The Law of Medical Misadventure in Japan

Robert B. Leflar

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THE LAW OF MEDICAL MISADVENTURE IN JAPAN

ROBERT B LEFLAR*

Introduction..................................................................................................................80
I. Prosecutions and Their Consequences......................................................................83
   A. Prosecutions in Medical Cases.............................................................................83
   B. Response by the Health Ministry and the Medical Profession.............................85
   C. One Prosecution Too Many: The Medical Professionals’ Counterattack and the String of Acquittals.................................................................88
II. Civil Liability.........................................................................................................90
   A. Substantive Law of Medical Malpractice..............................................................92
      1. Theories of Recovery......................................................................................92
      2. Standard of Care.............................................................................................92
      3. Level of Proof....................................................................................................93
      4. Informed Consent and Related Actions............................................................96
      5. Damages.............................................................................................................97
   B. Key Aspects of Procedural Law and Practice......................................................99
      1. In General...........................................................................................................99
      2. Discovery of Peer Review Findings.................................................................100
      3. Judicial Administration Reforms....................................................................101
      4. Settlement Practices, Overall Claiming Levels, and Malpractice Insurance Premiums......................................................................................................102
   5. Plaintiffs’ Attorney Fees and Court Filing Fees....................................................105
III. The No-Fault Compensation System for Obstetrical Injury.................................106
Conclusion.....................................................................................................................110

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All translations are the author’s unless otherwise indicated. Japanese as well as non-Japanese names are given surname last, for consistency’s sake. Japanese cases are parenthetically denoted by their common sobriquets. Yen amounts are stated in dollars at the approximate prevailing exchange rate for the year in question – in 2011, about US $1 = ¥80.
INTRODUCTION

This article sets out the essential and distinctive features of the Japanese systems—criminal, civil, and administrative—for sanctioning persons causing medically related injury and for compensating the injured.1 The article seeks to place those systems in historical and social context.

Patients in Japan obtain their health care on a price-controlled, fee-for-service basis. Insurance coverage is virtually universal: since 1961, every legal resident has been entitled to receive care through a mixture of private and public plans.2 The proportion of GDP that Japan devotes to health care, 8.5 percent as of 2008, is less than almost all other advanced industrial nations, and only about half that of the industrialized world’s least efficient health care system, the United States.3 Yet Japan’s longevity and infant mortality statistics are among the world’s best,4 and technological sophistication at Japan’s top hospitals parallels that available anywhere.

Nevertheless, iatrogenic harm—injury resulting from medical care—has long been a simmering concern. The number of civil malpractice claims, though relatively small, rose steadily through the 1980s and 1990s.5 During the same period, dissatisfaction with physicians’ paternalistic attitudes, a scandal over HIV-contaminated blood supply, a national debate over brain death issues, and concern over excessive and irrational drug prescriptions combined to undercut the public’s previously almost unquestioned faith in medicine’s beneficence.6 These developments fed a growing current of public opinion favoring transparency in medicine, reflecting

1. The article is not confined to medical malpractice, in the sense of treatment failing to meet the legal standard of due care. The article’s scope also encompasses other medically related death and injury; hence the use of "misadventure," a term bequeathed to us in this context by the New Zealanders. See Geoffrey Palmer, Compensation for Incapacity: A Study of Law and Social Change in New Zealand and Australia 255 (1979); Ken Oliphant, Defining "Medical Misadventure": Lessons from New Zealand, 1 MED. L. REV. 4 (1996).
5. See infra note 53, fig. 2.
movements toward greater openness in other spheres of society. Marking this trend toward transparency, around the turn of the 21st century, were court decisions advancing principles of informed consent, enactments of information disclosure measures, and provisions for patients’ access to their medical records.

Beginning in 1999, reports of a series of errors at hospitals of high repute filled the headlines and newscasts. The first notorious case arose from switched-patient surgeries in Yokohama. Under the eyes of the nation’s media, subsequent cases occurred in quick succession in Tokyo itself. A nurse accidentally injected a toxic agent, killing her patient. An inexperienced team of young doctors bungled delicate laparoscopic surgery while insufficiently trained on the equipment, having also neglected to secure an adequate supply of the patient’s rare blood type. A child died after an operation at a major pediatric cardiovascular surgery center, one among a series of children’s deaths at the center. In each of these cases, physicians and hospital personnel altered medical records, gave misleading accounts of events to bereaved families or investigating officials, or engaged in other


9. See MINISTRY OF HEALTH & WELFARE (JAPAN), KARUTE-TO NO SHINRYÔ JÔHÔ NO KATSUYÔ NI KANCSRU KENTÔKAI HÔKOKUSHO [REPORT OF THE STUDY COMMISSION ON THE USE OF MEDICAL CHARTS AND INFORMATION] (1998); Robert B Leflar, Law and Health Care in Japan: The Renaissance of Informed Consent, in TIMOTHY STOLTZFUS JOST, READINGS IN COMPARATIVE HEALTH LAW & BIOETHICS 154, 159 (2d ed. 2007) [hereinafter Leflar, Renaissance] (summarizing health ministry measures promoting patient access to medical records); and infra note 93 and accompanying text.

10. At Yokohama City Medical University Hospital, a lung patient had part of his heart valve removed, and a heart patient with a similar name had part of his lung excised. Three doctors and two nurses were found criminally liable for professional negligence. Judgment of Yokohama Dist. Ct. Sept. 20, 2001, 1087 HANREI TAIMUZU 296 (Yokohama switched-surgery case).

11. After this event at Tokyo’s Hirô Hospital, two nurses were convicted of criminal professional negligence, and the hospital director was found guilty of submitting a false death certificate and failing to report the death to police in a timely fashion. Judgment of Supreme Court April 13, 2004, 58(4) KEISHÔ 247 [hereinafter Hirô Hospital case].


untrustworthy acts. Many other cases of alleged malpractice surfaced around the country.

Media coverage of these iatrogenic deaths and injuries sparked public questioning of the medical profession's self-policing mechanisms—questioning that the profession was ill-prepared to answer. Institutional structures to monitor the quality of Japan's medical care have historically been weak. Medical licensure and discipline authority, exercised by the Ministry of Health, Labor & Welfare, seldom inquired into failures of patient safety.14 Hospital peer review was conducted with a soft touch, if at all, and the claimed impartiality of hospitals’ internal reviews of adverse events was met with increasing public skepticism. The hierarchical system of medical education and job placement strongly discouraged any open questioning of practices taught by revered professors (who controlled career postings), even if such practices were outmoded or scientifically unproven.15 The hospital accreditation system fostered good safety practices only marginally; hospitals need not receive accreditation to qualify for reimbursement for examinations, procedures and medications provided to patients, and only 29 percent of hospitals are accredited today.16 The nation's patchwork death inquiry system functioned with efficacy in only a few urban areas, and even there, seldom focused on medical-practice-associated causes of death and their prevention.17 Civil litigation over alleged malpractice, as discussed below, provided only a modest and intermittent brake on medical error. Until the 2009 introduction of a no-fault system for compensating obstetrical injuries, administrative compensation systems were confined to a few limited categories of disease sufferers.

14. See id. at 20 & n. 87 (summarizing research of Dr. Etsuji Okamoto and author's interview with health ministry staff concerning work of the Ministry's medical discipline committee, the Medical Ethics Council (Idō shingikai)).
15. See, e.g., CAMPBELL & IKEGAMI, supra note 2, at 188-189 (criticizing quality assurance and peer review in Japanese hospitals); Hideki Hashimoto, Naoki Ikegami et al., Cost Containment and Quality of Care in Japan: Is There a Trade-Off? 378 THE LANCET 1174, 1178 (2011) (“Physicians' practice patterns tend to be idiosyncratically set by the chair and professor of the university clinical department.”).
16. Of Japan's 8,650 hospitals, 2,469 are accredited as of November 2011. Japan Council for Quality Health Care, Byōin kinō hyōka kekka no jōhō teikyō [Information on Results of Hospital Evaluations], available at http://www.report.jcqhc.or.jp. In any case, accreditation criteria do not address compliance with standards of evidence-based medicine or honesty with patients about adverse events.
In short, at the turn of the 21st century, weaknesses in professional self-regulation, administrative oversight, the death inquest system, and civil litigation left Japanese medicine to operate within an accountability vacuum. Attempting to fill part of that gap in public accountability, the criminal justice system—its workings amplified by the media—stepped up its engagement with iatrogenic harm cases.

I. PROSECUTIONS AND THEIR CONSEQUENCES

A. Prosecutions in Medical Cases

Prosecutors have typically brought charges against health care personnel on any of three grounds. The first, and most common, is “professional negligence causing death or injury.” This crime is derived, like most of Japan’s Criminal Code, from the German penal code. The mens rea required for conviction, as a formal matter, is simple negligence, although as a practical matter the cases in which prosecutors obtain convictions typically involve acts or omissions amounting to gross negligence or recklessness.

18. This argument is developed more fully in Leflar, “Unnatural Deaths,” supra note 13, and Leflar & Iwata, supra note 12.

19. Keihō [Criminal Code] art. 211 (Gyō Mujō kashitsu chishishō-tō). The typical defendants charged with this crime are traffic offenders, but other professionals such as architects, pilots, and physicians are sometimes sanctioned as well.

When convicted, such professionals are fined but rarely serve prison sentences. See Haruo Yamaguchi, Iryō jiko no keiji shobun to purofuessonaru ōtonomii [Criminal Sanctions for Medical Accidents and Professional Autonomy], 695 Niigata-Ken Ishika Hō 2, 2 tbl.1 (2008) (reporting four cases of imprisonment out of 253 criminal sanctions in medical cases from 1950–2007). However, while under investigation physicians, like other suspects, may languish in police detention for a considerable period. For example, Dr. Kazuki Sata, who was arrested, prosecuted, and acquitted in the Tokyo Women’s Medical University Hospital case, Leflar, “Unnatural Deaths,” supra note 13, at 6, was detained and interrogated for three months. Interview with Dr. Kazuki Sata, in Tokyo (Aug. 7, 2009). Moreover, even if a convicted professional’s ultimate formal sanction is merely pecuniary, the conviction itself is usually enough to force a career change, through either loss of medical license or personal shame, so effectively the punishment is ultimately quite significant.

Although criminal prosecutions and civil damage claims are formally separate, they sometimes proceed in parallel fashion, and the proceedings of each can influence the other. See infra note 21.


Tokyo prosecutors responsible for medical cases informed the author that during the first wave of these prosecutions the most important factors in decisions about whether to prosecute were the bringing of a complaint by the patient or family, the degree of injury, the flagrancy of the medical personnel’s acts or omissions, the clarity of proof of negligence, and failure by medical personnel to provide compensation and apologies. Interview with Shūji Iwamura, Takayuki Aonuma, and Atsushi Satō, Tokyo District Prosecutor’s Office, and Prof. Futoshi Iwata, Sophia University, in Tokyo (July 25, 2001). The prosecutors averred, perhaps disingenuously, that social goals such as deterrence of medical error formed no part of their motivation for bringing charges.
A second ground for prosecution is concealment or destruction of evidence. Physicians and nurses attempting to cover up medical mistakes by altering patients' medical charts have been found criminally liable for this offense.

The third basis for recent prosecutions of physicians is failure to notify police in a timely fashion of "unnatural deaths." Physicians once assumed that this notification requirement, found in Article 21 of the Medical Practitioners' Law, applied only to violent deaths, suicides, infectious diseases threatening public health, and the like. However, when the CEO of Tokyo's Hirō Hospital in 2000 submitted a falsified death certificate for a patient killed by an accidental toxic injection and delayed reporting the death to police, prosecutors—fully aware of intensified public concern over medical errors—charged the CEO with violating Article 21. The Supreme Court, affirming his conviction in 2004, confirmed that the "unnatural death" notification requirement may encompass deaths causally related to medical management.

The Hirō Hospital CEO's arrest and subsequent conviction placed hospital administrators in a dilemma. For purposes of medical care, no clear definition of "unnatural death" exists. When a patient dies following less-than-optimal care, should the hospital routinely notify police, inviting criminal investigation disruptive of hospital routine and patient care, or avoid notification and risk public condemnation for a cover-up and possible criminal prosecution? The number of reports to police of medically related death and injury, and the number of cases police referred to prosecutors, increased for several years after 1999 (Figure 1). The "unnatural death" notification requirement, and the concomitant (if variable and sporadic) police oversight of medical practice, generated intense controversy.

![Fig. 1: Medical accidents reported to police; cases police sent to prosecutors, 1997-2010.](image-url)
Critics of the criminal justice system’s involvement in monitoring medical mistakes raise concerns relating to police lack of medical expertise, disruption of patient care by criminal investigations, disproportionality of criminal sanctions to the inadvertence typical of lapses in care, and criminal law’s tendency to focus on individual blame rather than addressing more significant problems of system failure. Even granting the substantial merit of these criticisms, criminal law’s prominence in regulating medical quality in the early years of this century is understandable in light of these factors: (1) public expectation that the criminal justice system’s protective reach does not stop at the hospital doors; (2) police and prosecutors’ commitment to professional duty in enforcing the criminal code, applicable by its terms to medical personnel as to everyone else; and (3) the need in a democratic society for public accountability of the medical profession for its errors, a need not adequately fulfilled in Japan by professional self-regulation, administrative oversight, the death inquest system, or civil litigation.

B. Response by the Health Ministry and the Medical Profession

The Ministry of Health, Labor & Welfare (MHLW) had given short shrift before 1999 to patient safety issues. In reaction to the controversy over highly publicized medical errors, the ministry, beginning in 2000, created a small patient safety office, drafted guidance manuals for hospitals to designate risk management staff, set up adverse event tracking systems and review committees, established local “medical safety support centers” to handle patients’ complaints and questions, required a class of large specialized hospitals to make reports to a quasi-public entity of acci-

26. Nat’l Police Agency, Iryō jiko kankei todokede-tō kensō no idō, rikkō sōchisō [Trends in Reports of Medically Related Cases and of Cases Sent to Prosecutors] (Aug. 8, 2011), reported in Iryō jiko todokede genshō tsuzuku; Keisatsu rikken mo 7.4%-gen [Decline in Medical Accident Reports Continues; Cases Sent to Prosecutors also Decrease 7.4%], NIHON KEIZAI SHINBUN (Aug. 8, 2011) [hereinafter Police Reports on Medical Cases].


29. The medical safety support centers (iryō anzen shien sentā) received statutory authorization in a 2006 amendment to the Medical Services Law, IRYŌ HÔ art. 6(11).
dents causing harm, and launched a study of the incidence of adverse events in Japanese hospitals. In this study, 4,389 records were randomly selected from 18 top hospitals that volunteered to participate. Reviewers employing criteria based on a previous Canadian study found an adverse event rate of 6.8 percent, and concluded that of those adverse events, about 23 percent were preventable.

Troubled by the prospect of police investigations and possible criminal liability while also recognizing the importance of clearer accountability in the handling of medical accidents, four major medical specialty societies proposed to MHLW a new system (independent of the criminal process) to review patient deaths possibly connected to medical management, inform the parties of facts found, and suggest preventive measures. The health ministry, understaffed and eager to demonstrate progress in addressing patient safety issues, agreed to fund a “Model Project for the Investigation and Analysis of Medical Practice-Associated Deaths.” The Model Project, launched in four urban regions in 2005 for an initial term of five years and now continuing on an extended basis in ten regions, is aimed at conducting impartial, high-quality peer reviews of possibly iatrogenic hospital deaths by experts unaffiliated with the hospital in question. Findings are reported to both the family and the hospital; a summary is made public, with names of the patient, medical staff, hospital, and location redacted; and suggestions for prevention of recurrences are offered. The Ministry of Justice and the National Police Agency gave up none of their...
jurisdiction over medical crime but acquiesced in the Model Project's operation, for the most part holding back from criminal investigations and prosecutions in the regions in which the project operated.  

Results from the Model Project are mixed. On the one hand, case uptake and review efficiency have not met expectations. Cooperation from hospitals in participating regions has been uneven—fewer than 100 cases were submitted for review during the project's initial five-year period—and despite the low numbers, delay in issuing case findings has been common. On the other hand, the quality of case reviews has likely been superior to most internal hospital reviews conducted prior to the project's inception, and the project's method—bringing together physicians, nurses, attorneys, academics, and health bureaucrats working toward common goals—has probably improved interdisciplinary cooperation in a society still hierarchically structured, each field generally in silo-like separation from the others.

Data collection and analysis for the Model Project and for the health ministry's other adverse event reporting systems are undertaken by the Japan Council for Quality Health Care (JCQHC), a quasi-public entity that also performs hospital accreditations. To some extent, JCQHC's information dissemination efforts have aided the objective of improving health care quality by encouraging medical facilities' experience-based learning. However, despite the public's enormous appetite for medical information, neither the health ministry nor JCQHC has made available much hospital-specific health outcomes information. Transparency regarding statistics about adverse events in health care is still a distant goal.

34. For a detailed overview of the Model Project, see Leflar, "Unnatural Deaths," supra note 13, at 31-39.

35. Reasons for the low case uptake include physicians' unfamiliarity with the case review process, rules that the process be invoked by hospitals not families, limitation of the Model Project to death cases (excluding nonfatal injuries), and a shortage of pathologists to perform the needed autopsies. See Leflar, "Unnatural Deaths," supra note 13, at 36-39; Norhiro Nakajima et al., Interim Evaluation of the Model Project for the Investigation and Analysis of Medical Practice-Associated Deaths in Japan, in J. MED. SAFETY 34 (Union of Risk Management for Preventive Medicine 2009).

36. See JCQHC Report, supra note 30, for a description of the information collection program.

37. The health ministry does require hospitals to report the number of operations they conduct annually for various specified procedures. Media outlets obtain this information and compile rankings of hospitals by procedure volume. See, e.g., SHUJUTSU-SŪ DE WAKARU II BYŌIN [TELLING GOOD HOSPITALS FROM THE NUMBER OF OPERATIONS] (Shikan Asahi ed., 2010); Iryō to kango [Medical and Nursing Care], in YOMIURI SHIMBUN (2008), updated version available at http://www.yomiuri.co.jp/ryou/medi/jitsuryoku. For an analysis based in part on these reports, see J. Mark Ramseyer, Universal Health Insurance and the Effect of Cost Containment on Mortality Rates: Strokes and Heart Attacks in Japan, 6 J. EMPIRICAL LEGAL STUD. 309 (2009) (concluding that price controls diminish availability of sophisticated care, costing lives).
Building on the Model Project's structure, the health ministry and the then-governing Liberal Democratic Party offered a proposal in 2008 essentially to expand the project's methods nationwide, setting up what would have amounted to a national structure for peer reviews of questionable hospital deaths, independent of the criminal justice system. Both patients' rights groups and the Japan Medical Association—usually divided by distrust—supported the proposal. However, the proposal was attacked by a well-organized chorus of antiregulatory critics within the medical profession. These critics were concerned that external reviews of hospital adverse events would be overly centralized and cumbersome,38 that the Article 21 "unnatural death" reporting requirement would not be abolished, and that police would not be entirely removed in all cases from the monitoring of medical practice. The opposition Democratic Party of Japan issued its own proposal, somewhat closer to the position of the antiregulatory critics.39 Many thought that the two proposals had enough in common that a compromise could be hammered out. But after the Democratic Party of Japan swept into power after the Summer 2009 elections, other issues took political precedence, among them Japan's continued economic slump and, most recently, the nation's response to the disastrous earthquake, tsunami, and nuclear power plant meltdown of March 2011 in northeast Japan. At this writing the proposed national peer review system remains on the back burner. However, with the August 2011 launching of a commission to study reforms in Japan's medical liability systems,40 it may be that peer review improvement projects will be placed back on the table.

C. One Prosecution Too Many: The Medical Professionals' Counterattack and the String of Acquittals

Police led obstetrician Katsuhiko Katō in handcuffs out of Ohno Hospital in rural Fukushima prefecture in 2006, after belatedly learning of the 2004 death of one of his patients subsequent to a particularly difficult childbirth. The reaction against Dr. Katō's humiliating arrest (broadcast on national news), detention, and prosecution was intense: petitions and remonstrances poured into the National Police Agency from medical organ-

38. Or perhaps too embarrassing. Most physician critics of the health ministry proposal seemed to this observer to be hospital-based, while the JMA, which supported the proposal, chiefly represents smaller doctor-owned clinics. The health ministry proposal would have impacted hospitals far more than clinics.


40. See infra notes 143–145 and accompanying text.
izations across the country. The fervor of this reaction launched a movement led by physicians employing the slogan “iryo hōkai”—“the collapsing health care system.”

The “iryo hōkai” movement has engineered a significant shift in public opinion. The movement’s proponents have called editorial and political attention to the shortage of physicians willing to attend childbirths, particularly in rural areas, and to repeated instances of hospital emergency rooms turning away ambulances for fear of liability exposure. As one chief cause of these problems, the movement has targeted alleged abuses of the criminal justice system, much as medical “tort reformers” attack the civil justice system in the United States. To be sure, other factors have contributed to Japan’s shortages in obstetrical care, such as the adoption of a residency matching system undercutting traditional hierarchical job placement practices that once ensured a supply of young physicians to smaller hospitals. Nevertheless, the Ohno Hospital prosecution served as an effective rallying point for critics of the criminal justice system’s medical oversight role. The “iryo hōkai” movement offers sympathetic portrayals of the plight of overworked, harassed, underappreciated physicians and the importance of protecting them from overreaching prosecutors. The movement appears to have turned media and public attention away, to a considerable extent, from concerns over medical error.

The “iryo hōkai” movement’s efforts have borne fruit not only on the editorial pages, but also perhaps in the minds of some of the nation’s judges. Acquittals in criminal trials are extremely rare in Japan; more than 99 percent of criminal trials result in convictions. But in four successive recent cases, including Dr. Kato’s prosecution, medical personnel were acquitted of all charges, and in the two cases that prosecutors appealed, the acquittals were affirmed.

41. For a listing of the protest petitions, see Fukushima kenritsu Ohno Byōin no iryo jiko mondai ni tsuite [The Medical Accident Problem at Ohno Fukushima Prefectural Hospital], http://www.med.or.jp/nichikara/fseimei/index.html (last visited July 6, 2011).


44. Japanese appellate procedure allows prosecutors to appeal not-guilty judgments on grounds of both fact and law without violating the double jeopardy principle. See id. at 175.

This series of acquittals, in the wake of medical society protests against physicians' arrests, constitutes a major public embarrassment for Japan's procuracy. Police and prosecutors have been further embarrassed by the recent arrests for unprofessional conduct of a top detective in the medical investigation unit of the Tokyo police force and of a top prosecutor for altering evidence in the unsuccessful prosecution of a health ministry official for alleged corruption. These acquittals and scandals, in the author's view, mark a watershed point in Japanese medical jurisprudence. Henceforth, police and prosecutors will be considerably more cautious in targeting health care personnel. Pressures for medical quality improvement must come chiefly from other directions.

II. CIVIL LIABILITY

Compared to the specter of criminal prosecution with its career-shattering effects, civil liability for medical injury has probably been less worrisome to Japanese physicians in recent years. Civil malpractice insurance is cheap, and in any case hospital-employed physicians—64 percent of the total number of doctors—are covered by their hospitals' liability insurance policies. Nevertheless, civil liability trends are a matter of concern to the medical profession.

The number of civil claims filed in court far exceeds the number of criminal prosecutions, and rose steadily from the 1980s until the peak


46. See, e.g., Current, Former Cops Arrested over Info Leak, DAILY YOMIURI, July 23, 2011, at 1 (arrest of Lt. Shirotori for leaking police documents to cosmetic surgery hospital under investigation for alleged case of fatal malpractice).


48. The number of medical cases police sent to prosecutors peaked in 2006, the year of the Ohno Hospital arrest and subsequent protests, and has since diminished somewhat. See supra Figure 1. Police investigations of medical crimes have not ceased, however, and prosecutions continue to be brought. In 2010 police sent papers to prosecutors in seventy-five medical cases, down from the peak of ninety-nine in 2006. See Police Reports on Medical Cases, supra note 26; Lasik Surgeon Held over Infections; Unsanitary Procedures, Lack of Sterilization Alleged at Defunct Ginza Clinic, DAILY YOMIURI, Dec. 8, 2010, available at http://www.yomiuri.co.jp/dy/national/T101207004781.htm?ref=dylwsj.

49. See infra notes 116-122 and accompanying text.


51. In 2003, for example, seventeen prosecutions were brought against physicians. See Toru Hiyama et al., The Number of Criminal Prosecutions Against Physicians Due to Medical Negligence Is on the Rise in Japan, 26 AM. J. EMERGENCY MED. 105 (2008). In the same year, 1,003 civil malpractice cases were filed. See infra note 56.
year of 2004, following which court filings have declined (Figure 2). In addition, the number of claims settled out of court is doubtless a substantial multiple of the number of court filings.52

This section of the article first sets out the salient doctrinal features of the substantive civil law of compensation for medical injury. The article then addresses key aspects of procedural law and practice, including the institution of health care divisions of trial courts in some metropolitan areas, practices relating to case settlement, estimates of the total numbers of malpractice claims (in court and out) and of medical malpractice premiums and payouts, and information on court filing fees and plaintiffs' attorneys’ compensation practices. Finally, the new system for no-fault compensation of certain obstetrical injuries is described.

A. Substantive Law of Medical Malpractice

1. Theories of Recovery

Civil claims for medical injury may be brought under either the Civil Code provision governing tort54 or the provision governing nonper-
formance of contract, and there are many examples of each. As a practical matter it generally makes little difference under which theory a claim is brought, for the standards and principles applied are the same in either case. The plaintiff must prove in contract cases a breach of the physician’s or hospital’s obligation, which is equivalent to proving a breach of the applicable standard of care in tort. In most cases, the plaintiff must prove under either theory that the breach caused ascertainable damages.

2. Standard of Care

The Supreme Court has expressed the legal standard of care to which physicians are held as “the standard prevailing in clinical medical practice at the time of treatment.” Physician custom is not invariably congruent with the legal standard of care, however. The Supreme Court has recognized that sometimes adherence to the custom of average medical practitioners does not fulfill the duty of care, as when a defendant doctor, following general practitioners’ common practice of ignoring an anesthetic drug’s labeled directions for use, failed to monitor the patient’s blood pressure in timely fashion.

Japanese courts hold large, sophisticated hospitals and their physicians to a higher standard of care in some respects than doctors in small clinics lacking equivalent resources. To quote the Supreme Court’s 1995 decision in a celebrated case involving a premature infant’s blindness from retinal injury, in determining the applicable standard of care the court “must consider various circumstances such as the nature of the [defendant] facility and the distinctive characteristics of the region’s medical environment.” This is taken to mean that the standard of care expected of a medical facility and its personnel depends on the facility’s size and function.

54. Civil Code art. 709, General Principle of Tortious Act: “A person who violates intentionally or negligently the right of another is bound to make compensation for damage arising therefrom.” HIROSHI ODA, BASIC JAPANESE LAWS 146 (1997).
55. Civil Code art. 415, Claim for Damages for Non-Performance: “If an obligor fails to effect performance in accordance with the tenor and purport of the obligation, the obligee may claim damages . . .” Id. at 98.
The standard of knowledge (chiken) expected of physicians depends on their specialty; non-specialists in a field are not held to the same standard as specialists. However, if a physician or facility is unable to treat a patient’s particular condition, whether due to lack of knowledge, skill, or resources, the care provider comes under a legal duty to transfer the patient to a facility that offers the requisite level of services.

3. Level of Proof

The level of proof required of plaintiffs on breach of duty and causation is “a high degree of probability” (kōdo no gaizensei). The phrase suggests a level of confidence somewhat higher than the “preponderance of the evidence” standard prevailing in civil cases in common law jurisdictions. Neither the Civil Code nor the case law offers an exact prescription of how judges are to decide closely balanced issues of fact. Regarding causation, the Supreme Court has stated that at least something less than a "high degree of probability" standard is expressed clearly by courts with regard to causation issues, but less clearly with regard to proof of breach of the duty of care. Judges, lawyers, and academics have suggested to the author that in practice, judges actually decide breach-of-duty issues on something like a preponderance standard, but write their opinions as though the evidence as to whether the breach of duty was established was clearly convincing.

60. The Court recognized, however, that the time required for the diffusion of medical knowledge from one field to another is "relatively short." Infant retrolental fibroplagia case, supra note 58, 1537 HANREI JIHO at 7-8, 883 HANREI TAIMUZU at 97; SUZUKI ET AL., supra note 59, at 37.

61. IRYÔ HÔ [MEDICAL SERVICE LAW], Law No. 205 of 1948 as amended, art. 1, para. 4 no. 3; Judgment of Supreme Court Nov. 11, 2003, 57 MINSHÔ 1466, 1845 HANREI JIHO 63 (acute encephalopathy case); SUZUKI ET AL., supra note 59, at 42-43.


The “high degree of probability” standard is expressed clearly by courts with regard to causation issues, but less clearly with regard to proof of breach of the duty of care. Judges, lawyers, and academics have suggested to the author that in practice, judges actually decide breach-of-duty issues on something like a preponderance standard, but write their opinions as though the evidence as to whether the breach of duty was established was clearly convincing.


Just what “a high degree of probability” means is a matter of debate. Kevin Clermont, while recognizing the existence of controversy, has argued that the standard of proof in Japanese civil cases “requires that facts be proven to a high probability similar to beyond a reasonable doubt.” Kevin M. Clermont, Standards of Proof in Japan and the United States, 37 CORNELL INT’L L.J. 263, 263 (2004) (emphasis added). He linked the Japanese standard to the intime conviction standard employed in French civil law. This writer’s interviews with Japanese judges indicate, however, that Clermont’s characterization of the Japanese proof standard as “similar to beyond a reasonable doubt” is too stringent.

Ramseyer and Nakazato, relying on an old Tokyo District Court case, fell into the opposite error regarding malpractice claims based on tort. They stated that “[a]lthough tort plaintiffs must usually prove causation and lack of care, in malpractice cases courts deliberately switch the burden. As a result, to defend, a doctor will need to show that he met the standard set by other doctors in his specialty in his community.” RAMSEYER & NAKAZATO, supra note 43, at 67 (citing Judgment of Tokyo Dist. Ct. Ct. June 7, 1967, 485 HANREI JIHO 21, 25-26). The authors apparently took an atypical case involving facts allowing for a res ipsa-like presumption of negligence, and generalized its ruling to apply to all tort-based malpractice cases. Ramseyer corrected the error in a subsequent article. Ramseyer, Malpractice Claims, supra note 23, at 673–674.
scientific standard of certainty will suffice. The author’s interviews with numerous trial judges, from several courts and encompassing the range of judicial seniority, reveal not so much a contrariety of opinion regarding the standard as an insistence that flexible case-by-case determinations are needed.

The ambiguity of the standard of proof inevitably follows from the need for discretion in addressing the subtle factual circumstances presented by many injury claims, and relates both to institutional concern with preserving the court system’s legitimacy and to trial judges’ personal desire for “cover” when their judgments are reviewed on appeal. Just as US judges, sending factually controverted cases to juries, are disburdened by the lenient standard of appellate review of juries’ factual findings, so Japanese trial judges take a certain comfort in the degree of deference that appellate courts usually allow the trial judges’ determinations (sometimes written, perhaps, with the same enhanced certainty of an umpire’s emphatic call of a close play at the plate) of whether plaintiffs’ proofs met the “high degree of probability” standard.

The potential rigor of the “high degree of probability” standard is also mitigated in three other ways: (1) the application of a res ipsa-like rebuttable presumption of negligence where the facts warrant it; (2) the adoption of “loss of chance” doctrine to justify partial compensation where negligence is proven but its causal consequences are difficult to ascertain;
and (3) judges’ common practice of pressuring attorneys to settle for partial compensation cases in which negligence is established but proof of causation is hazy.  

An indication that Japanese jurisprudence has moved toward a less rigorous stance regarding proof burdens is the 2000 Supreme Court case recognizing a “loss of chance” remedy for negligent failure to diagnose and treat a malady for which timely diagnosis and treatment would have afforded the patient a “considerable possibility” (sōtō no kanōsei), but not a “high degree of probability” (kōdo no gaizensei), of survival. Given that the preservation of life is a “fundamental value” worthy of legal protection, the Court ruled that the value’s invasion by an act of medical negligence required a legal remedy. The Court later expanded the loss-of-chance principle to encompass cases in which medical negligence was followed not by death but rather by serious impairment, but the level of impairment the patient would have suffered absent negligence was not proven to a high degree of probability. Subsequent cases in the lower courts have adopted a principle of proportionate liability, scaling damages in rough accordance with the percentage possibility of survival or full recovery had the defendant acted with due care.

4. Informed Consent and Related Actions

Apart from the duty to provide medical care meeting legal standards, physicians also have a duty to obtain from patients what has come to be called (for lack of any equivalent expression in standard Japanese) infomudo konsento. Adapting the Western concept of patient autonomy to established customary patterns and departing from a line of previous cases granting high deference to medical custom, Japanese courts came to recognize that in some circumstances traditional principles of medical ethics, according precedence to the duty to save human life at all costs, must give


70. Id. The plaintiff was awarded a solatium (isharyō) of ¥2 million (US $18,000).

71. Judgment of Supreme Court Nov. 11, 2003, 57 MINSHŌ 1466, 1845 HANREI JIHO 63 (acute encephalopathy and failure-to-transfer case).

72. Damages may be awarded even if the patient’s chance of survival or full recovery was less than 50 percent. Tokyo Judges 2010 Interview, supra note 68; interview with Yoshio Katō, noted plaintiff’s attorney, in Nagoya (July 26, 2010).
A leading Supreme Court case recognizing this principle affirmed a damage award to a Jehovah’s Witness who was given a blood transfusion despite her contrary expressed intent. Although the procedure was medically successful—she survived her cancer far longer than was predicted—the Supreme Court nevertheless affirmed a consolation or solatium (isharyd) award for “emotional suffering” of the nominal sum of ¥500,000 (US $5,000). This case constituted Japan’s recognition—contrary to US informed consent precedents requiring “decision causation”—that a dignitary interest apart from physical harm is worthy of protection in informed consent cases.

Parallel to physicians’ duty to obtain the patient’s informed consent before treatment is the physician’s obligation to explain accurately the results of treatment, including adverse results. This duty of explanation of treatment outcomes (benmei gimu) is held to arise from the patient-physician contractual relationship. The principle has been tested in recent years in cases in which patients and families were not given honest explanations of adverse outcomes, and courts have awarded solatium damages for physicians’ breaches of this duty.

5. Damages

Apart from solatium awards for intangible and dignitary injury, damages in Japanese medical malpractice cases are standardized in accordance with injury severity levels as defined in the traffic accident compensa-

73. Detailed examinations of the development of informed consent theory and practice in Japanese medicine can be found in Leflar, Informed Consent, supra note 6, and Leflar, Renaissance, supra note 9.

74. Jehovah’s Witness case, supra note 7. Excerpts of both the High Court and Supreme Court opinions are translated into English in MILHAUPT, RAMSEYER & WEST, supra note 7, at 347–356.

75. The term “decision causation,” indicating the requirement that a plaintiff prove that had risk disclosure been sufficient, the plaintiff would have decided on a different treatment course leading to less physical harm, was coined in Alan Meisel & Lisa D. Kabnick, Informed Consent to Medical Treatment: An Analysis of Recent Legislation, 41 U. PITT. L. REV. 407, 438–439 (1980) and popularized in Aaron Twerski & Neil B. Cohen, Informed Decisionmaking and the Law of Torts: The Myth of Justiciable Causation, 1988 U. ILL. L. REV. 60 (1989). For an argument that deprivation of informed choice should give rise to an action for dignitary harm in U.S. medical negligence and prescription drug litigation, see Margaret A. Berger & Aaron D. Twerski, Uncertainty and Informed Choice: Unmasking Daubert, 104 MICH. L. REV. 257 (2005).

76. For example, in a suit against a hospital and its staff for brain damage suffered by a child from heart stoppage due to a medication error and subsequent inadequate resuscitation efforts, the court found that the hospital had engaged in a cover-up of the facts. In addition to awarding damages and costs of ¥243 million (US $2.2 million) plus interest on the malpractice counts, the court awarded ¥1 million (US $9,000) for the contract breach. Judgment of Kyoto Dist. Ct. July 12, 2005, 1907 HANREI JIHÔ 112, 124–125. See also, e.g., Judgment of Tokyo High Ct. Sept. 30, 2004, 1880 HANREI JIHÔ 72; SUZUKI ET AL., supra note 59, at 66.
tion system. Once negligence and causation are determined, the plaintiff is entitled to an award within these fairly definite limits. Punitive damages are not available.

Awards for injury in Japanese medical malpractice cases do not seem to differ radically in amount from awards in other advanced nations, and may exceed them. Mark Ramseyer, drawing on a database of actions filed in 2004, observed that in wrongful death cases, for example, median and mean damage awards were respectively ¥37.5 and ¥40.6 million (roughly US $350,000 at then-current exchange rates)—recoveries higher in real terms than those observed on average in the high-award US jurisdiction of Florida.

77. SHIGEMI OSHIDA, YASUSHI KODAMA & TOSHIHIRO SUZUKI, JITSUREI NI MANABU IRYŌ JIKO [A REAL-WORLD VIEW OF MEDICAL ACCIDENT CASES] 20–21 (2002). Pain-and-suffering damages in death cases include awards to surviving family members for their grief, and may be adjusted up or down for unusual circumstances. Id. Damage amounts for each level of injury severity are set out in publications available not only to judges, lawyers, and liability insurers, but also to the general public. See, e.g., MINJI KOTSU JIKO SOSHŌ: SONGAI BAISHŌ-GAKU SANTEI KIJUN [CIVIL TRAFFIC ACCIDENT LITIGATION: COMPUTATION STANDARDS FOR DAMAGES] (Tokyo 3rd Bar Ass’n ed., 2006) (generally known as “Akanon” (“the Red Book’’)). For a description of damage calculations using the Red Book, see Eric A. Feldman, Law, Society, and Medical Malpractice Litigation in Japan, 8 WASH. U. GLOBAL STUD. L. REV. 257, 266 (2009), originally published as Eric A. Feldman, Suing Doctors in Japan: Structure, Culture, and the Rise of Malpractice Litigation, in FAULT LINES: TORT LAW AS CULTURAL PRACTICE 233 (David M. Engel & Michael McCann eds., 2009).

Damages of a given level of severity in medical malpractice cases may somewhat exceed those in auto accident cases, perhaps taking into account the additional difficulty of proving malpractice liability. Yoshiharu Kawabata, “Health-Related Litigation and Its Reform Through a Practitioner’s Eyes,” address at Penn State Dickinson School of Law Freeman Symposium on Health, Law, and Justice in Asia (Apr. 28, 2006) [hereinafter Kawabata, Dickinson Lecture] (plaintiffs’ attorney’s estimation of 10–20 percent damages bonus in malpractice cases).

78. RAMSEYER & NAKAZATO, supra note 43, at 89 n. 53.

79. See Leflar & Iwata, supra note 12, at 200 & n. 40 (observing similar scale of damages in Japanese and US wrongful death cases). By contrast, Eric Feldman views the Japanese scale of damages as both “more predictable and more modest” than US levels. Feldman, supra note 77, at 266. A caveat: in performing international comparisons over time of malpractice awards (or anything else), yen-denominated sums have grown considerably, relative to other currencies, concomitantly with the rise in the yen’s exchange value.

80. Ramseyer, Malpractice Claims, supra note 23, at 653. Awards ranged from ¥200,000 to ¥189 million (US $2,000–$1.6 million). Id. Judges arrive at these damage awards by calculating, in addition to out-of-pocket medical and funeral expenses, the present value of the decedent’s expected earnings, subtracting almost half of that value for foregone living expenses, and adding a standardized amount for pain and suffering—a method drawn from the standardized evaluation of traffic accident damages, see supra note 77. Payments from collateral sources are not included in damage awards. For a helpful summary of the law of damage calculations in tort, see Eri Osaka, Reevaluating the Role of the Tort Liability System in Japan, 26 ARIZ. J. INT’L & COMP. L. 393, 395–396 (2009).

81. A study of Florida malpractice awards from 1990–2003 found that the median and mean payments for wrongful death claims were $195,000 and $290,000. Neil Vidmar et al., Uncovering the Invisible Profile of Medical Malpractice Litigation: Insights from Florida, 54 DEPAUL L. REV. 315, 340 (2005) (tbl. 7); see also Leflar & Iwata, supra note 12, at 200 (similar analysis).
Most malpractice claims are settled (either extrajudicially or during the litigation process) or dropped, rather than being tried to judgment. Settlement negotiations in any medical malpractice case depend on assessments by plaintiff and defense counsel of the strength of plaintiff's proof of three elements: (1) negligence, (2) causation, and (3) damages. One result of Japan's standardized damages schedule is that prejudgment negotiations become relatively predictable in respect of the damages element. Not only judges, lawyers, and liability insurers, but hospital management and patients and families as well, have access to the formulas for calculating damage amounts. In many US medical malpractice actions, plaintiffs' and defendants' attorneys' widely varying assessments of the plaintiff's damages obstruct resolution of the case. In Japan, these valuation conflicts are muted. This is a partial explanation for the lower litigation rates for Japanese medical malpractice claims in comparison with the US.

Patients' medical and rehabilitation expenses resulting from medical misadventure are covered, in the main, by the health insurance programs in which virtually all patients are enrolled. As a legal matter, the insurance programs have a right of subrogation to patients' claims against providers whose negligence necessitated the expenses. As a practical matter, subrogation claims appear to be rare, although they are not unknown in cases of serious impairment where medical and rehabilitation expenses are very high. One reason for their rarity, according to an experienced hosp-
tal defense attorney, is that in settled cases the release agreement frequently contains a clause prohibiting the parties from disclosing the settlement or its amount to anyone, even the social insurance entity. If the insurer that covered the patient’s medical expenses never learns of the claim or the settlement, and has no hawk-like monitor examining the case, then its subrogation right never comes into play.

B. Key Aspects of Procedural Law and Practice

1. In General

Japanese civil litigation is conducted by professional judges without juries, in keeping with principles of German law introduced in the late 19th century. Typically two or three judges hear each case. Trials take place in sequential hearings over a period of months or years, and attorneys for all parties submit documentary evidence, testimony, and arguments on a scheduled basis during this period. Medical malpractice trials in particular, with their typically complex and controverted facts, have been notorious for their prolonged duration. One infamous case, Dickensian in its protracted length, required twenty years for its ultimate resolution in the Supreme Court in favor of the injured patient.

Additional criticisms of the medical injury litigation system have centered on inadequate discovery procedures and the difficulty of coping with the allegedly frequent alteration of medical charts by hospital personnel, making it hard for plaintiffs to obtain accurate evidence about adverse events. These criticisms have been answered to some extent by expansion of discovery procedures in a 1998 reform of the Civil Procedure

86. Id. Kodama memorably characterized this phenomenon as “the puzzle of the Sphinx.”
88. See RAMSEYER & NAKAZATO, supra note 43, at 139–141 (describing discontinuous trial system).
90. See ISHIKAWA, supra note 23 (setting out examples of altered medical charts); Ramseyer, Malpractice Claims, supra note 23 (noting that the practice “commonly happens”).
Code by the routine availability on demand of patient charts through evidence preservation (shōko hozen) actions and direct patient requests to the medical facility.

2. Discovery of Peer Review Findings

An issue that concerns physicians and hospitals in Japan, as it does in the United States, is the availability for litigation purposes of peer reviews of adverse events. Such reviews have become more common in the past decade pursuant to guidance issued by the health ministry, and are standard procedure in cases handled by the Model Project. Three legal grounds support at least partial release of peer review documents: (1) national and local Freedom of Information rules applicable to public hospitals; (2) an implied contractual obligation of hospitals to investigate medical accidents and report the results to patients and families; and (3) liberalized discovery procedures under the revised Civil Procedure Code.

In a leading case interpreting the new discovery rules, the Tokyo High Court ruled that the portion of the hospital report containing fact-gathering interviews with hospital personnel was non-disclosable in order to protect interviewees' "free formation of ideas," but the portion of the report containing "objective" conclusions about the patient's course, the causes of her death, and proposed corrective measures must be disclosed. Experienced


94. See Leflar & Iwata, supra note 12, at 205–206 (citing guidance documents).

95. See supra notes 33–35 and accompanying text.

96. See Information Disclosure Law, supra note 8.


98. See Leflar & Iwata, supra note 12, at 206–213.

defense attorneys routinely advise hospital clients to prepare for disclosure of anything that goes into such case reports.\textsuperscript{100}

3. Judicial Administration Reforms

Responding to criticisms of excessive delays in medical malpractice litigation, the Supreme Court's administrative office instituted several reforms aimed at improving the celerity and efficiency of the judicial process. The most noteworthy of these reforms were (1) clearly delineated time-lines for trials; (2) concentrated evidence gathering; (3) the use of judge-appointed expert witnesses; and (4) the creation of health care divisions (\textit{iryō shūchūbu}) in some metropolitan district courts. The first three reforms were launched in 1998, at the time of a reform of the Civil Procedure Code. The health care divisions began operating in 2001.\textsuperscript{101}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure3.png}
\caption{Disposition of Medical Malpractice Civil Cases Filed in Court, 1994-2010.\textsuperscript{102}}
\end{figure}

As Figure 3 indicates, the duration of litigated medical cases began declining even before these reforms were launched, but the reforms appear to have succeeded in further reducing litigation delays.

\footnotesize{\textsuperscript{100} Tokyo Judges 2010 Interview, \textit{supra} note 68; interview with Yasushi Kodama, a leading hospital defense attorney, Miyakezaka Sogo Law Offices, in Tokyo (July 30, 2010).}

\footnotesize{\textsuperscript{101} For discussions of these reforms, see Feldman, \textit{supra} note 77, at 273–275; Robert B Leflar, \textit{Public and Private Justice: Redressing Health Care Harm in Japan}, 4 DREXEL L. REV. 243 (2012).}

\footnotesize{\textsuperscript{102} Supreme Court Medical Malpractice Case Statistics, \textit{supra} note 53.}
4. Settlement Practices, Overall Claiming Levels, and Malpractice Insurance Premiums

Malpractice case filings in court, set out in Figure 2 above, represent only a fraction of all medical injury claims made by patients and paid by medical providers or their liability insurers. Extrajudicial dispute resolution is encouraged both by law and through the activities of entrepreneurial academics. What proportion of all medical injury claims is filed in court is difficult to ascertain, since insurers are famously close with their payout data. Three leading Tokyo attorneys, one representing hospitals, one the Japan Medical Association, and the third plaintiffs, all suggested to the author that court-filed claims constitute merely the "tip of the iceberg" of all claims.

Mark Ramseyer has constructed a useful range of estimates of overall medical malpractice claiming levels, including claims not filed in court, from three sources: (1) court statistics, (2) insurance premiums, and (3) informed observer estimates. Court claims data are firm: 1,110 malpractice claims were filed in court nationwide in 2004, for example, or one lawsuit per 115,000 Japanese residents. Insurance premium data are less precise, and require somewhat speculative manipulations. Estimates from

103. See supra note 53 and accompanying figure.

It was once a common practice for physicians and hospitals to offer mimaikin, small gifts of money in token of sympathy, to injured patients and families (whether or not they had legal representation) before any lawsuit was filed. See Robert B. Leflar, Personal Injury Compensation Systems in Japan: Values Advanced and Values Undermined, 15 U. HAW. L. REV. 742, 749 (1993). That practice has become less common since public distrust of medical skill and probity following the publicized disasters of 1999–2004 made the offering of small mimaikin seem "ridiculous." Interview with Yasushi Kodama, a leading hospital defense attorney, Miyakezaka Sogo Law Offices, in Tokyo (Aug. 4, 2011).

108. See Supreme Court Medical Malpractice Case Statistics, supra note 53. The population of Japan in 2004 was about 127 million.
109. Ramseyer estimates that annual malpractice insurance premiums total about ¥69 billion (US $860 million). Ramseyer, Malpractice Claims, supra note 23, at 664. A recent estimate from Sompo Japan, a major liability insurer, puts the total somewhat lower, at ¥41 billion (US $510 million). Sompo
knowledgeable Japanese observers of the claims made/court claims filed ratio, while worthy of respect, are unverifiable.

Employing each of these sources in turn, Ramseyer provides a range of estimates of annual medical malpractice claims in Japan based on 2004 data: between 2,230 and 13,875 total claims per year, in court and out,\textsuperscript{110} with the likely truth somewhere between. Japan’s population is 127 million, so that represents a range of one malpractice claim annually per 9,000 to 60,000 residents. To give international perspective to that range, annual malpractice claims (in court and out) in the US, with its population of about 300 million, were credibly estimated in 2006 as 50,000 to 60,000, that is, one claim per 5,000 to 6,000 residents,\textsuperscript{111} or between 1.5 and 12 times Ramseyer’s estimated Japanese claiming rate. Annual medical malpractice claims filed in court (not extrajudicially) in 2004 in Canada, with a population of 32 million, amounted to 1,083 claims,\textsuperscript{112} or one lawsuit per 30,000 residents, about four times Japan’s per capita lawsuit filing rate of one lawsuit per 115,000 residents.\textsuperscript{113} A reasonable approximate estimate would be that a Japanese patient is one-fourth to one-sixth as likely to make a claim against a medical provider as a North American patient.\textsuperscript{114}

Malpractice liability insurance to cover these claims is provided to clinic physicians in private practice chiefly through private insurance plans organized by national and prefectural medical associations, and to private and many public hospitals through commercial carriers such as Sompo Japan Insurance Inc., Ishi baishō sekinin ni tsuite [Physicians’ Liability Insurance] (Aug. 3, 2011) (on file with author). Of this sum, roughly 60 percent is paid out to claimants. Ramseyer, Malpractice Claims, supra note 23, at 664.

\textsuperscript{110} Id. at 667.


\textsuperscript{112} Canadian Health Services Research Foundation, Myth: Medical Malpractice Lawsuits Plague Canada (2006), available at http://www.chsrf.ca/publicationsandresources/Mythbusters/ArticleView/06-03-01/70e601b8-487a-44d0-b390-4e4a0a453493.aspx, cited in Ramseyer, Malpractice Claims, at 667–668.

\textsuperscript{113} For an earlier comparison of malpractice claim filing rates in Japan and several Western nations, see Nakajima et al., supra note 106, at 1638. An extensive literature, unnecessary to explore here, seeks to explain the difference in propensity to litigate between Japan and the US. For overviews of the debate, see, for example, JOHN OWEN HALEY, AUTHORITY WITHOUT POWER: LAW AND THE JAPANESE PARADOX 108–111 (1991); MILHAUPT, RAMSEYER & WEST, supra note 7, at 141–176 (2006); Andrew D. Feld, Culture and Medical Malpractice: Lessons from Japan. Is the “Reluctant Plaintiff” a Myth? 101 AM. J. GASTROENTEROLOGY 1949 (2006).

\textsuperscript{114} Adding some credence to this estimate are statistics from major liability insurer Sompo Japan indicating that physician and hospital liability insurance, as a proportion of all casualty insurance, is 0.37 percent in Japan and 1.52 percent in the U.S., approximately a 1 to 4 ratio. See Sompo Japan Insurance Inc., supra note 109, at 9 (calculated from figures given in table).
Japan and Tokyo Marine. Private physicians’ standard insurance policies come with a ¥1 million (US $13,000) deductible and cover liability up to ¥100 million (US $1.3 million). Standard hospital policies cover the same liability level, but typically with no deductible. Physicians employed by hospitals receive standard coverage under their hospitals’ policies, but some physicians purchase additional personal coverage. Excess liability insurance covering large-claim liability above standard policy limits, considered “vitaly important” to self-insured hospitals in the US, is available in Japan for liability in the range of ¥100-200 million (US $1.3-$2.5 million). However, there are so few large claims that marketing reinsurance for claims exceeding these amounts is uneconomical.

Liability insurance does not constitute a significant part of ordinary practitioners’ daily concerns, although hospital administrators must keep the issue in mind. Liability insurance is regulated nationally by the Financial Services Agency, which has control over rate-setting. For physicians in private practice, premiums are uniform nationwide: ¥70,000 yen annually (US $875, tax-deductible), with no differentiation based on practice specialty or location. Hospital-employed physicians pay somewhat less. Since a 2004 premium revision, hospitals’ insurance premiums, once also uniform, have varied depending on their bed count and treatment levels. Hospitals insured by the Japan Hospital Federation with more than 500 beds, for example, pay ¥23,160 (US $290) per bed per year, while

115. Some national hospitals and national university hospitals cover liability costs through taxpayer-funded operating budgets or through a quasi-public entity, Kokuritsu byōin kikō [National Hospital Organization], rather than by purchasing liability insurance from private firms. See http://www.hosp.go.jp/ (National Hospital Organization website).


117. Ramseyer, Malpractice Claims, supra note 23, at 664-665; Kawabata interview, supra note 106.

118. Frank A. Sloan & Lindsey M. Chepke, Medical Malpractice 247 (2008).

119. Interviews with Satoko Nishimura, insurance policy specialist, in Tokyo (July 19 and Aug. 3, 2011); see also Kodama interview, supra note 85 (effect of “high-cost health care expense system” on liability for catastrophic injury).

120. This ¥70,000 premium is charged to JMA members owning clinics or small hospitals. Physicians may also purchase additional insurance to cover the ¥1 million deductible and liability for injuries resulting from non-medical acts, such as slip-and-falls at physician-owned hospitals. This additional insurance sells for ¥8,620 (US $110). Sompo Japan Insurance Inc., supra note 109, at 3-4.

121. Non-JMA members (mainly hospital-employed physicians) can purchase a standard policy for ¥55,000 (US $700), and physician trainees for ¥34,000 (US $400). Id. These doctors are typically covered by the hospital’s liability insurance anyway, so it is unclear to the author why many of them purchase it.
hospitals with 200-299 beds pay ¥21,536 (US $270). Hospitals’ premiums are experience-rated, to some extent; physicians’ premiums are not.

5. Plaintiffs’ Attorney Fees and Court Filing Fees

One barrier confronting patients considering medical malpractice lawsuits, identified by numerous scholars and critics of the Japanese court system, has been plaintiffs’ attorneys’ fee structure. In contrast to the United States, in which pure contingent fee arrangements with no up-front payments are standard, in Japan plaintiffs customarily had to pay lawyers a substantial up-front retainer according to a standardized schedule enforced by the bar association, plus a filing fee to the court based on the amount claimed. Together, these payments amounted to the yen-equivalent of several thousand dollars, closing the courthouse door to most seriously injured patients without substantial means. Recent reforms have lowered these barriers somewhat: court filing fees in high-damage cases substantially decreased in 2003, and the bar association withdrew its attorney fee

122. ZENKOKU KÔSHI BYÔIN RENMEI NO BYÔIN BAISHÔ SEKININ HOKEN-TÔ NO GOANNAI [JAPAN HOSPITAL FEDERATION GUIDE TO HOSPITAL LIABILITY INSURANCE] 5-8 (2010); interview with Mitsugu Ikeda, Japan Hospital Federation, in Tokyo (July 29, 2010). The Japan Hospital Federation (JHF) includes a selection of public and private hospitals including the Japan Red Cross hospital group. University hospitals carrying out high-risk procedures on a frequent basis, non-JHF members, are reported to pay higher premiums in the range of ¥30,000 (US $375) per bed. See Leflar, “Unnatural Deaths,” supra note 13, at 8 n. 28. Smaller hospitals of less than 100 beds, where fewer high-risk procedures are performed, are charged only ¥16,000 (US $200) per bed. Sompo Japan Insurance Inc., supra note 109, at 4.

123. Ikeda interview, supra note 122; Nishimura interviews, supra note 119.

124. Nishimura interviews, supra note 119; Nakajima et al., supra note 106, at 1635. Claims experience for individual physicians is too limited to warrant the expense of compiling experience ratings. Cf. SLOAN & CHEPKE, supra note 118 (explaining limitations of experience rating in the US medical malpractice insurance market). The actuarial difficulty of rating individual physicians’ likely future claim exposure is even greater in Japan, with its low litigation rates, than in the US.


126. See Maeda et al., supra note 125, at 61 tbl. 9 (noting start-up fees of ¥3 million—then about US $24,000—for cases involving minor plaintiffs claiming lifelong earning deprivation). Occasionally patients do file pro se claims, however, and once in a while, they win. Id. at 59–60; interview with Shunsuke Funase, successful pro se plaintiff, in Naguri, Saitama-ken (Aug. 9, 2009).

127. Feldman, supra note 125, at 797 n. 45. Filing a claim for ¥10 million (US $125,000) now requires a filing fee of ¥50,000 (US $625); a claim of ¥100 million (US $1.25 million) requires a fee of ¥320,000 (US $4,000). For the current filing fee schedule, see http://www.courts.go.jp/saiban/tetuzukitetsuuryou.html (last visited July 16, 2011).
schedule as contrary to antimonopoly law. Currently, some attorneys handling malpractice cases for plaintiffs offer potential clients a degree of flexibility in payment arrangements. For example, the attorney may charge a fee for preliminary case evaluation smaller than the standard retainer and, if the attorney takes the case, a discounted retainer amount may be paid in installments; or the retainer may be decreased while the attorney's share of the recovery, contingent on success, is increased. A contingency arrangement of 15-25 percent of the total recovery, with various adjustments, is common. Still, most attorneys are said to work within the basic framework of the former customary fee schedule.

III. The No-Fault Compensation System for Obstetrical Injury

Japan has a notable history of enacting no-fault administrative compensation systems providing relief for injured persons apart from that available under the civil law, whose various limitations made compensation in circumstances of high social concern difficult or impossible. These compensation systems include schemes aiding people injured by environmental pollution, vaccinations, adverse drug reactions, infections from biological products, blood transfusions, and asbestos exposure. The most recent of these no-fault administrative compensation systems provides relief to parents of a limited class of newborn infants with severe brain damage.

Birth injury cases are among the most serious in every legal system. Profound brain injuries compounded with lifelong rehabilitative needs add up to enormous potential damages. Obstetricians face the prospect that even a minor slip may subject them and their insurance carriers to vast damage judgments.

128. Kawabata, Dickinson Lecture, supra note 77.
129. Katō interview, supra note 72; Suzuki and associates interview, supra note 68. Katō and Suzuki are both leaders of cooperating groups of plaintiffs' attorneys specializing in medical malpractice cases.
130. Katō interview, supra note 72; Suzuki interview, supra note 68; Feldman, supra note 77, at 264 & n. 24
Litigation over birth-related injuries has generated considerable concern among Japanese obstetricians. Among civil malpractice actions, suits over obstetrical injuries have apparently resulted in a higher-than-average proportion of plaintiffs’ judgments. Of perhaps even greater concern, prosecutors instituted criminal proceedings in 2006 (intensely publicized, but ultimately unsuccessful) against an obstetrician who lost a patient during a difficult delivery, casting a shadow of fear over the profession and giving impetus to the antiregulatory iryō hōkai movement described above.

At the instigation of the Japan Medical Association, the Japan Society of Obstetrics & Gynecology, and the then-governing Liberal Democratic Party, the health ministry initiated a no-fault compensation system for a limited class of obstetrical injuries. Launched on January 1, 2009, the system is modeled in some respects on Florida’s neurological injury compensation system. It is administered by the quasi-public Japan Council for Quality Health Care (JCQHC), and is financed through a fixed per-birth levy from the social insurance system paid to private insurance companies that stand to reap profits (or possibly suffer losses) from the system’s operation.

133. See Nana Uesugi et al., Analysis of Birth-Related Medical Malpractice Litigation Cases in Japan: Review and Discussion Towards Implementation of a No-Fault Compensation System, 36 J. OBSTETRICAL & GYNECOLOGICAL RES. 717 (2010) (69 percent of sixty-four cases in database of reported birth defect cases resulted in some recovery); compare Ramseyer, Malpractice Claims, supra note 23, at 626–627 (some recovery in 30–40 percent of all medical malpractice cases litigated to final judgment). It is possible, however, that the publishers’ selection of cases to be reported biased the database used by Uesugi et al. in favor of cases in which plaintiffs recovered. See id. at 642–644.

134. See supra, text pt. I.C.

135. Criteria for compensation are rather strict. Infants must be diagnosed with cerebral palsy of the first or second degree of severity, must weigh more than 2000 grams at birth, and with few exceptions must be born after thirty-three weeks of pregnancy. Infants who die within six months and those whose anomalies are congenital are excluded from compensation. Eligibility determinations are performed by expert panels. The level of compensation is fixed: a one-time payment of ¥6 million (US $75,000), plus ¥24 million (US $300,000) paid out over the first twenty years of the child’s life, for a total of ¥30 million (US $375,000) per child. MHLW, Sanka iryō hoshō scido ni tsuite [The Obstetrical Compensation System], http://www.mhlw.go.jp/topics/bukyoku/isct/anzen/sanka-iryou/index.html (last visited Aug. 6, 2011).

136. The Florida system, like Virginia’s Birth-Related Injury Fund, is a no-fault system for compensation of some serious neurological injuries sustained during or close to childbirth. For an overview of the two systems, see Sloan & Chepke, supra note 118, at 280–287.

137. The cash flow is circuitous. Funding for the system is generated by a levy of ¥30,000 (US $375) on each birth. JCQHC collects this amount from hospitals and maternity clinics that choose to participate, and channels the money to the private insurers. The hospitals and clinics in turn collect an identical amount from each expectant mother. By Cabinet Order, the amount of the lump-sum childbirth subsidy that each mother receives from her health insurance plan was increased by the same ¥30,000 at the time the compensation system was launched. See Taro Tomizuka & Ryozo Matsuda, Introduction of No-Fault Obstetric Compensation, HEALTH POL’Y MONITOR (Oct. 2009), available at http://hpm.org/survey/jp/a14/4.
The system’s stated goals are to provide prompt compensation, without the need for legal proceedings, to parents of infants suffering cerebral palsy related to brain injuries during childbirth, and to improve the quality of maternal care and prevent future cases. Of particular note, Japan’s obstetrical injury compensation system was instituted in a manner that required no legislation. It is a voluntary system—no childbirth facility is obligated to participate. It is operated outside of government by JCQHC. Social insurance funds finance the system, and no specific legislative appropriation is needed. Parents still have a right to sue medical providers for negligence, as before the system was instituted.

Although it is premature to evaluate the new compensation system, it does appear to have gained traction. Essentially all childbirth facilities in the nation (99.7 percent) have signed up to participate. For births occurring in 2009, the first year of operation, as of mid-2011 the system had reviewed 152 applications for compensation and accepted 139. This appears to exceed by a substantial margin the proportion of cerebral palsy cases compensated by the Florida system. For a recently launched program, the new system seems to be capturing a substantial proportion of cerebral palsy cases. It remains to be seen whether the system’s financing will suffice in the long term, but it is running a considerable surplus at present, greatly benefitting participating private insurers (and imposing a substantial cost onto the social insurance system).

138. Tomizuka & Matsuda, supra note 137.
139. Dai-8-kai Sanka iryo hoshō seido un’ei iinkai shidai [Agenda for 8th Meeting of Obstetrical Compensation System Management Committee], at 3 (July 6, 2011) (table in agenda materials), available at http://www.sanka-hp.jcqhc.or.jp/pdf/obstrics_meeting_08.pdf. The high participation rate is chiefly explained by the fact that neither the hospital or clinic, nor the expectant mothers for whose custom the hospitals and clinics compete, bear any financial risk from participation, due to the cost pass-through explained in note 137 supra. Interview with Naoki Ikegami, Chair, Dep’t. of Health Policy & Management, Keio U. Sch. of Medicine, in Tokyo (Aug. 8, 2011).
140. Compensation System Committee Agenda, supra note 139, at 5.
141. The Florida compensation system, and a similar system operating in Virginia, are reported to be compensating no more than 2 percent of cerebral palsy cases in those states. See SLOAN & CHEPKE, supra note 118, at 282. One estimate placed the annual incidence of cerebral palsy cases in Japan at about 630, Tomizuka & Matsuda, supra note 137, although it is unclear whether that estimate is based on a disease definition congruent with the standards for compensation applied in the new Japanese system. Supposing the estimate of 630 cases is not far off the mark, and well over 100 of them are accepted for compensation in a year, it is clear that the Japanese system is capturing a far higher percentage of cases for compensation than the Florida system.
142. In 2009, the system’s first full year of operation, it collected ¥31.5 billion (US $340 million) in premiums ($30,000 x 1,054,340 births). Through the end of 2010, the system had accepted compensation claims for ninety-nine applications regarding those 2009 births, thereby incurring payment obligations over twenty years totaling just ¥3 billion (99 x ¥30 million, see supra note 135)—only a tenth of premiums collected. Compensation System Committee Agenda, supra note 139, at 17.
on the quality of obstetrical care and on malpractice claiming practices remain to be researched.

The success or failure of the no-fault obstetrical compensation system may also have implications for the future of Japan’s medical malpractice system as a whole. Support for no-fault compensation comes from what some outside observers might consider unlikely quarters. For example, the Japan Medical Association has long espoused the merits of a national no-fault compensation system for medical injuries in general.143 The Japan Federation of Bar Associations has likewise come out in favor of a no-fault system, albeit of a different nature.144 The Ministry of Health, Labor & Welfare has just launched a blue-ribbon study commission on no-fault compensation for medical injury.145 Administrative compensation systems based on no-fault principles have a solid grounding in Japanese legal tradition over several decades.146 If the obstetrical injury compensation system proves successful, it is not beyond contemplation that broad-based support for a general no-fault compensation system for medical injury could emerge.

CONCLUSION

Distinctive features of Japanese law and society relating to medical misadventure include the following:

Criminal law: In the early years of the 21st century, after a series of publicized errors at hospitals of high repute focused public attention on slipshod practices and dishonesty in the medical world, the criminal justice


146. See supra note 136 and accompanying text.
system, amplified by media reportage, sounded a wake-up call to a medical profession previously lacking in accountability mechanisms. The health ministry and organized medicine responded with various measures to improve patient safety; the extent to which those measures may have been effective is unknown. Prosecutors' sometimes-excessive involvement in policing medical quality, however, has recently provoked a reaction from the medical profession eliciting media and public sympathy, perhaps contributing to an unusual string of acquittals of medical defendants, and clipping the prosecutors' wings.

Civil law: Civil Code provisions governing compensation for medical injury are fault-based and do not differ greatly in principle from rules applied in North America and Western Europe. The burden of proof of causation is relaxed in informed consent and loss-of-chance cases. Procedural reforms, including the institution of health care divisions of district courts in some metropolitan areas, have helped speed up the pace of judicial proceedings, once notoriously glacial. Damage awards appear to be at least as high on average as in the United States, at current exchange rates, and are applied on a more consistent, standardized basis than in the United States. The volume of claims filed in court is considerably lower than North American levels, and has declined since the peak year of 2004. Most compensation payments are made outside, not within, the court system. Even so, overall claiming rates are low relative to North American practices. Malpractice insurance premiums, uniform nationwide for physicians in private practice without regard to specialty or geography, are far cheaper than in the United States.

Administrative compensation programs: Building on a tradition of no-fault administrative compensation schemes for people injured by pollution, defective drugs, vaccines, blood transfusions, and asbestos, Japan instituted in 2009 a nationwide no-fault compensation system for infants with severe birth-related brain injuries. Backed by the medical establishment, financed through public funding, administered by a quasi-public entity and offering substantial profit opportunities (as well as a theoretical risk of loss) to private insurers, the new compensation system has already achieved virtually universal buy-in by childbirth facilities hoping for protection from future litigation. Evaluation of the system's operation is still premature but worthy of scholarly attention. Should the obstetrical compensation system prove successful, it may serve as a springboard for the expansion of no-fault principles to cover a wider scope of medical injuries. Both the Japan Medical Association and the Japan Federation of Bar Associations are on record as favoring a no-fault compensation system of some sort, and a blue-ribbon commission is now examining the topic.