than 1250 encounters with patients per year.<sup>807</sup> The physician does not work in a hospital but in primary health care and may also carry out home visits. As a rule, the GP is the first contact for anyone faced with a health issue. The GP can refer the patient to a specialist when needed.<sup>808</sup>

95. France also has a GPs model similar to that of Belgium. The GP has to undergo six years. Undergraduate training whose curriculum includes mandatory training in a general practice setting, which lasts 1.5 months (full-time equivalent). In addition, they have to take a 3-year postgraduate course whose curriculum includes two years of training in a hospital setting (with a mandatory six month period at a university hospital), and 6 to 12 months at a GP surgery.<sup>809</sup> The first line of healthcare in France is provided by family doctors or GPs (*médecins généralistes*). These doctors are mostly self-employed and work either alone or in group practices.<sup>810</sup>

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<sup>807</sup>T. Cartier, L. Ryssaert, and Y. Bourgueil, *Building Primary Care in a Changing Europe: Case studies, Belgium*;

<https://www.ncbi.nlm.nih.gov/books/NBK459000/>

<sup>808</sup> *Regulated Healthcare Professions in Belgium*, 2016;

<https://www.health.belgium.be/en/health/taking-care-yourself/patient-related-themes/cross-border-health-care/healthcare-providers-0>

<sup>809</sup> Letrilliart, L., Rigault-Fossier, P., Fossier, B., *Comparison of French Training and Non-training General Practices: A Cross-sectional Study*, BMC Medical Education, Vol. 16, 2016, p. 2.

<sup>810</sup> *The Guide to French Healthcare System*;

[https://www.expatica.com/fr/healthcare/french-healthcare-france-health-care-system\\_101166.html](https://www.expatica.com/fr/healthcare/french-healthcare-france-health-care-system_101166.html)

96. England also has a GP model just like Belgium and France. Entry to medical education can occur in two ways. First, students can either access medical schools directly from secondary school (which is the traditional way with students usually pursuing 5-6 years of studies to obtain their degree). Second, after having received a first bachelor's degree (in which case they may be able to complete their degree in 4 years only). Following this qualification, new medical graduates follow a 2-year period of Foundation Training. During that time, they rotate every 3 to 4 months between different specialities. The first year leads to registration with the General Medical Council. The completion of the second year allows the trainee to apply for special training programmes. After having undertaken this Foundation Training, these physicians in training can choose between specialist or a general practitioner clinical training route, which can last between 3 to 8 years depending on the area of specialisation. Hence, to become a doctor in England, on average, a student can expect between 10 to 15 years of university education and post-graduate training.<sup>811</sup> Postgraduate training is undertaken to become a general practitioner and has changed significantly since the National Health Service was formed in 1948. It had been the case that once a doctor had completed medical school, no formal training was required to work as a general practitioner. It was common for young doctors having spent some time in hospital medicine practice to serve as apprentices to family doctors to learn the trade and eventually set up a practice of their own or join another doctor in partnership, often taking over from a

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<sup>811</sup> Health Workforce Policies in OECD countries, *Trends in Medical Education and Training in the United Kingdom*, General Medical Council, 2011, p. 1;

<http://www.gmc-uk.org/publications/10586.asp>.

retiring doctor.<sup>812</sup> In 2008, it became compulsory for all new doctors entering general practice to complete a three-year postgraduate training programme, involving an exit examination and become members of the Royal College of General Practitioners (RCGP).<sup>813</sup>

97. GPs deal with a whole range of health problems. They also provide health education, offer advice on smoking and diet, run clinics, give vaccinations and carry out simple surgical operations. GPs usually work in practices as part of a team that includes nurses, healthcare assistants, practice managers, receptionists, and other staff. Practitioners also work closely with other healthcare professionals, such as health visitors, midwives, mental health services, and social care services. If the GP cannot deal with a problem, the patient will usually be referred to a hospital for tests, treatment, or to see a consultant with specialist knowledge. GP practices are required to make information about their services readily available to their patients. Most practices have a practice leaflet available - please ask for one.<sup>814</sup>
98. Quite different from Belgium, France, and England, the model of family doctor is not officially available in Vietnam. Hence, it is very difficult for setting up the model. The new tasks that Vietnam needs to consider

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<sup>812</sup> Tait I. *History of the College. Royal College of General Practitioners*, 2002 [online], the Archivist, 2012;

<http://www.rcgp.org.uk/about-us/history-heritage-and-archive/history-of-the-college.aspx>

<sup>813</sup> Patrick, H., *General Practice in the United Kingdom - A training Evolution*, Rev Bras Med Fam Comunidade. Rio de Janeiro, Vol. 9, 2014, p. 79-80.

<sup>814</sup> *NHS General Practitioners (GPs) Services*, 2016;

<https://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/NHSGPs.aspx>

are the direction of educating family doctors, acknowledging their legal practice, and patients' approaching this model.

99. The first task is to restructure the education system in medicine. Currently, it takes six years to graduate with a bachelor's degree in medicine. After that, to become a specialist, the physician must study for two more years. The physician must pass the prerequisite examination.<sup>815</sup> Very different from other countries, Vietnam seems to forget the practical training of doctors to improve the professional skills is extremely important after graduation. Evidently, the law does not regulate practising and training as compulsory when the physicians work in health medical establishments.<sup>816</sup>
100. Recently, the framework of the new national education system was promulgated by the Government, and the training duration at the university was reduced to 1 year, from 3 to 5 years, instead of 4 to 6 years. Based on the capacity framework required by the Government. The training for the medical sector is four years, equivalent to a Bachelor's degree and six years for a Master's degree. According to the new proposed training model, medical students who study for six years only will gain the first stage of medical training. To be fully qualified in the speciality of choice, the students must take one or two more sessions (3 to 5 years or more) to complete a medical training program. At that time, new learners can practice independently according to their specialisation. Continuing education will train a team of doctors who are more specialised and effective in medical examination and treatment. For

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<sup>815</sup> Decision on Promulgating the Regulation on Training on Internal Doctors, No. 19/2006/QĐ-BYT.

<sup>816</sup> Law on Medical Examination and Treatment.

those who choose to become GPs, they will have to take two more years to obtain a Medical General Doctor certificate. After acquiring the certificate, the physicians have to spend another year practising in hospitals. After that after one year of practice in a hospital, the physicians have to pass a practising exam to be allowed to start to work as a GP.<sup>817</sup> If this proposal is made, this certificate must be implemented rigorously. In other developed countries, there is an independent capacity assessment body. Usually, it is the state medical council which does not involve schools. Candidates must pass the examination of this board to practice medicine. This change should be accompanied by medical educational reorientation so that the family doctor model can be successfully implemented.

101. The second task is that of acknowledging doctors' legal practice. According to the research findings, there are significant contradictions in the application of and granting of practice certificates and the scope of operation of two provisions of laws such as LMET and the Circular on Pilot guidance for GP and GP establishment.
102. Based on LMET, conditions for a physician to obtain a medical practising certificate is that the physician must have professional diplomas granted or recognised in Vietnam<sup>818</sup> and must practice 18 months in hospitals.<sup>819</sup> Meanwhile, it is stricter in as per the Circular on

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<sup>817</sup> *Proposal of the Department of Science, Technology and Training - Ministry of Health in the Seminar on Renewal of Training Human Resources for Health;*

<https://tuoitre.vn/dao-tao-y-khoa-trong-4-nam-phai-thi-hanh-nghe-1329666.htm>

<sup>818</sup> Article 18, 1.a, Law on Medical Examination and Treatment.

<sup>819</sup> Article 24, 1.a, Law on Medical Examination and Treatment.

Pilot guidance for GP and GP establishments to obtain the medical practising certificate. It states that applicants would like to gain a certificate of practice of family doctors, the applicant must have at least a diploma of general practitioner and one of the first specialist-degree (equivalent to a master's degree) or a second specialist-degree (equivalent to a PhD degree); a certificate of family medical examination and a certificate<sup>18</sup> consecutive months or more practising at general hospitals.<sup>820</sup>

103. Although the regulations of the Circular on Pilot guidance for GP and GP establishment are stricter than LMET, the scope of work of physicians who are allowed to open a health medical establishment is wider (can provide all health services which Law does not prohibit in health examination and treatment) than the rest. While, the scope of work of a GP according to the Circular is defined as that “the family doctor has the function of medical examination, treatment, management, protection, care and improvement of health for individuals, households, and communities.”<sup>821</sup> Therefore, the Circular seems to discourage the development of GPs rather than motivating it. The State should, therefore, adjust the Law to balance conditions necessary for one to achieve a medical practice certificate and their scope of work.
104. The third challenge is that people are not familiar with the family doctor model. As a matter of habit, they go to private clinics or hospitals for medical examination and treatment. Therefore, there is a need for people to have access to this model, especially in the field of primary health care. There are possible solutions to this problem. For instance, quality

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<sup>820</sup> Article 6, 1.a and 1.b, Circular on Pilot Guidance for GP and GP Establishment, No. 16/2014/TT-BYT

<sup>821</sup> Circular on Pilot Guidance for GP and GP Establishment, No. 16/2014/TT-BYT

assurance, availability of highly skilled human resources, modern medical equipment availability, minimisation of waiting time and reasonable cost, etc.

105. Family physician's services will reduce the time and work burden for the specialists concerned and save patients hospitalisation costs while enhancing health insurance and economic benefits.
106. In cognisance of the benefits of having the family doctor's clinic model, recently, Vietnam has developed the Project "Building and developing a family doctor's clinic from 2013 to 2020".

1. The 2013-2015 period will be piloted in eight provinces and the cities of Hanoi, Ho Chi Minh City, Hai Phong, Can Tho, Thai Nguyen, Thua Thien Hue, Khanh Hoa, and Tien Giang.

2. The 2016-2020 period is projected to replicate the model nationwide.

Hopefully, when this model is fully implemented, it will bring into full play its real benefits

### ***3.1.7. Eliminate corruption***

107. In the health sector, three areas can be considered to be at high risk of corruption. First, corruption occurs often in the management area such as medical licensing, buying medical facilities, and medical recruiting. Secondly, physicians receive "extra thanks envelope" from patients, and over-prescription of drugs due to 'unclean eating' between health care workers and drug companies while the third area is SHI. People in charge

of insurance dishonestly reimburse to patients, use of inferior quality drugs, and personally profit from the insurance fund, etc.<sup>822</sup>

108. If Vietnam is serious about transforming its health sector as the primary strategy of the country, it should seriously focus on eliminating corruption from the system. Mainly, all forms of corruption in the three mentioned areas should be prevented and ended. At present, Vietnam seems to have quite adequate provisions on sanctions related to corruption such as the Law on Administrative Penalties, Civil Code, Criminal Law, and other relevant regulations depend on a level of infringement. However, the application of these rules to eliminate corruption in the health system has not been strict. Therefore, enforcement of the law is necessary to eliminate corruption in the healthcare sector.

***3.2.Reforming medical malpractice liability insurance by revising the Law of Medical malpractice liability insurance as a compulsory insurance***

109. The decree on Liability Insurance in Medical Examination and Treatment, No.102/2011/NĐ-CP cannot be realised as presented in Chapter 4. It can be said that Vietnam issued this Decree in a hurry without evaluating the actual developments in the health sector. Firstly, hospitals do not have the funds and are not supported by the state budget to purchase insurance coverage. As a result, the hospitals fail to purchase liability insurance. Secondly, the State has not enacted the provisions of liability insurance to assist insurance companies in developing this

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<sup>822</sup> Minh Quang, *Serious Corruption in Medical Section*, Tuoi Tre, 2009;

<http://tuoitre.vn/tin/chinh-tri-xa-hoi/20091126/tham-nhung-trong-nganh-y-te-nghiem-trong/349888.html>

package. Hence, when it comes to implementation and practice, the inadequacies associated with peculiarities in the medical sector emerge. Finally, the Decree itself contains illogical rules (already discussed in Chapter 4) which may not be applicable in practice.

110. Based on these reasons, it is recommended that the Government should be:

***(1) Amending and supplementing the Law on Insurance Business as the central law of the medical malpractice liability insurance.***

111. Vietnam has used the Law on Insurance Business (enacted in 2000) with many unsuitable regulations. This law mainly focuses on the administration and management of the insurance companies but does not pay enough attention to the insurance transactions between the insured and the insurers.

112. For instance, the concept of insurance contracts is too vague which does not define the characteristics of the types of insurance. It states:

*“An insurance contract means an agreement between a purchaser of insurance and an insurance enterprise, under which the purchaser of insurance must pay a premium and the insurance enterprise must pay insurance proceeds to the beneficiary or indemnify the insured person on the occurrence of the insured event.”*

The types of insurance contracts shall comprise:

- (a) Contracts of personal insurance;
- (b) Contracts of property insurance;
- (c) Contracts of civil liability insurance.

113. The objects covered by these types of insurance are not the same, but the provisions of the law do not clarify the differences. The objects covered by the insurance policy are life expectancy, life, health, and safety of the person. In the meantime, the subject matters covered by the property insurance policy include real property, money and valuable papers in money and property rights. The insured object of the contract of civil liability insurance is the civil liability of the insured person for a third party by the law.
114. In addition, although the Law on Insurance Business regulates civil liability insurance, it does not have any provisions on professional liability insurance too. This brings a difference from Belgium, France, and England laws which regulate provisions on professional liability. As a result of this loophole, the insurers create their own "insurance products" governed by their own rules. This is more often than not tends to benefit the insurers but not the insured.

***(2) Revise the Decree on Liability insurance in Medical Examination and Treatment.***<sup>823</sup>

118. The Decree is very sketchy, and it contains several unsuitable regulations. For example, the Decree does not define the concept of medical professional liability insurance as well as regulate the third parties' rights. Also, there is a problem in that the Decree only admits one kind of trigger, a claims-made policy. Evidently, it provides that the insurer will compensate claims arising before the effective date of the policy.<sup>824</sup>

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<sup>823</sup> No. 102/2011/ND-CP.

<sup>824</sup> Article 6.2 - Decree on Liability Insurance in Medical Examination and Treatment

***(3) Extending the deadline of the Decree***

115. In addition to attempting to answer the current questions, the State should extend the deadline for health professionals to purchase liability insurance. The Decree stated that by December 31<sup>st</sup> 2017, all health care providers must purchase professional liability insurance. In fact, this is not possible, and it is evident that many health institutions have not yet undertaken this liability insurance. To provide an accurate renewal term, the Government needs to review the number of people who have not purchased insurance as well as the reasons for not having insurance.

***(4) Defining the sanctioning regulations***

116. This research notes that in this regulation, there is no content related to sanctions when it is infringed, and this deficiency should be addressed. The researcher recommends that administrative sanctions such as fines, suspension of operations or withdrawal of a license depending on the severity of the breach may be some of the penalties for medical establishments without MMIL.

***(5) A new medical establishment must have medical malpractice liability insurance***

117. Besides, the Decree should apply right now as a mandatory requirement for health professionals who would like to be licensed to open hospitals or clinics. If the State continues to permit the establishment of new health establishments, MMLI cannot be compulsory insurance. This makes the compulsory process more difficult and time-consuming.
118. The Government should revise legal provisions relating to professional liability insurance including Laws on Business Insurance and the Decree on Liability Insurance in Medical Examination and Treatment. In particular, the Decree should be supplemented with specific provisions

of medical professions liability such as the medical liability insurance concept, the rights of third parties, and kinds of triggers (add more fact occurrence policies, loss occurrence policies).

#### 4. Conclusion

119. Repeating the concept of MM that occurs when a negligent act, an omission by a doctor or other medical professional results in harm to a patient. MM is a behavior which deviates from the generally accepted standard of care. MM is a form of professional negligence, which forms part of the law of tort.
  
120. With a truth that Vietnam has confronted to MM crisis. In particular, recently, there have been many severe cases that have occurred due to the negligence of the doctor. Not only Vietnam but also in the world have got shocked by the MM cases. Undoubtedly, the following cases caused both physical and emotional injuries for the patients. That was a doctor once amputated the healthy leg of a patient instead of the disease-stricken one;<sup>825</sup> another doctor removed the healthy kidney instead of the weak one;<sup>825</sup> expectant mothers have died because of delays in administering the necessary emergency aid;<sup>826</sup> children have died after being injected with wrong vaccines;<sup>827</sup> patients

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<sup>825</sup>Chi Quoc, *Wrongly Kidney Operation, Hospital Compensates Lifetime for Patient*, Tuoi Tre, 2017;

<http://tuoitre.vn/tin/phap-luat/20170629/cat-nham-than-benh-vien-boi-thuong-suot-doi-cho-benh-nhan/1340662.html>

<sup>826</sup>T. Luy, *The Hospital Caused Deaths of Mother and Child was Sued*, Soha, 2016;

<http://soha.vn/gia-dinh-to-benh-vien-tac-trach-lam-chet-ca-me-va-2-con-20160912204507444rf20160912204507444.htm>

<sup>827</sup>Quoc Nam, *Five 5 Years in Prison for the Nurse Caused Three Children's Deaths due to Mistaken Vaccination*, Tuoi Tre, 2015;

have died because of negligence during the installation and testing of kidney dialysis machines,<sup>828</sup> etc.

121. Understandingly, the crisis has happened because of other factors such as insufficiency of MM regulations, low access to health care services and health insurance, lack of medical facilities, low skilled and insufficient medical resources, and corruption in the health sector. Mainly, lack of or ineffectiveness of the current MM legal provisions makes Vietnam falls in the crisis of MM.
122. There is an arduous query that how does Vietnam confront and deal with this crisis? The Vietnamese government has tried to find and deploy suitable solutions, but these problems continue to bedevil the Vietnamese MM law. Quickly, the answer to the question is to study MM laws from other developed countries such as Belgium, France, and England is one of the great solutions. Explain for the choice of Belgium, France, and England to do a comparison with MM law in Vietnam, it should be the reasons. Vietnam has been influenced by the legal system of France because France used to invade Vietnam for many years (1858-1954). At that period, France built up the legislation in Vietnam with French pattern, particularly Civil Code. In addition, Belgium is an excellent example of MM law to learn. Belgium has a civil law that is similar to France, but it has introduced some differences such as health system, no-fault system, and liability insurance. On the other hand, England applies the common law which is different from Vietnam. However, there are

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<http://tuoitre.vn/tin/phap-luat/20150327/xet-xu-bon-bi-cao-vu-ba-tre-tu-vong-sau-tiem-vacxin/726095.html>

<sup>828</sup>*Eight People Died of Dialysis: Chemicals Uncleansed*, VietnamNet, 2017;

<http://vietnamnet.vn/vn/thoi-su/vu-8-benh-nhan-chay-than-tu-vong-quen-rua-hoa-chat-trong-duong-nuoc-380065.html>

several benefits from common law which Vietnam can study when reforming the judicial system.

123. The thesis investigates the legal systems in Belgium, France, England, and Vietnam about healthcare systems, MM laws, compensation systems, liability insurance, and patients' rights. MM laws keep a core position in the search and are complemented by the other contents. All the results of the research show the aim to answer the three research questions as well as the recommendations for Vietnam to study.
124. To MM law in Vietnam requires improvement in many respects. Among them, the change of the Government's outlook on reforming the healthcare system. This change is critical to correcting the medical malpractice crisis. This change should focus on improving the profession of health care providers. For health care providers to spend time improving their professional skills, their income has to be secure and lucrative. At the same time, the government should come up with solutions geared toward reducing working hours related. Also, the government should not underestimate the importance of proper investment in medical equipment for Vietnam faces a challenge of out-of-date equipment or ineffective use of available medical equipment.
125. Vietnam should expand SHI to minimise the number of the uninsured people. The number of uninsured people focuses on the poor and people who are not aware of the role of SHI. In addition, SHI should also focus on the people who do not trust the quality of health care services provided by SHI even when they are insured by improving the quality of expertise, health equipment, behaving politely with patients, and applying advanced technology in management, etc. The government ought to

work towards retaining the current insured population while working towards enticing more citizens to take up insurance.

126. It is time for Vietnam to adopt the model of family doctor because of its benefits. Family doctors can help physicians' services regarding reducing time and work burden for the specialists concerned while minimising patients' hospitalisation, health insurance, and economic costs. Developing a family doctor programme in medical education and modifying the law in licensing and regulating the practice of family physicians should be prioritised.
127. The insured people should have free choice of health care services. The State should abolish the four existing levels of hospitals and mandate the choice of the appropriate medical facility to the patient. The new system of healthcare should be divided into primary health care and secondary health care. By this change, the State can also tackle the health problem of overcrowding of patients in hospitals and ineffective utilisation of human healthcare resources and medical equipment.
128. Enforcement of the law is necessary to remove corruption in the healthcare sector. The corruption is a problem that inhibits comprehensive development in the health system in Vietnam.
129. The Government should pay particular attention to reforming MM law. The change ought to be consistent and reasonable. The said reform would eliminate the shortcomings in the MM law of Vietnam. As a matter of urgency, Vietnam should redefine the standard of care by defining the concept of 'standard of care,' forming the National Clinical Guideline, and establishing the Central Clinical and City Clinical Authorities.

130. In addition, the legitimate rights and interests of the patient are ignored when Vietnam fails to legalise the “loss of a chance.” For the determination of the physician's liability to be properly performed in the case of "loss of a chance," the theory of ‘but-for-test’ should be referenced. Also, Vietnam should consider the rate when applying the theory "loss of a chance."
131. Moreover, to reform MM law, Vietnam should have a Central Clinical Authority and City Clinical Authorities who work independently. These organisations can quickly respond to the needs of determining the responsibility of the physician when negligence occurs.
132. An essential work in reforming MM law is the recognition of the ‘no-fault’ compensation system. Adoption of this system would eliminate the restrictions in the tort compensation system. The Government should redefine the concept and ‘pilot apply’ in some cases (vaccination and blood transfusion) and extension of the scope after that and set up conditions applicable to compensation.
133. Viet Nam should add within its law pecuniary and non-pecuniary damage to ensure patient's compensation will be made satisfactorily. They would cater to the damage to future earning capacity or a chance to get a promotion (economic damage) and loss of enjoyment and the ability to have sex (non-economic damage).
134. In particular, when revising MILI, the State should place Insurance Business in the preferred position in which MMLI can apply its regulations. Besides, the policy on liability insurance in medical examination and treatment should be reformed too because it contains many unsuitable provisions. Moreover, for new medical establishments, MMLI should be a mandatory condition to be allowed to operate.

135. The research points out the framework for reforming the MM law with several key features in the health sector such as MM law, professional liability insurance, and patients' rights. Of course, the most critical work is to ameliorate the MM law.
136. Evidently, there is a need to reform MMLI. One of the targets of this work is to revise the law on MIL become compulsory to the healthcare providers and allowing the third party to claim for compensation.
137. The last recommendation is that the addition of more regulations on patients' rights is also an important part of the comprehensive change in the MM law of Vietnam. Vietnam should adopt and apply the patients' rights which are recognised in Europe but missing in Vietnam's law.
138. All recommendations can be positively applied in Vietnam. There are the recommendations that can be implemented based soon on Vietnam's current situation of development today. For example, the government can realise the model of family doctor, develop the legal concepts such as "standard of care," "loss of chance," add types of pecuniary and non-pecuniary damage, allow the third party to claim for compensations, and supplementing more regulations on patients' rights. These recommendations do not trouble much the government because they will not change the existed system and regulations. Moreover, it will not heavily cause the financial burden to the nation.
139. On the other hand, some recommendations need to be adapted step by step based on the country's factors such as the economy, human resource, the existed legal system. For example, to allow the insured to have a free choice in using health care services, the government has to ensure that all medical establishments must meet the standard in providing qualified healthcare providers and medical facilities. This will gain the truth of the

patient who will not discriminate healthcare levels (level I, II, II, IV as prescribed) and public/private hospitals. Another recommendation which is also need to follow the roadmap. That is the establishment of the no-fault compensation system. This system needs to be hugely financed by the government. Viet Nam is now giving priority to developing modern industry and infrastructure. However, healthcare is also a very important sector which maintains and protects people's health. As with other priority sectors, the government should take reasonable means to invest the country on synchronous development.

140. Hopefully, the recommendations stated above based on the comparative research on the MM laws of Belgium, France, and England as well the author's recommendations will be applicable in Vietnam.

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