Medical Malpractice: A Comparative Perspective Between China and the United States

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Abstract: At the beginning of the 1970s, the United States turned onto the winding road of medical malpractice compensation. With the goal of properly dealing with this issue, the United States embarked on a process of continuous reform. In recent years, the number of disputes over medical malpractice liabilities in China has increased considerably. However, dealing with these disputes in accordance with the provisions of the current law is not going smoothly, and maybe we can learn from the experiences of the United States. The relevant measures for the solutions to medical malpractice in the United States and China will be analyzed from a comparative perspective. These include enactments of medical malpractice, the classification of medical malpractice, the doctrine of liability fixation, the burden of proof, the criterion of judging negligence, the liability subject, the authentication system, expert witnesses, standards of compensation, and suggested reforms in the system of the medical malpractice liability, including stipulating the medical malpractice liability of administration in the Civil Code, optimizing the criteria of recognizing negligence, applying organizational fault liability, establishing pilot projects of no-fault medical liability, developing an open mechanism for medical malpractice disclosures and improving the capacity to deal with medical chaos.

Keywords: medical malpractice, medical malpractice liability, negligence, medical institutions, medical staff

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Introduction

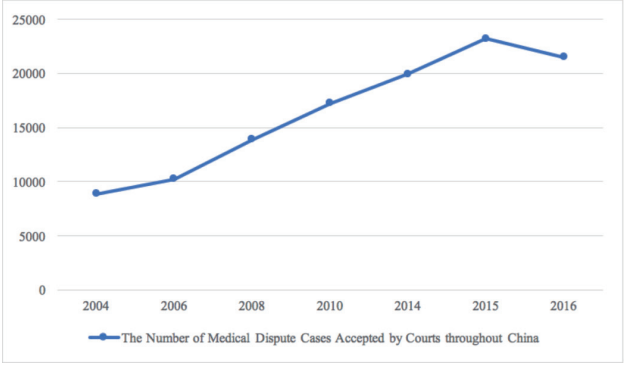
Dr. Michael J. Davidson, a cardiovascular surgeon with Brigham and Women's Hospital and a father of three was shot dead by Stephen Pasceri whose mother "had some issue" during a prior medical treatment in the hospital (Freyer, Kowalczyk & Murphy, 2019).

On the other side of the Pacific Ocean, there are more similar incidents. In 2008, Zhan's father died of sudden acute left ventricular failure when he was being treated in the Central Hospital of Ezhou. Then Zhan and other family members left the portrait of his dead father in the hospital's office, quarreled with the doctor, and threatened to hit the doctor by car.①

There is no doubt that medical disputes are closely related to medical malpractice.② The number of people who die each year from preventable medical mistakes in hospitals is more than the total number of Americans who died in the Korean and Vietnam wars. With as many as 100,000 deaths a year, medical malpractice kills almost as many people as AIDS, breast cancer, and motor vehicle accidents combined. Put another way, about 275 Americans may be dying every day because of preventable mistakes in hospitals alone (Gibson & Singh, 2003, p. 41). The number of medical malpractice lawsuits in China also has increased year by year, judging from the cases of medical disputes heard by the courts. The number of medical dispute cases approximately doubled between 2006 and 2016, as Figure 1 indicates.

This article will outline and analyze China's approaches to medical malpractice and compare them to the ways of the United States including the enactments of medical malpractice, the classification of medical malpractice, the doctrine of liability fixation and burden of proof, the criterion of judging negligence and liability, the authentication system, expert witnesses, the standards of compensation, and reform of the system of medical malpractice liability. Proposals will be put forward at the end of the article. Such as stipulating the medical malpractice liability of administration in the Civil Code, optimizing the criteria for judging negligence, and the application of organizational fault liability.

*FIGURE 1*③



① See "Typical cases of serious harm to medical order," Retrieved March 5, 2020, from http://www.nhc.gov.cn/wjw/xinw/xwzx.shtml.

② There are a lot of complicated reasons which lead to medical disputes. For example, medical chaos professionals. This article only focuses on medical malpractice.

③ Providing Judicial Guarantee for Building Harmonious Doctor-Patient Relations and Promoting the Construction of Healthy China—The Responses of the Person in Charge of the Research Office of the Supreme People's Court to Journalists' Questions on the Interpretation of the Supreme People's Court on Several Issues Concerning the Application of Law in the Trial of Cases Involving Disputes over Medical Malpractice Liabilities. Retrieved March 8, 2020, from http://www.faxin.cn/lib/lfsf/sfContent.aspx?gid=H5699.

The Enactments of Medical Malpractice

The Enactments of the United States

In the United States, there is no independent legal system for medical malpractice. It is usually dealt with as a general civil tort. The laws related to medical disputes mainly come from three aspects: First, federal laws, regulations and judicial precedents. Second, state laws, regulations, and judicial precedents. Third, the rules of federal and state courts. Although the common law system relies on precedents as the basis of trial, and there are only a few statutory laws which are not adequately specific, the main laws relevant to medical disputes at the federal level in the United States are quite complete, including the Federal Tort Claims Act, the Volunteer Protection Act, the Emergency Medical Treatment and Active Labor Act, the National Childhood Vaccine Injury Act and the National Practitioner Databank (Zhang & Li, 2009, p. 244).①

The above legislative framework clarifies the medical malpractice liability and the judgment principles of medical disputes from multiple perspectives, while the National Practitioner Databank completely records the lawsuits against medical practitioners and the payment of insurance.

The Enactments of China

The legislation regarding medical malpractice in China has gone through a path of two liability regimes, from administration to tort. A national regime of administrative liability for medical accidents was established by the Rules on the Handling of Medical Accidents and reformed by the Regulations on the Handling of Medical Accidents. Both enactments were administrative regulations drafted by the Ministry of Health of the People's Republic of China and promulgated by the central government (State Council) (Wang & Oliphant, 2012, p. 29). Responding to dissatisfaction about the low levels of compensation paid under the administrative liability regime, the Supreme People's Court began unobtrusively to allow injured patients access to higher compensation awards by recognizing their ability to bring their claim on the basis of tortious liability arising under the General Principles of the Civil Law. The dual system of liability and compensation for iatrogenic injury created chaos in practice. Then the Tort Liability Law of the People's Republic of China was adopted at the 12th session of the Standing Committee of the 11th National People's Congress on December 26th, 2009, coming into force on July 1st, 2010. And medical malpractice liability was stipulated as an independent chapter consisting of 11 articles, which was quite different from other countries. However, there were still some issues that needed to be clarified, such as whether inspections by medical association medical review boards should continue to be a prerequisite to suits against hospitals or whether plaintiffs in medical cases may rely on inspections carried out by judicial inspection organizations (Liebman, 2016, p. 119). Therefore, the Interpretation of the Supreme

① It should be noted that most medical malpractice in the United States is filed at the state level.

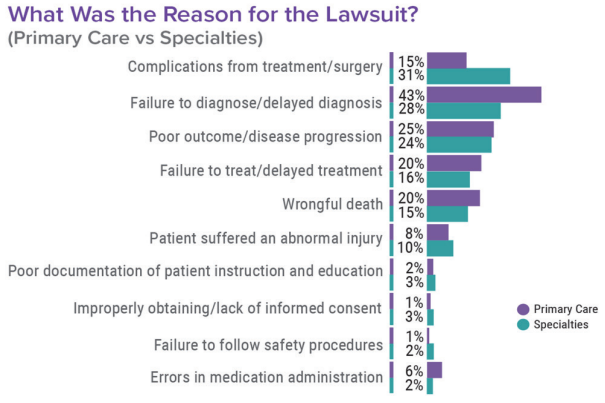
People's Court on Several Issues Concerning the Application of Law in the Trial of Cases Involving Disputes Over Medical Malpractice Liabilities was enacted in 2017.

The Classification of Medical Malpractice

The Classification of Medical Malpractice in the United States

According to the medical malpractice statistics of 2017, which were obtained through Medscape, the famous professional medical search engine website of the United States, the main reason why physicians were sued consists of complications from treatment or surgery, failure to properly diagnose, delayed diagnosis, poor outcomes, disease progression, failure to treat, delayed treatment, wrongful death, abnormal injury, poor documentation of patient instruction and education, improperly obtaining or lack of informed consent, failure to follow safety procedures and errors in medication administration(Levy & Kane, 2017). (Figure 2)

FIGURE 2



The above reasons mainly cover the fields of diagnosis, treatment, and information provisions. So, it is not difficult to summarize that the categories of medical malpractice of the United States are respectively technical malpractice in diagnosis/treatment and malpractice in information management and notification. It is worth noting that errors in the medication and medical device also belong to the medical malpractice of treatment rather than product defects. Hospitals are generally exempt from strict product liability doctrines as stated in Restatement (Second) of Torts § 402A (Boumil & Hattis, 2017, p. 280). Because U.S. courts tend to identify medical institutions as the providers of medical services rather than the vendors of medicine or medical devices.①

The Classification of Medical Malpractice in China

Chinese scholars have concluded that there are four types of medical malpractice in China, including the medical malpractice of ethics, the medical malpractice of technology, the medical malpractice of products and the medical malpractice of administration. (Yang, 2009, p. 120).

First, the medical malpractice of ethics, which is stipulated in Article 55 and 62 of the Tort

① See Carmichael v. Reitz, 17 Cal.App.3d 958 (Cal.App.1971). Hector v. Cedars-Sinai Medical Center, 180 Cal.App.3d 493 (Cal. App.1986).

Liability Law, refers to situations where patients do not have access to comprehensive information or explanations of their illness, patients do not obtain timely and useful medical advice from the medical institutions and medical staff, patients' secrets about the illness are not kept confidential and a kind of treatment is taken or stopped without the consent of patients, etc.. To some extent, China's medical malpractice of ethics is similar to the medical malpractice in information management and notification of the United States.

Second, the medical malpractice of technology is stipulated in Article 57 of the Tort Liability Law. This kind of medical malpractice happens when any medical staff member fails to fulfill obligations of medical care up to the medical level at the time during the provision of medical care, such as the failure in testing, diagnosing of patients' condition, the choosing of treatment methods, the implementation of treatment measures, the tracking of progression of disease, the caring of postoperative patients, etc.. Obviously, the connotation and extension of America's technical malpractice in diagnosis/ treatment are also similar to China's medical malpractice of technology.

Third, the medical malpractice of products is stipulated in the Article 59 of Tort Liability Law. Unlike the United States, the medical malpractice of products is defined as independent medical malpractice in China, rather than a part of the medical mal-practice of technology. This practice has a lot to do with China's medical environment which is quite distinctive from America's.

Hospitals in the United States have the right to treat and diagnose, not to sell drugs. That is, hospitals merely diagnose and treat. Patients buy drugs in another pharmacy. Medical care and drug sales are essentially separate. The legal precedents of the United States also confirmed that hospitals were not the vendors of medical apparatus and instruments, but the providers of medical services.

While Chinese medical institutions have actually acted as sellers of medicine and medical devices for a long time. The mark-up of medicine and medical apparatus is a policy which began to be implemented in the difficult period of the 1950s in China. Under this policy, medical institutions, including non-profits, were allowed to sell medicine and medical devices to their patients at a higher price than the cost. The phenomenon of "drug-maintaining-medicine" has existed in China's medical environment for decades. Taking Shanghai as an example, the total revenue of state-own hospitals in 2007 was RMB39 billion, which consisted of: (1) government subsidy of RMB3.64 billion (9.5%); (2) income from the provision of medical services amounting to RMB16.94 billion (43%); (3) drug sales amounting to RMB17.51 billion (45%); and (4) income from other sources of RMB950 million (2.5%) (Wang, 2010). Medical service has become a sales-service hybrid transaction. In terms of patients' process of obtaining medical products, medical institutions and their medical staff are "acquisition intermediaries" (Dong, 2011, p. 202). In 2009, the State Council promulgated the "Opinions on Deepening the Reform of the Medical and Health System" which clearly pointed out that the mark-ups of medicine and medical apparatus should be canceled gradually. It took hospitals at all levels around China nearly ten years to abolish the

mark-up.[①]

Strictly speaking, the medical malpractice of products stipulated in the Tort Liability Law is not medical malpractice but product defects. There are evident differences between their liabilities, which will be described in the remainder of this article.[②]

Fourth, the medical malpractice of administration has not been explicitly stipulated by the Tort Liability Law. But in order to solve the medical malpractice cases that cannot be classified into the above three types of medical activities, the medical malpractice of administration was proposed and gradually adopted by the community of scholars and judicial practitioners. The medical malpractice of administration refers to medical malpractice caused by the violation of the norms and responsibilities of medical administration (Ai, 2020, p. 104). Such as the damage caused by medical staff's deserting their posts and hospitals' breach of security obligations. The failure to follow safety procedures in the United States is one of the types of administration malpractice in China.

The Doctrine of Liability Fixation and Burden of Proof

The Doctrine of Liability Fixation and Burden of Proof in the United States

The medical malpractice liability in the United States mainly adopts the principle of negligence liability under which the burden of proof lays on the patient (Hyman & Silver, 2011, p. 169). In order for a patient to recover in negligence, he or she must show five elements: (1) Duty. The plaintiff must show that a legal obligation extends from the defendant to this plaintiff for the injury. (2) Breach of Duty. The plaintiff must show that the defendant breached his duty to the plaintiff. (3) Cause-in-Fact. The plaintiff must show that the defendant's conduct was a cause-in-fact of the plaintiff's injury. (4) Proximate Cause. The plaintiff must explain that the defendant's negligent conduct is also the proximate cause of the injury. (5) Damage. The plaintiff must show that the defendant's conduct caused damages to the plaintiff (Vandall, Wertheimer & Rahdert, 2018, p. 192).

However, medical malpractice often involves complex diagnoses, treatment or other behaviors which are difficult for ordinary people to understand. In many operations, patients are even unconscious because of anesthesia, so it is too strict to require patients to bear the burden of proof for the defendant's medical malpractice. Therefore, many American courts apply the rule of "the thing speaks for itself" in medical malpractice lawsuits. If the plaintiff cannot provide direct evidence and the circumstantial evidence is sufficient to infer that the defendant has done the conduct of negligence

① From 2012 to 2013, the "zero mark-ups" policy of medicine began to be implemented in county-level state hospitals. From 2013 to 2014, several experimental units which carried out the "zero mark-ups" were built among some tertiary hospitals of provinces and municipalities. After 2014, the government began to speed up the implementation of the policy of abolishing the mark-up. By the end of September 2017, all public hospitals throughout the country have canceled the mark-up of medicine and medical apparatus.

② The reason why the Tort Liability Law adopted such provisions is that, on the one hand, when the Tort Liability Law was promulgated, the mark-up of medicine and medical apparatus has not been completely abolished nationwide, which means medical institutions still played the role of sellers, and on the other hand, it is for the sake of the interests of patients.

which led to the injury, the burden of proof would be transferred to the defendant. Then the defendant should prove the absence of negligence and causality. Otherwise, he or she must bear the liability for injury (Zhu, Zhan, Zhang, Chen & Chen, 2010, p. 130). In order to apply this rule, the following conditions must be met: First, in general, if it is not due to the negligence of a person, the accident usually would not occur. Second, the methods, tools or agents causing the accident are under the exclusive control of the defendant. Third, the accident does not occur on the basis of the voluntary act or negligence of the plaintiff. The most common instance in which the rule is invoked is the leaving of sponges or instruments in the operative site, but other examples, like failure to sterilize instruments or performing a procedure on the wrong patient can be cited (Shindell, 1966, p. 56).

Except for the principle of negligence liability, there is another doctrine of liability fixation in the United States—the principle of no-fault medical liability. Virginia in 1987, and Florida in 1988, became the first two states to pass medical malpractice no-fault programs.① The Birth-Related Neurological Injury Compensation Act in each state creates a compensation fund to cover participating physicians and hospitals for severe brain and spinal cord injuries resulting from obstetrical care (Latz, 1989, p. 495). However, it should be noted that the no-fault medical liability is not as same as the no-fault tort liability. No-fault tort liability refers to "no-fault liability", that is, the liability assumed by the special provisions of the law regardless of the actor's fault. It is mainly applied to the field of tort law while the no-fault medical liability is often applied as a non-tort model of liability. There are significant differences between the two in the scope of liability. For instance, the party who is liable for no-fault infringement often bears both economic and non-economic damages. Punitive damages can even be applied when the defendant's infringement is highly condemned. The no-fault medical liability does not include the compensation liability for non-economic damages and cannot apply punitive damages. In addition, even if the patient is at fault, it does not hinder full compensation. By contrast, the victim's own risk-taking can be the defense of no-fault tort liability (Lin, 2010, p. 184).

The Doctrine of Liability Fixation and Burden of Proof in China

For the United States, the principle of negligence liability is the foundation principle for medical malpractice, and the no-fault medical liability is the reform measure and development trend for medical malpractice. China, however, has taken a circuitous and tortuous path. (Figure 3)

In our view, Yangge Dance is an apt simile for this path. Yangge Dance is a popular folk dance in rural China. Its basic pattern is three paces forwards, followed by two paces back; then a step to the right, followed by a step to the left (Wang & Oliphant, 2012, p. 21).

① Virginia Birth-Related Neurological Injury Compensation Act and Florida Birth-Related Neurological Injury Compensation Plan.

FIGURE 3

Name of Legal Document	Classification	Doctrine of Liability Fixation	Burden of Proof (R N D C) ①
Rules on the Handling of Medical Accidents (Expired)		Principle of negligence liability	Plaintiff: R N D C②
Regulations on the Handling of Medical Accidents		Principle of negligence liability	Plaintiff: R N D C③
Some Provisions of the Supreme People's Court on Evidence in Civil Procedure (Revised)		Principle of presumption of negligence	Plaintiff: R D Defendant: N C④
Tort Liability Law	Medical malpractice of technology	Principle of negligence liability	Plaintiff: R N D C (3 Exceptions: inversion)⑤
	Medical malpractice of ethics	Principle of presumption of negligence	Plaintiff: R D C⑥
	Medical malpractice of products	Strict liability	Plaintiff: F D C⑦
Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes over Medical Malpractice Liabilities	Medical malpractice of technology	Principle of negligence liability	Plaintiff: R N D C (Authentication: N C)⑧
	Medical malpractice of ethics	Principle of presumption of negligence	Plaintiff: R D C (Authentication: C)⑨
	Medical malpractice of products	Strict liability	Plaintiff: F D C⑩ (Authentication: C)

The Criterion of Judging Negligence

The Criterion of Judging Negligence in the United States

In the medical field, the reasonable physician standard was adopted in the United States as the standard for duty of care to judge whether negligence existed in a physicians' practice. But it has been a long and complex process to determine the standard for a general reasonable physician.

① R: physician-patient relationship (the existence of medical behaviors); N: negligence; D: damage; C: causality F: product defects.
② There was no doctrine of liability fixation nor the burden of proof in the Rules on the Handling of Medical Accidents, so the courts dealt with medical disputes on the basis of the general principle of liability fixation in the General Principles of Civil Law and the general burden of proof in the Civil Procedure Law. See paragraph 2 of Article 106 of the General Principles of Civil Law.
③ Id.
④ Article 4 (8) of the Some Provisions of the Supreme People's Court on Evidence in Civil Procedure (Deleted by the Decision of the Supreme People's Court to Amend the Some Provisions on Evidence in Civil Procedures)
⑤ Article 58 of the Tort Liability Law.
⑥ Article 55(2) of the Tort Liability Law.
⑦ There is no specific provision in the Tort Liability Law. The provincial and municipal courts have explained the burden of proof, respectively. Most courts believe that patients should prove product defects and damage. Paragraph 1 of Article 10 of the Guidance Opinions of Beijing Higher People's Court on Several Questions of Hearing Medical Damage Compensation Disputes (Trial Implementation): "In case of medical products damage compensation disputes, the patient shall bear the burden of proof of product defects, damage results and causality." Paragraph 3 of Article 9 of the Guidance Opinions of Anhui Provincial Higher People's Court on Several Questions of Hearing Medical Dispute Cases: "In case of medical products damage compensation disputes, the patient shall bear the burden of proof of product defects and facts of damage."
⑧ Article 4 of the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes Over Medical Malpractice Liabilities.
⑨ Paragraph 1 of Article 5 of the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes Over Medical Malpractice Liabilities.
⑩ Article 7 of the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes Over Medical Malpractice Liabilities.

American courts put forward the locality rule in the 1880s. Under the original locality rule, one physician's actions are measured exclusively by the standard of care evidenced by other physicians in the same locality (McCoid, 1959, p. 569).

The locality rule has been dominant for decades. However, it also has been criticized and questioned because of its limitations. There was, then, an apparent trend to find a suitable substitute for the locality rule. Eventually, the locality rule was abolished and replaced by the national standard.①

There was another rule which was also firmly entrenched in legal practice: the customary practice rule. After the applicable locality rule had been determined, it was necessary to analyze the medical malpractice case in terms of the customary practice element of the standard of care. In medical negligence cases custom within the profession is, almost exclusively, the standard of care (Johnson, 1969-1970, p. 742).

The customary practice rule was then superseded by the accepted practice rule. This was because the local customary standard may narrow and evade the review and supervision of medical behaviors required by law and if customary practice is taken as the standard, physicians will be too conservative and lose the motivation to take better medical measures (King, 1977, p. 44).

In addition, in order to judge the existence of medical negligence more discreetly, courts in the United States have also adopted other rules, such as the respectable minority rule② and the material test rule (patient-oriented standards).③

The Criterion of Judging Negligence in China

The judgment of negligence in China is based on whether the medical party has fulfilled the reasonable obligations of diagnosis and treatment in medical activities. How to determine whether the diagnosis and treatment are reasonable is based on the provisions in Article 57 of the Tort Liability Law which states that the medical level at the time during the provision of medical care is the criterion for judging whether the reasonable obligation of diagnosis and treatment is fulfilled, which is called the abstract judgment criterion by scholars. However, there are no specific regulations on how to determine the "medical level for the moment". And scholars have not put forward a unified opinion.

In addition, according to the provision in 58(1) of the Tort Liability Law, laws, administrative regulations or any other provisions on the procedures and standards for medical care can also be used to judge. This is called the concrete judgment criterion by scholars.

Some scholars believe that there is a sequence of application between the above two criteria. First, whether the medical staff violated laws, administrative regulations or any other provisions on the procedures and standards for medical care need to be judged. If not, then whether they fulfill obligations of medical care up to the medical level at the time during the provision of medical care is

① See Brune v. Belinkoff, 235 N.E.2d 793 (Mass. 1968).
② See Downer v. Veilleux, 322A.2d 82,87 (Me. 1974). Chumbler v. McClure, 505 F.2d 489,492 (6th Cir. 1974).
③ See Canterbury v. Spence, 464 F. 2d 772 (DC Cir. 1972).

judged to determine whether there is negligence (Wu & Huang, 2010, p. 32). Other scholars deem that provisions on the procedures and standards for medical care are just one of the bases to identify the medical level (Zeng, 2016, p. 191).

In order to ease the dilemma of the criterion of "medical level for the moment" in judicial applications and make more scientific and legitimate judgments of the reasonable obligation of diagnosis and treatment, factors such as the urgency of the patient's condition, individual differences of the patient, local medical level and qualifications of medical institutions and medical personnel are regarded as comprehensive factors for consideration by Article 16 of the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes Over Medical Malpractice Liabilities.

The Liability Subject of Medical Malpractice

The Liability Subject of Medical Malpractice in the United States

There are many kinds of medical practice models in the United States, such as solo practice, group practice and employed physician practice (Masters, 2015). According to the different practice models, the liability subject of medical malpractice will be distinctive.

Solo practice.

Solo practice is described by its name—a practice without partners or employment affiliations with other practice organizations, which is strongly preferred by some internists. Although previously a common model, this type of medical practice is becoming less and less popular. Under this model, physicians have to bear the liability for their medical malpractice.

Group practice.

(Figure 4)

Group practice is typically divided into single-specialty and multispecialty practice. The characteristic of single-specialty practice is the presence of two or more physicians who provide patients with one specific type of care (i.e., primary care or a specific subspecialty practice), while multispecialty group practice is defined as offering various types of medical specialty care within one organization.

FIGURE 4

Types of Group Practice	Full Name	The Liability Subject
GPWW	Group Practice Without Walls	Group
PHO	Physician Hospital Organization	Group
MSO	Management Service Organization	Physician
ISM	Integrated Salary Model	Group
Equity Model		Group
Foundation		Physician

Employed physician practices.

Hospitals are liable for the negligence of their employees who cause injuries in the course of their duties. Where the physician is employed on a fixed salary, there is no problem in establishing that he or she is the hospital's employee and that the hospital is liable for his or her negligence. Even if a physician bills patients directly and not through the hospital, he or she may still be held to be an agent of the hospital. If the hospital has the right to control the method of practice or restrict his or her practice to patients, he or she may, even though he or she bills separately, subject the hospital to liability. A hospital which continues to allow a known incompetent to be a member of its active staff and treat patients, either privately or through the emergency room, may be liable if his or her privileges are not revoked. If a patient can show a negligent selection of staff, the patient may be able to recover damages from the hospital even though the physician is an independent contractor (Holder, 1975, p. 211, 213, 217).

Independent contractor.

Some internists work in independent contractor relationships. In this model, the practice (either solo or group practice) remains independent, but a facility and possibly clinical coverage is shared with other physicians or physician groups. These independent contractors have no choice but to pay for their malpractice by themselves.

The Liability Subject of Medical Malpractice in China

Public hospitals are the most widespread medical institutions in China and the most common places for physicians to practice medicine. Medical staff sign labor contracts with hospitals and become employees. There are very few doctor groups in China and doctors in these groups are almost always employees of hospitals at the same time.

Article 54 of the Tort Liability Law stipulates that, "Where a patient sustains any harm during diagnosis and treatment, if the medical institution or any of its medical staff is at fault, the medical institution shall assume the compensatory liability." As for the nature of this liability, most Chinese scholars harbor the idea that it is vicarious liability. That is, as employers, hospitals are only responsible for the medical malpractice of their employees. Thus, the range of liability of Chinese hospitals is more narrow than that of hospitals in the United States.

The Authentication and Expert Witness System

The Authentication and Expert Witness System in the United States

There is no medical technical authentication system in the United States. The courts mainly judge the existence of medical malpractice on the basis of the testimony provided by expert witnesses from both parties.[①] The key to determining whether there is medical malpractice is often the expert's professional

① Medical experts must appear in court as witnesses in the United States.

authority and a better understanding of the patient's condition. Some jurisdictions require that the expert is obliged to have recent practice or teaching experience. Such requirements, however, although narrow the field of possible experts, do not change the nature of the court's inquiry (Sage & Kersh, 2006, p. 176). Rule 702 of the Federal Rules of Evidence is the provision about testimony by expert witnesses, "A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if: (a) the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; (d) the expert has reliably applied the principles and methods to the facts of the case."

In the effort to diminish the number of malpractice suits filled without cause and to provide expert testimony without undue difficulty for those patients who do have legitimate claims, malpractice "screening panels" have been established in various areas of the United States. In all states except New Hampshire and New Jersey, these panels only give advisory opinions and in no case may a patient be compelled to submit his or her claim to a panel instead of going to court. And in some states, there are organizations which are known as "physician review committees" inside the medical society. When an action is filed, the physician will notify the insurance carrier and the committee which is appointed by the medical society. At a hearing, the physician and the lawyer will present their side of the issue and the committee will advise the defendant whether he or she should settle or defend the claim. These organizations are not designed as a solution to the medical malpractice issue or to assist patients by making a determination of the merits or justice of the claim. In fact, they just play the roles of advisers who bring forth proposals for physicians and insurers (Holder, 1975, p. 416).

The Authentication and Expert Witness System in China

The medical authentication system in China used to be quite confusing.

First, "technical authentication" was a central feature of the administrative liability regime of medical malpractice established by the Rules on the Handling of Medical Accidents.[①] This was the procedure by which a committee of medical experts, selected by the health administration (i.e., the responsible provincial, regional or municipal department of health), would investigate the circumstances giving rise to a claim and report their conclusions to the appropriate tribunal. A decision of a local committee could be appealed to a higher level (e.g., a provincial committee) but the outcome of the process was in practice binding on the tribunal (whether the health administration or a court), except to the extent that the court could remit the case to be reviewed either by the original committee or a higher-level committee (Wang & Oliphant, 2012, p. 31). However, there were huge conflicts of interest under this authentication system. The reason was that the technical authentication was organized by the health administration which was also the administrative authority of the hospital that was being sued.

① Article 11 of the Rules on the Handling of Medical Accidents.

Second, the right to organize medical accreditation was transferred from the health administration to the medical association by the Regulations on the Handling of Medical Accidents.[①] Nevertheless, it did not completely erase the administrative color of the medical authentication system. The medical associations still had close links with the health administration: though formally independent, in reality, the medical associations perform a semi-official role and were dependent upon the government at all levels, with leading positions in them being taken by leaders of the health administration departments. Consequently, the new authentication system was perceived to involve medical institutions "shielding" one another, and still tended to protect hospitals from liability (Wang & Oliphant, 2012, p. 34).

Third, the double-track medical authentication system has been established and has long existed in China.[②] The Supreme People's Court decided that a binary-structure system should apply to the process of authentication, depending on whether administrative or tortious liability was at stake. If, in civil proceedings pursued on the basis of medical accidents, the court decided-upon application by either party concerned or in the exercise of its own powers—that there should be a technical authentication, this would be conducted by a medical association prescribed by regulation. However, where an authentication procedure was required in a dispute over compensation for patient injury not attributed to a medical accident (i.e., in an action brought under the tort liability regime), a "judicial authentication" would be organized by the court itself, rather than by the health administration (as under the Rules on the Handling of Medical Accidents) or a medical association (as under the Regulations on the Handling of Medical Accidents). Under the administrative liability system, most technical authentications concluded that there had been no medical accident, and medical institutions were consequently exempted from liability to a large extent (Wang & Oliphant, 2012, p. 38). The absence of the authentication procedure in the Tort Liability Law and related judicial interpretations led to the increasingly separate and diversified operations in judicial practice.

Finally, the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes over Medical Malpractice Liabilities stipulates the procedure for medical authentication and ends the double-track authentication system, owing to the Interpretation's focus on selecting authentication experts rather than a certain authentication institution.[③] As long as an authentication expert has the ability of authentication and meets the requirements of authentication, he or she can be appointed as an expert in medical malpractice cases, regardless of whether the expert is from the medical expert base of the medical association or the judicial authentication institution.

In addition, the rate of appearance of authenticators during the trial of medical malpractice cases in China is extraordinarily low. Through the investigation of medical malpractice cases accepted by

① Article 20 and 21of the Regulations on the Handling of Medical Accidents.
② The Notice of the Supreme People's Court on the Trial of Civil Cases Involving Medical Disputes with Reference to the Medical Accident Regulations (Expired), Section II, para. 1.
③ Article 9 of the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes over Medical Malpractice Liabilities.

Changping District Court in Beijing in 2007, it is found that the rate of authenticator appearances in these cases was less than 1% (Cui, 2007). In order to change this situation, the Interpretation of the Supreme People's Court on Several Issues Concerning the Application of Law in the Trial of Cases Involving Disputes Over Medical Malpractice Liabilities has set adverse consequences for the authenticator's refusal to testify in the court without justifiable reasons.①

There is also an expert witness system in China, though quite immature. In the United States, the requirement of an expert witness in a medical malpractice case means that the plaintiff may lose if he or she cannot obtain one (Vandall, Wertheimer & Rahdert, 2018, p. 215). Unlike the United States, having access to an expert witness is not a determinant for the plaintiff to successfully recover damages.

The Standard of Compensation for Medical Malpractice

The Standard of Compensation for Medical Malpractice in the United States

Awards are meant to make the injury victim whole. This is the rationale for compensatory damages. Compensatory damage is a general category which includes payment for monetary losses, such as medical care, lost earnings, and other services that are directly attributable to the injury. Payment for nonmonetary loss is also a part of compensatory damages. However, the nonmonetary loss can be categorized under several headings. Depending on the circumstances of the case, these may include payment for pain and suffering, emotional distress, loss of companionship, loss of enjoyment of or a chance at life, and others. The object of compensatory damage is to make an individual as well off as before the injury occurred. When there is permanent damage to health, this cannot be accomplished by restoring the person to his or her original health. However, assuming that people get utility out of money as well as health, money is used to compensate for the loss of health. The rationale for payment for nonmonetary loss is that not all of the loss is monetary. Excluding payment for nonmonetary loss would reduce the potential deterrent effects of tort. Injuries can be painful. They can result in the loss of a lifelong partner. They can limit a person's opportunities for enjoyment of life, such as participation in nonprofessional sports (Sloan & Chepke, 2008, p. 108). Many states in the United States cap liability exposure for either non-economic or total damages. (Hyman, Black, Silver & Sage, 2009, p.355) (Hyman & Silver, 2011, p. 173, 174). (Figure 5)

FIGURE 5

State	Cap	Compensation
Louisiana	Total	$500,000 plus future medical expenses
New Mexico	Total	$600,000 plus future medical expenses

① Article 13 of the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes over Medical Malpractice Liabilities."

State	Cap	Compensation
Colorado	Total, non-economic	$1 million total; $300,000 non-economic
Indiana	Total	$ 1.25 million
Massachusetts	Total (hospitals); non-economic(all)	$20,000 total (non-profit hospitals); $500,000 non-economic (all defendants)
Nebraska	Total	$1.75 million
Virginia	Total	$1.95 million
California	Non-economic	$250,000
Idaho	Non-economic	$250,000
Kansas	Non-economic	$250,000
Montana	Non-economic	$250,000
West Virginia	Non-economic	$250,000, except $500,000 in death cases
Oklahoma	Non-economic	$300,000
Texas	Non-economic	$250,000-$750,000, depending on number and type of defendants
Nevada	Non-economic	$350,000
Ohio	Non-economic	Greater of $250,000 or three times economic damages, up to $500,000
Hawaii	Non-economic	$375,000
Georgia	Non-economic	$350,000-$I.05 million, depending on number and type of defendants
South Carolina	Non-economic	$350,000-$I.05 million, depending on number and type of defendants
Alaska	Non-economic	$400,000
Utah	Non-economic	$409,000
Illinois	Non-economic	hospitals
Mississippi	Non-economic	$500,000
North Dakota	Non-economic	$500,000
South Dakota	Non-economic	$500,000
Maryland	Non-economic	$650,000
Missouri	Non-economic	$350,000
Florida	Non-economic	$500,000, except $1 million in death cases
Michigan	Non-economic	$641,000
Wisconsin	Non-economic	$750,000

The Standard of Compensation for Medical Malpractice in China

The standard of compensation stipulated in the Regulations on the Handling of Medical Accidents is basically the same as the general standard of personal injury compensation, however, the disability compensation and death compensation which belong to mental damage compensation are lower than the general standard of personal injury compensation. Therefore, the standard of compensation for medical malpractice damage in China is also limited, which is the same as that in most states of the United States.①

There is no special provision in the Tort Liability Law to deal with the compensation for injuries arising from medical malpractice. Consequently, the general approach applicable to compensation for tortious personal injury, found in Articles 16 to 23 of the Law, is to be followed. Article 16 provides,

① As Figure 5 shows, most states in the United States impose limits on non-economic compensation.

"Where a tort causes any personal injury to another person, the tortfeasor shall compensate the victim for the reasonable costs and expenses for treatment and rehabilitation, such as medical treatment expenses, nursing fees and travel expenses, as well as the lost wages. If the victim suffers any disability, the tortfeasor shall also pay the costs of disability assistance equipment for the living of the victim and the disability indemnity. If it causes the death of the victim, the tortfeasor shall also pay the funeral service fees and the death compensation."

Compared with the United States, China's compensation standard is far lower. Moreover, there is a big gap in the amount of compensation between similar medical malpractice cases in China.

Medical Professional Liability Insurance

Medical Professional Liability Insurance in the United States

The United States was one of the earliest countries to develop medical liability insurance and it has established a relatively sound medical liability insurance system. About 10 states, represented by Florida and Colorado, have stipulated that medical professional liability insurance belongs to compulsory insurance. Medical institutions and doctors must participate in medical professional liability insurance when practicing. In the insurance laws of other states, medical professional liability insurance is not compulsory, but medical institutions and doctors' participation in medical professional liability insurance has become a basic condition for practicing. Therefore, almost all medical institutions in the United States have commercial medical professional liability insurance. For example, in California and Missouri, having medical professional liability insurance is a fundamental reference factor for medical institutions to obtain licences. In Indiana and New Mexico, although medical professional liability insurance does not fall within the scope of compulsory liability insurance provided by law, the State Act advocates medical institutions and medical staff to participate in the insurance (Shi, 2010, p. 23).

The Medical Professional Liability Insurance in China

China's medical liability insurance is still at an immature stage of development. On July 9, 2014, the National Health and Family Planning Commission of PRC (cancelled in accordance with the Institutional Reform Plan of the State Council approved at the 1st Session of the Thirteenth National People's Congress) and five other ministries and commissions issued Opinions on Strengthening Medical Liability Insurance (hereinafter referred to as the "*Opinions*"), pointing out, "By the end of 2015, the coverage rate of tertiary public hospitals should reach 100% and that of secondary public hospitals should reach more than 90%." On December 27, 2016, the Notice of the State Council on Issuing the 13th Five-year plan on Deepening Medical and Health Care System Reform proposed that by 2020 medical liability insurance should cover all public hospitals and over 80% of primary medical and health institutions nationwide.

On this basis, most provinces and municipalities impose compulsory insurance on public hospitals, while a few provinces and municipalities impose incentive voluntary medical liability insurance on public hospitals. [①] (Figure 6)

FIGURE 6[②]

Province	Nature of the Insurance
Beijing	Compulsory
Tianjin	Compulsory
Zhejiang	Compulsory
Gansu	Compulsory
Hainan	Compulsory
Henan	Compulsory
Chongqing	Compulsory
Guangxi	Compulsory
Shanghai	Compulsory
Jiangsu	Compulsory
Sichuan	Voluntary
Hunan	Voluntary
Guangdong	Voluntary
Fujian	Voluntary

However, in spite of the regulations issued by provinces and municipalities, the humble goal which was proposed in the *Opinions* has not yet been completely achieved in that some medical institutions and insurance companies are not willing to participate in the medical liability insurance system.

Reform of the System of Medical Malpractice Liability

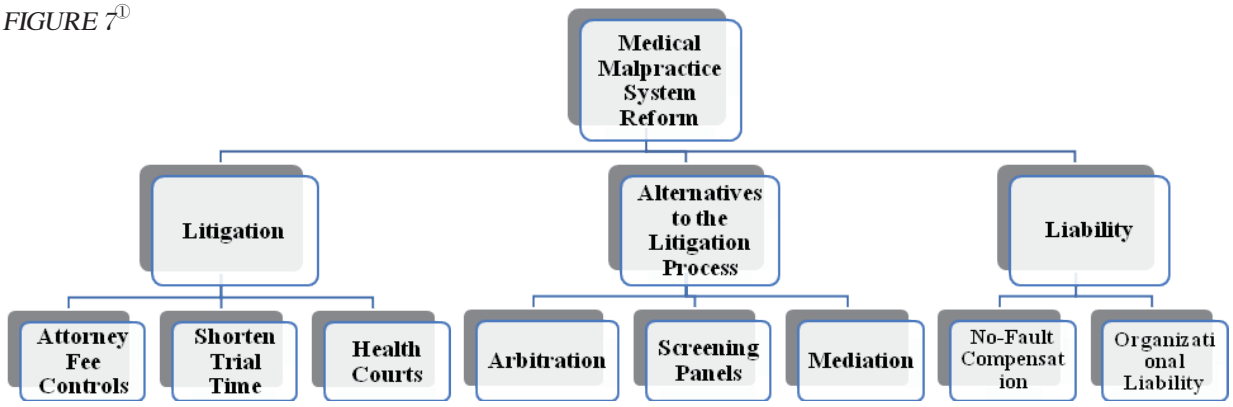
Reforms of the System of Medical Malpractice Liability in the United States

Professor Michelle M. Mello of School of Public Health, Harvard University, pointed out that the main problems in the medical malpractice system include: (1) The system does a poor job compensating patients injured by medical malpractice. (2) The system has high transaction costs. (3) Awards in malpractice

① Non-public hospitals could purchase medical liability insurance voluntarily.

② Article 2 of the Opinions on Implementing Medical Liability Insurance of Beijing; article 7 of the Disposal Methods of Medical Disputes of Tianjin; article 31 of the Preventive and Disposal Methods of Medical Disputes of Zhejiang; article 14 of the Work Program of Medical Liability Insurance of Gansu; section II of the Notice of Hainan Health Department and Hainan Insurance Regulatory Bureau on the Unified Implementation of Medical Liability Insurance System in Public Medical Institutions of Hainan Province; article 2 of the Work Program of Medical Liability Insurance of Henan; article 2 of the Notice of Chongqing Health Bureau and Chongqing Insurance and Supervision Bureau on the Unified Implementation of Medical Liability Insurance in Public Medical Institutions above the Second Level; paragraph 2 of Article 7 of the Opinions of the General Office of the People's Government of Guangxi Zhuang Autonomous Region on the People's Mediation of Medical Disputes; paragraph 2 of Article 9 of the Methods for Prevention and Mediation of Medical Disputes of Shanghai; article 50 of the Regulations on the Prevention and Handling of Medical Disputes of Jiangsu; article 30 of the Provisional Measures for the Prevention and Disposal of Medical Disputes of Sichuan; article 8 of the Methods for Prevention and Handling of Medical Disputes of Hunan; article 9 of the Methods for Prevention and Handling of Medical Disputes of Guangdong; article 45 of the Methods for Prevention and Handling of Medical Disputes of Fujian;

FIGURE 7[①]



cases are inequitable. (4) The system focuses on the misdeeds of individual healthcare providers, but medical errors are often due to breakdowns in whole systems of care. (5) There is no real evidence that the medical liability system deters negligent care. (6) The system has perverse effects on patient safety initiatives (Mello, 2006).

In order to continuously solve the problems emerging from the medical malpractice system, states in the United States have implemented a number of reforms. The following are some important reform measures: (Figure 7).

Reforms of the System of the Medical Malpractice Liability in China

First, the legislative process of medical malpractice in China is a history of reform. From the Rules on the Handling of Medical Accidents to the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes over Medical Malpractice Liabilities, the burden of proof on patients has been mitigated and the way of authentication has been defined in the judicial interpretation.

Second, China has also been exploring alternative dispute resolutions. For example, the Tianjin People's Mediation Committee of Medical Malpractice Disputes has established a "three-mediation" system in which people's mediation plays the main role when hospital mediation, people's mediation and judicial mediation work together. As an independent third-party mediation organization, the Medical Malpractice Disputes Mediation Committee does not charge any fees in the process of mediation. The office location, funds and salaries of mediators are provided by the government to ensure independence.

① The Limitation of the size of recoveries is also part and parcel of the reform, which is explained in the seventh part of this article. Attorney Fee Controls: see Hyman & Silver, 2011, p. 169. Shorten Trial Time: see Kant Patel & Mark E. Rushefsky, Health Care Politics and Medical Malpractice Claim 3rd ed, New York: M.E. Sharpe, Inc., p. 287. Health Courts & Mediation: see Georgia Board for Physician Workforce 2011, Medical Liability & Tort Reform in Georgia, Retrieved March 16, 2020, from https://gbpw.georg-ia.gov/sites/gbpw.georgia.gov/files/imported/GBPW/Files/Fact%20Sheet%20-%20Medical%20Liability%20%26%20Tort%20Reform%20in%20GA%20_final%201.25.11_.pdf. Arbitration: see Holder, 1975, p. 422. Screening Panels: see Holder, 1975, p. 416. No-Fault Compensation: see Weiler, 1991, p. 132. Organizational Liability: see Weiler, 1991, p. 122.

Finally, China's medical liability insurance practices have only recently been created and are now in the process of popularization while nationwide activities collectively referred to as "establishing safe Hospitals" is being implemented, which includes the active implementation of medical liability insurance as an essential assessment factor.

Suggestions for Handling Medical Malpractice in China

It is undeniable that there are still numerous issues on dealing with disputes of medical malpractice in China. Many medical disputes have evolved into medical chaos, aggravating doctor-patient relationships which are often already strained. In order to ease the relationships between the two parties, and to solve medical malpractice disputes more effectively, the following suggestions are put forward.

Stipulating the Medical Malpractice Liability of Administration in the Civil Code

First, there are no detailed classifications of medical malpractice in the United States, but massive judgments set precedents for future cases. However, for China, a typical country of statutory law, it is significant to make lucid and detailed legal provisions to provide a basis for the protection of people's rights and judicial judgments. Therefore, the medical malpractice of administration should be stipulated by law. Second, the four types of medical malpractice mentioned above, which have been adopted by the community of scholars and judicial practitioners, should be confirmed in the Civil Code.

Optimizing the Criteria for Judging Negligence

The criteria for judging negligence in the United States have evolved from a single mode to multiple modes, from a relatively conservative attitude to an open and objective attitude. In order to alleviate the difficulty of the identification of negligence and balance the interests between the medical party and patients, relevant provisions of the Interpretation of the Supreme People's Court on Several Issues concerning the Application of Law in the Trial of Cases Involving Disputes over Medical Malpractice Liabilities should be absorbed by the Civil Code and the standard of "medical level for the moment" + "individual differences" ought to be applied to recognized negligence in a wide and sweeping manner. Other factors such as the degree of emergency, a patient's disease severity, individual differences of patients, local medical levels, and the qualifications of a medical institution and its medical staff should be considered comprehensively.

Moreover, the decentralizing of the application of the procedures and standards for medical care is also imperative. First, based on the complexity of medical practice and the rapid development of medical research, the judgment of negligence must be flexible because rigid procedures and standards for medical care can negatively impact the objective judgment of negligence. Second, the provisions on the procedures and standards for medical care consist of mandatory provisions and guiding provisions. In some medical fields, the procedures and standards are inconsistent or even conflicting,

which increases the difficulty of application (Xiong, 2019, p. 41).

Clarifying the Nature of Liability of Medical Institutions as Organizational Fault Liability

While some medical malpractice incidents are attributable to incompetence or inattention by a physician, many more result because of systems-level failings (Hyman & Silver, 2011, p. 176). Modern medical practice has become a group activity—Plural medical personnel share part of their medical behaviors according to their own specialties and complete the organizational pattern of treatments for patients. Medical negligence should be judged by whether the system has reached the level of proper medical care.

A similar concept referred to as "enterprise liability" has been proposed by American scholars. Hospitals under enterprise liability would be the exclusive subject of liability for all malpractice claims brought by hospitalized patients regardless of the provider's status as employee, independent contractor, or holder of admitting privileges, and regardless of the site of the provider's malpractice (Abraham & Weiler, 1994, p. 393).

In the United States, a physician is liable for a nurse's negligence in the course of routine nursing care when the nurse acts under the direct and personal control of the physician (Holder, 1975, p. 205). While there is no relevant regulation in China, if a nurse who does not sign a labor contract with the hospital, the nurse must bear the liability by himself or herself, which will affect the compensation for patients and the work routine of the non-employee medical staff.

Compared with the vicarious liability, the application of organizational fault liability expands the scope of protection for patients since it can solve the issues of medical staff who are not employed by a hospital, such as nursing aides and consulting physicians. Moreover, the burden of proof of patients could be relieved. Patients do not need to prove which specific medical staff behaved negligently, which link of the medical system caused the negligence, or whether the medical institution was of fault in the selection, management, training and organizing of their medical staff. What they need to present is evidence which can prove that the diagnosis or treatment provided by a medical institution failed to meet the objective level of the duty of care for diagnosis and treatment.

Establishing Pilot Projects of No-Fault Medical Liability

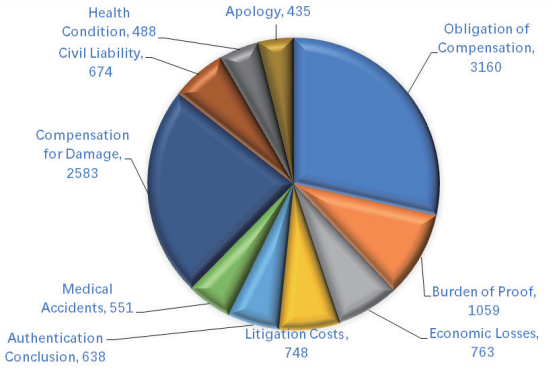
Under no-fault medical liability, victims of all medical malpractice would be eligible for compensation solely because of the nature of the losses they have suffered, not because their injuries were fortuitously produced by the carelessness of a doctor or nurse (Weiler, 1991, p. 134).

As discussed earlier, no-fault compensation funds are available in a limited number of states in the United States for specific conditions. In the past, these has focused primarily on birth-related litigation but dramatically increasing attention is turning towards no-fault systems for general medical liability. The benefit of such a system is to reduce the costs associated with the complicated judicial process. These costs are able to offset as much as 70% to 80% of insurance costs.

This is also of great significance to China. First, the litigation of medical disputes will be reduced.

A word frequency analysis on 17,787 judgments of medical malpractice cases in China carried out by the reading column "Data Blog" of the Netease News shows that "obligation of compensation" and "compensation for damage" are the most frequently used words in the results of the judgments. That is to say, the ultimate foci of medical dispute cases are money and responsibility. (Figure 8) (Guo & Ye, 2019).

FIGURE 8



The application of no-fault medical liability would solve the two foci of litigation precisely. Compensation is available to patients without huge expenses of money and time in the courts, which is also beneficial to the saving of judicial resources.

Second, patients will have easier access to compensation. The coverage rate of medical liability insurance is not as high as that of the United States, which increases the risk of invalidation of guaranteed compensation for victims of medical malpractice. If no-fault medical liability is adopted, patients suffering from iatrogenic injuries can be compensated directly. Medical institutions, especially those without medical liability insurance, will not have the opportunity to conceal negligence and shirk their responsibility for compensation. Thus, a national policy of no-fault medical liability will prompt medical institutions to purchase medical liability insurance.

Finally, compensation can be distributed more fairly among victims. From 2014 to 2016, in a total of 324 cases in which there was no fault of medical institutions and no causality between medical practice and negative results, the court still decided that the medical institutions should bear the responsibility of compensation (Man, 2018, p. 95). Some patients even got massive compensation by making medical chaos in hospitals, while many patients who suffered serious injuries due to medical malpractice did not obtain corresponding compensation. The application of the no-fault medical liability will alter this situation. Victims of iatrogenic injuries will be compensated according to their level of damage rather than a judge's sympathy, the scale of chaos made by a patient's family members or the administrative rank of patient's petition departments.①

The specific application of no-fault medical liability in China:

(1) Establishing some pilot projects.

Due to the tremendous disparity of economic and medical development among Chinese provinces, it is difficult to apply no-fault medical liability to all medical institutions in every province and municipality. A more reasonable approach would be to set up pilot projects in some metropolitan areas with sound social security systems and high purchase rates of medical liability insurance. Obstetrics,

① In China, the petition is a way for the masses to go beyond the grass-roots state organs and seek help from the relevant organs of the higher rank. Many patients in medical disputes will choose to petition. And the involving of administrative organs is a common phenomenon. In order to maintain social stability and assuage victims' discontent, patients are more likely to get more compensation after the intervention of administrative organs.

neurosurgery and emergency departments can be listed as preliminary pilot departments.[①](2) Allowing patients to make a choice.

The application of no-fault medical liability does not mean that patients could not have access to litigation. Plaintiffs with strong cases prefer to litigate in the tort system since they can recover a greater amount, while plaintiffs with weak cases prefer the no-fault system (Hyman & Silver, 2011, p. 172). So patients should be given the right to choose to get no-fault compensation or to go to court to bring a lawsuit, which was proposed by American senators in Senate Bill 215 in 1975.[②] When patients choose to accept no-fault compensation, they can no longer bring lawsuits against medical institutions, unless it can be proved that the medical staff or institution acted with intention or gross negligence.

Developing An Open Mechanism of Medical Malpractice Disclosure in the Medical Field

The United States has led the modern public disclosure movement. The first major U.S. report cards were published more than thirty years ago by the federal government agency that administers Medicare. Information is now readily available in the United States about the comparative performance of health insurance plans, hospitals, and individual physicians (Marshall, Shekelle, Davies & Smith, 2003, p. 136). Adam Webb, professor at Emory University also emphasized the importance of early and full disclosures.[③] Yelp, an American website which has a high click-through rate, categorizes the living demands as eating, clothing, medicine, housing and transportation, which provides important references for patients by introducing doctors, charging standards, patients' comments and the credit rating of a third-party (Yin, 2018, p. 459). Major insurance companies also provide information on fees, ratings and patient evaluations of their co-doctors.

The Administrative Measures for the Disclosure of Information of Medical and Health Service Entities demanded that medical institutions should disclose the information which should be widely known or needs the participation of the general public, the information reflecting its establishment, functions, working rules, working procedures, etc..[④] However, it was repealed in 2016. Patients and the medical party are in the position of information asymmetry. It is of great significance to disclose the information on medical malpractice. On the one hand, it provides a reference for patients to seek medical treatment. On the other hand, it allows doctors' peers to learn from the lessons of medical malpractice and be more cautious about their own medical practice. But it can not be denied that there is still a long way to go in establishing an open mechanism of medical malpractice disclosure in China. There is great resistance to the disclosure of medical malpractice from the medical profession. Compared with American doctors, doctors in China have lower incomes and heavier workloads. Some chief doctors will even receive hundreds of patients every day. There is a strong personal

① Since the application of no-fault medical liability will lead to increased medical costs borne by patients. Patients may give up visiting a certain department because of the increased costs. Compared with other medical departments, the demand elasticity of obstetrics, neurosurgery and emergency departments is weak. See Frank J. Vandall, Applying Strict Liability to Professionals: Economic and Legal Analysis, Indiana Law Journal, 1983, vol.33, Iss.01, p. 33.
② § 1717, S. 215, 94th Cong., 1st Sess., 121 CONG.REC. 681(1975).
③ The author participated in a seminar on "Lessons from Closed Malpractice Claims" sponsored by Professor Webb at Emory University on January 23, 2019.
④ Article 7 of the Administrative Measures for the Disclosure of Information of Medical and Health Service Entities.

attachment between doctors and hospitals and disclosing medical malpractice will undoubtedly destroy their iron rice bowls.①

Improving the Ability to Deal with Medical Chaos

The capacity of the medical system to respond to medical chaos in parallel with measures to prevent and properly solve medical malpractice should be enhanced. Aggressive and violent patient related behavior causing medical chaos seriously jeopardizes the normal medical order and the legitimate rights and interests of the medical staff.

Even though, since 2015, people who have caused serious disruptions to the medical order have been required to bear criminal responsibility,② medical chaos in China is becoming more common. Battery and assault to medical staff are still frequently reported. For example, on January 20, 2020, Yong Tao, an ophthalmologist at Beijing Chaoyang Hospital, was gashed by a patient.

In order to express the dissatisfaction with the reasonable treatment effect or get more compensation, some family members of victims broke the order and property of hospitals deliberately. What is worse, there are a great many individuals who choose instigating or replacing the family members of patients to create disturbances in hospitals and then collect some parts of the compensations as a career.③

To optimize the handling of medical chaos, it is necessary to establish medical integrity archives and blacklists of patients and link patients' personal integrity with medical social insurance.

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① In China's public hospitals, the status of the majority of doctors belongs to the staffing of government-affiliated institutions which is called the "iron rice bowl." It means a permanent work position they would never lose whether they work hard or not.

② Article 290 of the Criminal Law of the People's Republic of China.

③ Those people are medical chaos professionals, which has been mentioned at the beginning of this article.

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