

PUBLIC AND PRIVATE JUSTICE: REDRESSING HEALTH CARE HARM IN JAPAN

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ABSTRACT

Japanese legal structures addressing health care-related deaths and injuries rely more on public law institutions and rules than do the common-law North American jurisdictions, where private law adjudication is predominant.

This Article explores four developments in twenty-first-century Japanese health care law. The first two are in the public law sphere: criminal prosecutions of health care personnel accused of medical errors, and a health ministry-sponsored "Model Project" to analyze medical-practice-associated deaths. The Article addresses a private law innovation: health care divisions of trial courts in several metropolitan areas. Finally, the Article introduces Japan's new no-fault program for compensating birth-related obstetrical injuries.

Conclusions: (1) Criminal law's importance as a force to improve medical quality will likely diminish, due to public and professional reaction against prosecutorial overreaching. (2) The health ministry's "Model Project," despite various limitations, reflects a welcome emphasis on objective peer review of adverse events in hospitals, and on transparency to patients, families, and the public about events leading to health care harm. (3) The track record of trial courts' health care divisions in shortening clogged court dockets is encouraging. Employment of court-appointed experts not beholden to the parties is intriguing, but more easily accommodated by continental legal systems of an inquisitorial nature than by common-law systems based on adversarial principles. (4) The no-fault obstetrical compensation system is off to a promising start, though premiums are collected at a

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[†] Translations are the author's unless otherwise noted. Yen-denominated sums are given with their approximate dollar equivalents for the year in question. Japanese names are given surname last, for consistency's sake. Some of the sources cited in this Article were unavailable for review by the *Drexel Law Review* but have been verified by the author.

level that far outstrips compensation obligations. If the system proves successful, Japan may consider extending no-fault principles to redress a wider range of health care harms.

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I. INTRODUCTION

Responding to the intensifying interest in non-traditional reforms of American law relating to medical injury,¹ this article addresses four features of Japanese law and practice dissimilar to the U.S. system, which relies chiefly on private law adjudication. In Japan, while private medical malpractice lawsuits and privately paid extrajudicial compensation arrangements are certainly important, criminal and administrative features of public law represent a more prominent part of the system for redressing health care harm than they do in the United States.

1. The outpouring of recent scholarship is prodigious. See, e.g., FRANK A. SLOAN & LINDSEY M. CHEPKE, *MEDICAL MALPRACTICE* (2008); *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* (William M. Sage & Rogan Kersh eds., 2006); Carolyn M. Clancy, *Patient Safety and Medical Liability Reform: Putting the Patient First*, *PATIENT SAFETY & QUALITY HEALTH CARE*, Sept.–Oct. 2010, at 6; David Hyman et al., *Estimating the Effect of Damages Caps in Medical Malpractice Cases: Evidence from Texas*, 1 *J. LEGAL ANALYSIS* 355 (2009); Allen Kachalia & Michelle M. Mello, *New Directions in Medical Liability Reform*, 364 *NEW ENG. J. MED.* 1564 (2011); Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 *N.Y.U. L. REV.* 391 (2005); Charles Silver et al., *Malpractice Payouts and Malpractice Insurance: Evidence from Texas Closed Claims, 1990-2003*, 33 *THE GENEVA PAPERS ON RISK & INS. ISSUES & PRAC.* 177 (2008).

The four aspects of the Japanese system to be addressed are (a) the role of criminal law in the regulation of medical quality; (b) a “Model Project” to provide impartial investigation of hospital death cases in a way that might lead both to safety improvements and to more rapid private claims resolution; (c) health care divisions of metropolitan trial courts; and (d) the new obstetrical injury no-fault compensation system.² None of the four is directly translatable into reform in the United States, given legal and cultural differences. As features of the intersection of law and medicine in the world’s third largest economy, however, they are valuable for comparative purposes and worthy of attention by health law scholars and policy analysts.

II. JAPAN AWAKENS TO THE MEDICAL ERROR PROBLEM

The problem of medical error first appeared on the radar screen of the Japanese public in a notable way in 1999, when in a case highly publicized by the mass media, a lung patient at Yokohama City Medical University Hospital had a part of his heart valve removed, and a heart patient with a similar name had surgery on his lung. The doctors and nurses involved were prosecuted for and convicted of the crime of “professional negligence causing death or injury.”³

In the years following 1999, into the limelight came instances of tragic blunders at famous hospitals, one after another, where patients, families, and officials were deceived by doctors about the facts.⁴ The media played an important role in the public awakening: reporters competed to dig up the details of the tragedies, shake the complacency of the medical establishment, and embarrass the health ministry. The publication, at about the same time, of the Institute of Medicine’s (IoM) *To Err Is Human*⁵ had a significant impact. It

2. Many of these features are addressed in greater detail in Robert B Leflar, *The Law of Medical Misadventure in Japan*, 87 CHI.-KENT L. REV. (forthcoming 2012).

3. Yokohama Chihō Saibansho [Yokohama Dist. Ct.] Sept. 20, 2001, 1087 HANREI TAIMUZU [HANTA] 296.

4. For details about well-known cases of medical error at twenty-first century Japanese hospitals, see Robert B Leflar, “Unnatural Deaths,” *Criminal Sanctions, and Medical Quality Improvement in Japan*, 9 YALE J. HEALTH POL’Y L. & ETHICS 1, 6–7 (2009), reprinted in 29 ZEITSCHRIFT FÜR JAPANISCHES RECHT [J. JAPANESE L.] 5 (2010) (F.R.G.); Robert B Leflar & Futoshi Iwata, *Medical Error as Reportable Event, as Tort, as Crime: A Transpacific Comparison*, 12 WIDENER L. REV. 189, 193–95 (2005), reprinted in 22 ZEITSCHRIFT FÜR JAPANISCHES RECHT [J. JAPANESE L.] 39 (2006) (F.R.G.).

5. INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et al. eds., 1999).

showed that medical error was a serious problem not only in Japan, but in other advanced nations as well. The IoM report gave the medical safety issue extra legitimacy: if the United States and other industrialized countries were gearing up to address the issue, then Japan should take action as well.

The health ministry began by setting up a small patient safety office in 2000. This office drafted guidance manuals advising hospitals to employ risk management personnel, initiated a chiefly voluntary adverse reaction reporting system,⁶ and launched a study of the incidence of adverse events in Japanese hospitals.⁷ That study, using a definition of “adverse event” from a well-known Canadian study,⁸ found that adverse events had occurred in 6-7% of hospitalizations, and that 23% of those adverse events were preventable.⁹

TABLE 1: Adverse Events in Hospitals in Eight Countries¹⁰

Study		Records Date	# of Records	Adverse Event Rate
USA	California	1974	20,864	4.7%
	Harvard MPS: NY	1984	30,195	3.7%
	Utah-Colorado	1992	14,052	2.9%
Australia: QAHCS		1992	14,179	16.6%
Denmark		1998	1097	9.0%
New Zealand		1998	6579	11.2%
United Kingdom		1999	1014	10.8%
Canada		2000	3745	7.5%
France		2002	778	14.5%
Japan		2004	4389	6.8%

6. Ministry of Health, Labor & Welfare (MHLW), Iryō jiko johō shūshū-tō jigyo [Medical Accident Information Collection Project], <http://www.mhlw.go.jp/topics/bukyoku/isei/i-anzen/jiko/index.html> (last visited Dec. 7, 2011). The entity collecting the reports is the Japan Council for Quality Health Care. See Nihon Iryō Kinō Hyōka Kikō [Japan Council for Quality Health Care], Iryō Jiko Jōhō Shūshū-tō Jigyō Yōkō [Outline of Medical Accident Information Collection Project], <http://www.med-safe.jp> (last visited Dec. 7, 2011).

7. HIDEOTO SAKAI, IRYŌ JIKO NO ZENKOKUTEKI HASSEI HINDO NI KANSURU KENKYŪ [REPORT ON THE NATIONWIDE INCIDENCE OF MEDICAL ACCIDENTS: III] (2006).

8. G. Ross Baker et al., *The Canadian Adverse Events Study: The Incidence of Adverse Events Among Hospital Patients in Canada*, 170 CAN. MED. ASS'N J. 1678, 1678 (2004).

9. See SAKAI, *supra* note 7, at 5, 18 (reporting 6.0% adverse event rate); Yasuyuki Sahara, Iryō Anzen Chōsa Iinkai ni tsuite [Medical Safety Study Committees] (MHLW medical safety official's presentation to the National University Hospital Medical Safety Management Association, June 26, 2008) (correcting adverse event rate in Sakai study to 6.8%) (on file with author).

10. CHARLES VINCENT, PATIENT SAFETY 42 (2006).

This table is from Charles Vincent's useful book, *Patient Safety*,¹¹ with the Japanese study inserted by this author as the bottom row. The various studies were conducted by different methods, so the results are not comparable.¹² What the table does indicate is that the rate of adverse events in hospitals worldwide is alarmingly high. More recent research indicates that the true adverse event rate may well be higher still.¹³

III. MEDICAL ERROR AND PUBLIC LAW

A. Criminal Law

The story of how Japan has approached the problem of medical error over the last decade begins with criminal law, not civil law or administrative measures. Although criminal prosecutions are far fewer in number than civil malpractice actions, the prosecutions rather than the civil suits garnered most of the headlines. It is the prosecutions that have concerned doctors and hospital administrators the most, because their reputations and careers are on the line.¹⁴ For several years following 1999, the number of medically-related

11. *Id.*

12. It cannot be said that the Australian hospitals, for example, are four times more hazardous than the American ones. Rather, the Australian researchers were more precise and meticulous in counting adverse events than the Americans were. *Id.* at 42–43. A limitation of the Japanese study is that it employed patient records from eighteen large hospitals that volunteered to participate. SAKAI, *supra* note 7, at 5. Those hospitals likely had a high degree of confidence in their results; rates from other hospitals of similar size may well be higher. On the other hand, procedures performed at smaller, local hospitals tend to be simpler and carry less risk. At any rate, it cannot be said that the 6.8% adverse event rate reported in the Japanese study is representative of the nation as a whole.

13. See, e.g., David C. Classen et al., 'Global Trigger Tool' Shows that Adverse Events in Hospitals May Be Ten Times Greater than Previously Measured, 30 HEALTH AFF. 581, 585 (2011).

14. The situation appears to be similar in other Asian countries, such as Taiwan, which maintains a legal system based to some extent on its Japanese colonial legacy. In Taiwan, by one scholar's account, the number of medical prosecutions has actually exceeded the number of civil malpractice cases. See P.J. Lin, *Criminal Judgments to Medical Malpractice in Taiwan*, 11 (Suppl. 1) LEGAL MED. (TOKYO) S376 (2009), abstract available at [http://www.bmlsearch.com/?&kwr=19261531\[pmid\]&cmpgn912037=GPD0912L14Nvx1tv&dt02=237477&dt03=0.90333&xplps3=Matches](http://www.bmlsearch.com/?&kwr=19261531[pmid]&cmpgn912037=GPD0912L14Nvx1tv&dt02=237477&dt03=0.90333&xplps3=Matches) (last visited Dec. 7, 2011) ("In Taiwan, criminal suits account [for] 79% of all medical malpractice [lawsuits]."). However, court statistics indicate that in recent years only 20% of medical malpractice actions are criminal; 80% are civil. Civil & Criminal Medical Malpractice Cases Filed in District Courts in Taiwan, 2003–2009 (266 criminal medical malpractice cases filed; 1091 civil cases) (document provided by Judge Gisele Chiu, Taipei High Court, Aug. 11, 2010, on file with author). Whatever the actual proportion may be, the prospect of criminal prosecution is sufficiently high to catch Taiwanese physicians' keen attention.

deaths and injuries reported to police increased dramatically, as did the number of cases police referred to prosecutors and the number of indictments and convictions of medical personnel.¹⁵

The three chief grounds on which medical prosecutions in Japan are based are: (1) “professional negligence causing death or injury,” the standard charge;¹⁶ (2) falsification of documents submitted to public authority,¹⁷ as in the case of a falsified death certificate or altered medical record submitted to the police or courts; and of considerable recent importance, (3) a physician’s failure to report an “unnatural death” to the police in violation of Article 21 of the Medical Practitioners’ Law.¹⁸

This “unnatural death” reporting requirement was originally aimed at murders, suicides, traffic accident deaths, contagious disease deaths, and similar matters within the jurisdiction of police or public health authorities.¹⁹ The scope expanded, however, when a patient died from a mistaken injection at Tokyo’s Hirō Hospital in 1999.²⁰ The hospital CEO both submitted a false death certificate and delayed reporting the death to police.²¹ The CEO was arrested and charged on both counts.²² The Supreme Court of Japan affirmed his convictions,²³ thereby establishing that deaths resulting from medical mismanagement might count as “unnatural deaths” that must be reported on pain of criminal sanction.

There are thousands of hospital deaths every year, a substantial proportion of which might be related to medical management. Therefore, the Hirō Hospital’s CEO’s arrest put physicians and hospital administrators all over Japan in a dilemma: if the hospital does report, police investigators might descend on it, seizing patient files, interrogating staff, disrupting patient care, and damaging the hospital’s reputation. If the hospital does not report, and police later learn of the death—perhaps from a family member’s complaint or from a

15. See Leflar, *supra* note 4, at 12–13.

16. KEIHŌ [PEN. C] 2007, art. 211.

17. *Id.* art. 104, 156.

18. ISHI HŌ [Medical Practitioners’ Law] art. 21.

19. See Leflar, *supra* note 4, at 22–23.

20. *Id.* at 23.

21. *Id.*

22. *Id.*

23. Supreme Court April 13, 2004, 58(4) SAIKŌ SAIBANSHO KEIJI HANREISHŪ [KEISHŪ] 247.

disgruntled hospital employee's whistleblower report—then the hospital administrator could be convicted of a violation of Article 21, as was the Hirō Hospital CEO.

How did criminal law come to have such significance in the field of medical law in Japan? In part, the answer lies in the fact that the criminal statutes are of general applicability. Just as a professional truck driver's gross negligence resulting in a motorist's death can subject the driver to a criminal penalty, so a surgeon's or nurse's gross negligence can do the same. The Japanese public's expectation is that the reach of the protective function of the police does not stop at the hospital door.²⁴

A second reason for the heightened importance of criminal law in the policing of the quality of Japanese medicine for several years after 1999 has to do with public accountability. Every institution in a democratic society owes that society a duty to account in some fashion for the harms it causes. In Japan, other structures of accountability in medicine have been weak. Professional licensure sanctions for safety-endangering practices are extremely rare.²⁵ Peer review has not been an established tradition.²⁶ Hospitals need not be accredited in order to be reimbursed for their services, and more than two-thirds are not accredited.²⁷ Private medical malpractice lawsuits historically have been relatively infrequent (although their number has

24. Seldom are health care personnel prosecuted for causing medical injury in North America. See James A. Filkins, "With No Evil Intent": *The Criminal Prosecution of Physicians for Medical Negligence*, 22 J. LEGAL MED. 467, 472 nn.51–53 (noting nine U.S. appellate cases and estimating a small number of trial prosecutions over a twenty year period); R. v. Manjanatha (1995), 131 Sask. R. 316 (Can. Sask. C.A.) (a rare Canadian prosecution). A recent example of an American prosecution is the trial of Michael Jackson's physician for providing the cultural icon the narcotic drugs that contributed to his death. See Jennifer Medina, *Doctor Is Guilty in Michael Jackson's Death*, N.Y. TIMES, Nov. 9, 2011, available at <http://www.nytimes.com/2011/11/08/us/doctor-found-guilty-in-michael-jacksons-death.html>.

25. See Yasushi Tsukamoto, *Criminal Prosecution Arising from Medical Mishaps: A Japanese Perspective*, 24 MED. & L. 673, 680 (2005) (noting that it is "very rare" for administrative sanctions to be imposed following medical accidents); see also Leflar, *supra* note 4, at 20 n.87 (discussing Etsuji Okamoto, *An Analysis of Administrative Sanctions and Criminal Prosecutions of Doctors in Japan*, 52 JAPANESE J. PUB. HEALTH 994, 996 tbl.1 (2005), which summarizes the types of charges, and numbers and sanctions associated with each).

26. See JOHN CREIGHTON CAMPBELL & NAOKI IKEGAMI, *THE ART OF BALANCE IN HEALTH POLICY: MAINTAINING JAPAN'S LOW-COST, EGALITARIAN SYSTEM 187–90* (1998) (discussing the quality of care in Japan).

27. According to the Japan Council for Quality Health Care, Japan's quasi-public hospital accreditation authority, 2,469 of 8,650 hospitals were accredited as of November 2011. See JAPAN COUNCIL FOR QUALITY HEALTH CARE, BYŌIN KINŌ HYŌKA KEKKA NO JŌHŌ TEIKYŌ [Information on Results of Hospital Evaluations], <http://www.report.jcqh.or.jp>.

increased somewhat in recent years).²⁸ Physicians' medical liability premiums, uniform across all specialties and in all geographic areas, are extremely cheap by U.S. standards²⁹ and do not constitute a significant deterrent to poor care. In the absence of other effective accountability structures, the criminal justice system, amplified by the media, has served as an accountability mechanism of last resort.³⁰

That description characterized the role of the criminal justice system in the regulation of Japanese medical quality during most of the first decade of this century. However, in the past few years, the picture has somewhat changed.

In 2006, the police and prosecutors went too far. The location of their mistake was Ohno Hospital, in northeast Japan (less than three miles from Fukushima No. 1 Power Plant, where reactor meltdowns occurred in March 2011). More than a year previously, Dr. Katsuhiko Katō, the lone obstetrician at that rural public hospital, had lost a woman in childbirth who was suffering from a rare and dangerous condition, *placenta previa*. The police obtained an internal hospital report indicating possible negligence in handling the delivery.³¹ Such a report was apparently required by the hospital's liability insurer for the family of the deceased to obtain compensation. After a lengthy investigation, police arrested Dr. Katō, led him out of the hospital in handcuffs while national television broadcasted the arrest, and charged him with professional negligence and failure to report a patient's "unnatural death."³²

The medical profession was up in arms after this humiliating spectacle. Across the country, a barrage of protests and petitions bombarded the National Police Agency for overreaching its proper

28. See *infra* notes 44–58 and accompanying text.

29. Physicians in private practice pay a standard premium of ¥70,000 per year (US \$875). Hospital-employed physicians are covered by their employer, but may buy separate additional coverage for ¥55,000 (US \$700). See Leflar, *supra* note 2.

30. For a fuller development of how the criminal justice system has served as an accountability mechanism, see Leflar, *supra* note 4, at 6–7; Leflar & Iwata, *supra* note 4, at 193–95.

31. Seiichi Hiraïwa, *Kenritsu Ohno Byōin Jiken: Bengoshi no Tachiba kara* [The Ohno Prefectural Hospital Case: Defense Counsel Perspective], in SARANARU IRYŌ NO SHINRAI NI MUKETE: MUZAI JIKEN KARA MANABU [LEARNING FROM THE ACQUITTALS: REBUILDING TRUST IN MEDICINE] 76–84 (2011) (proceedings of Japan Medical Association Research Institute symposium).

32. *Obstetrician Held over Malpractice*, INT'L HERALD TRIB./ASAHI SHIMBUN, Feb. 20, 2006, at 22.

bounds.³³ Nevertheless, the prosecutors pressed charges, confident in their conviction rate of over 99% for all crimes.³⁴ In Japan, prosecutors rarely lose.

To the prosecutors' surprise, Dr. Katō was acquitted,³⁵ along with several other doctors and nurses in a string of other medical cases from 2006–2009.³⁶ This remarkable series of setbacks constitutes a serious embarrassment for the national prosecutors' office. What it means, in the author's view, is that prosecutors will show much more restraint in future years in exercising their charging discretion regarding medical crimes.

B. Administrative Response: The "Model Project" and Peer Review

Recognizing the limitations of criminal law as a regulator of medical error, the health ministry launched several administrative initiatives to address patient safety issues. Perhaps the most notable of these initiatives has been the "Model Project for the Investigation and Analysis of Medical Practice-Associated Deaths."

Public confidence in the trustworthiness of hospitals' internal reviews of patient deaths and injuries had been shaken by the hospitals' dishonest handling of information in the infamous cases of 1999 and the years following.³⁷ The medical establishment realized that the public expected greater transparency on the part of the medical profession, with due regard of course for patients' privacy. But, at the same time, the medical societies sought an alternative to police investigations as a way of reviewing hospital deaths that might be related to medical management.

33. A nationwide protest petition and resolution was sponsored by two medical associations. Japan Soc'y of Obstetrics and Gynecology & Japan Ass'n of Obstetricians and Gynecologists, Seimei [Proclamation] (Mar. 10, 2006), *available at* http://www.jsog.or.jp/news/html/announce_10MAR2006.html.

34. See J. MARK RAMSEYER & MINORU NAKAZATO, *JAPANESE LAW: AN ECONOMIC APPROACH* 178 (1999) (noting an overall conviction rate of 99.9% in 1994).

35. Fukushima Chihō Saibansho [Fukushima Dist. Ct.] Aug. 20, 2008, 16 IRYŌ HANREI KAISETSU 20.

36. Tōkyō Kōtō Saibansho [Tokyo High Ct.] Mar. 27, 2009, *aff'g* Tōkyō Chihō Saibansho [Tokyo Dist. Ct.] Aug. 27, 2007, 1282 HANREI TAIMUZU [HANTA] 233 (Tokyo Women's Medical University Hospital heart surgery case); Tōkyō Kōtō Saibansho [Tokyo High Ct.] Nov. 20, 2008, *aff'g* Tōkyō Chihō Saibansho [Tokyo Dist. Ct.] Mar. 28, 2006 (Kyorin U. *waribashi* [chopstick] case); Nagoya Chihō Saibansho [Nagoya Dist. Ct.] Feb. 27, 2007, 1296 HANREI TAIMUZU [HANTA] 308 (obstetrics case). Under Japanese appellate procedure, prosecutors may appeal not-guilty judgments on grounds of fact or law.

37. See Leflar & Iwata, *supra* note 4, at 195–98.

So at the suggestion of four major medical societies, in 2005, the health ministry set up the “Model Project for the Investigation and Analysis of Medical-Practice-Associated Deaths.”³⁸ This “Model Project,” which began in four urban areas and is now operating in ten, is a system by which hospitals can submit cases of questionable deaths to an independent review panel of outside experts. These experts conduct an autopsy, review the medical records, interview the participants in the patient’s care, and compile a report for both the family and the hospital. The experts recount exactly what happened and what measures should be taken to prevent similar events in the future. A summary of the case, with names redacted, is made public and posted on the Internet. In short, it is a proper peer review with a far greater level of expertise and transparency than had been customary before. One object of the enterprise is to make patient safety-related information available nationwide.

The Model Project has its limitations. It addresses only death cases, not the more frequent cases of serious injury. It is limited in geographic scope to regions with sufficient pathology expertise for the performance of autopsies—a field in which Japan has personnel difficulties.³⁹ Case reports have taken longer than expected, angering some of the families. And perhaps most worrisome, the number of participating hospitals and the number of cases submitted are considerably smaller than was expected at the project’s outset.⁴⁰

Nevertheless, the Model Project marks a step forward from previous practices of review of medical mistakes. The level of transparency, in terms both of candor with patients and families and of disclosure of adverse events to the public at large, is far greater than was typical of Japanese medical practice in the late twentieth century. The review process, involving not only medical specialists from different fields but also attorneys, nurses, and health officials, has laid a foundation for improved dialogue and cooperation among the various disciplines. In the long term, the experience of participating in or observing serious, objective peer reviews is likely to become more and more familiar to providers of health care nationwide, en-

38. For a more detailed overview of the operation of the Model Project, see Leflar, *supra* note 4, at 32–39.

39. See, e.g., Ken-ichi Yoshida, *Report of Unusual Deaths and the Postmortem Inspection System*, in *ENCYCLOPEDIA OF FORENSIC AND LEGAL MEDICINE* 123–24 (2005).

40. For a more detailed explanation of the Model Project’s limitations, see Leflar, *supra* note 4, at 32–39.

hancing hospitals' capability for self-critical analysis and thereby improving medical quality control.⁴¹

Proposals have emanated from the health ministry, major political parties, the Japan Medical Association, and others for legislation to expand the Model Project's methods nationwide.⁴² The proposals differ in matters of detail.⁴³ Political logjams, cabinet reshuffles, and the more immediately pressing national issues of economic stagnation and the March 2011 earthquake, tsunami, and nuclear disaster in northeast Japan have all turned public attention away from medical safety issues and have obstructed progress on legislation to promote peer review. Nevertheless, differences in the various stakeholders' positions on the issue do not seem insuperable, and it is likely that some consensus proposal can attain widespread support if and when the political stars align.

IV. MEDICAL INJURY AND PRIVATE JUSTICE

A. *Civil Claim-Filing Trends and International Comparisons*

Civil malpractice actions supplement administrative and criminal law structures for medical quality control. Compensation for medical injuries in Japan is essentially negligence-based.⁴⁴ Claims can be brought in contract as well as tort; but as a practical matter, the standards applied in contract are essentially the same as in tort: fault standards.⁴⁵ The physician-patient contract is viewed as containing an implied quality-of-performance term, and the quality impliedly promised is the fault-based tort law standard of care.⁴⁶

Figure 1 shows the trends over time in the number of malpractice cases filed in court. The number stayed relatively level until the mid-1980s, then started rising gradually from approximately 200 cases annually to about 600 in 1998.⁴⁷ Following the series of notori-

41. *Id.*

42. Reform proposals in this area are commonly referred to as "jiko-chō" proposals. The term is taken from "iryō jiko chōsakai," or medical accident investigation committee.

43. For a description of the major competing proposals as of 2008–2009, see Leflar, *supra* note 4, at 39–48.

44. Eric A. Feldman, *Law, Society, and Medical Malpractice Litigation in Japan*, 8 WASH U. GLOB. STUD. L. REV. 257, 262 n.19 (2009).

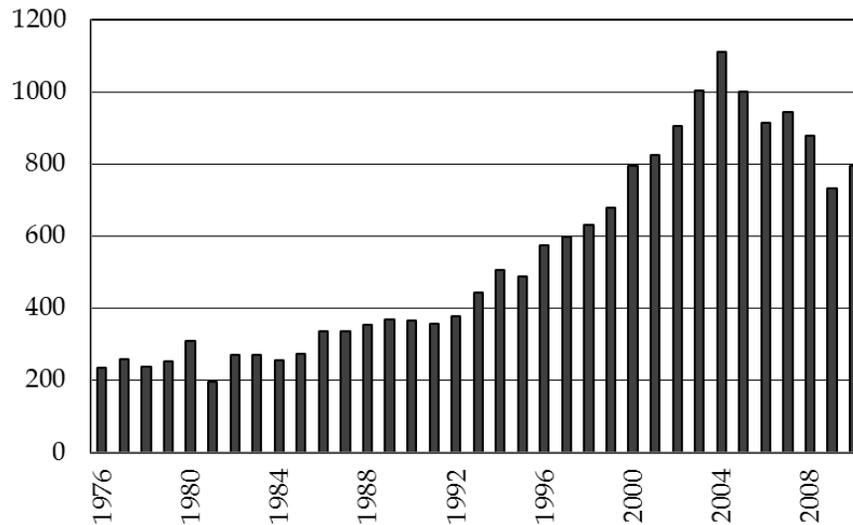
45. *Id.*

46. Leflar, *supra* note 2, at __.

47. The Administrative Office of the Supreme Court compiles the number of new medical malpractice filings annually. See Supreme Court of Japan, *Iji kankei soshō jiken no shori jōkyō*

ous medical error cases starting in 1999, the number of court claims rose rapidly to a peak of 1100 in 2004.⁴⁸ Since then, case filings have fallen back to the 700–800 level in 2009 and 2010. Apart from the spike in cases from 1999 to 2004, the overall picture is one of a steady increase in cases filed.⁴⁹

FIGURE 1: Japanese Medical Malpractice Cases Filed in Court, 1976–2010⁵⁰



The chart represents only cases filed in court. Attorneys experienced in the field have stated that informal settlements far exceed court filings.⁵¹ The custom in Japan, unlike the United States, is that cases typically are filed in court only when negotiations between the parties (with or without legal representation) fail. Extrajudicial dis-

oyobi heikin shinri kikan [Disposition of Medically Related Litigation and Mean Durations of Proceedings] [hereinafter *Supreme Court Medical Malpractice Case Statistics*], http://www.courts.go.jp/saikosai/about/iinkai/izikankei/toukei_01.html (last visited Dec. 7, 2011).

48. *Id.*

49. *Id.*

50. *Supreme Court Medical Malpractice Case Statistics*, *supra* note 47.

51. Interview with Yoshiharu Kawabata, in Tokyo, Japan (July 27, 2009); Interview with Yasushi Kodama and Tatsuo Kuroyanagi, in Naha, Okinawa, Japan (Feb. 25, 2006).

pute resolution is both encouraged by law,⁵² and promoted by noted scholars in the health law field.⁵³

Professor Mark Ramseyer of Harvard has compiled some helpful comparative estimates of the number of malpractice-based claims in Japan and North America, based in part on insurance premium data.⁵⁴ Comparing the number of *court filings* per 100,000 population, Ramseyer estimates that the Canadian court filing rate is about four times the Japanese court filing rate.⁵⁵ Attempting to capture the *total number* of malpractice claims, in and out of court, Ramseyer offers an estimated range of between 2230 and 13,875 claims per year in Japan, or one malpractice claim per 9000 to 60,000 Japanese.⁵⁶ Taking the estimated 50,000 to 60,000 annual claims in the United States, in court and out,⁵⁷ and accounting for the difference in the two nations' populations, the U.S. malpractice claiming rate would work out to somewhere between 1.5 and 12 times Japan's claiming rate.⁵⁸

52. See Saiban-gai Funsō Kaiketsu Tetsuzuki no Riyō no Sokushin ni kan-suru Hōritsu [Law for the Promotion of the Use of Extrajudicial Dispute Resolution Procedures], Law No. 151 of 2004.

53. See, e.g., YOSHITAKA WADA, IRYŌ ADR [MEDICAL ADR] (2009); YOSHITAKA WADA & TOSHIMI NAKANISHI, IRYŌ KONFURIKUTO MANEJIMENTO: MEDIEISHON NO RONRI TO GIHŌ [MEDICAL CONFLICT MANAGEMENT: MEDIATION THEORY AND SKILLS] (2006).

54. J. Mark Ramseyer, *The Effect of Universal Health Insurance on Malpractice Claims: The Japanese Experience*, 2 J. LEGAL ANALYSIS 621, 663–68 (2010).

55. *Id.* at 667–68.

56. *Id.* at 667.

57. See Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*, in MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM 11, 13 (William M. Sage & Rogan Kersh eds., 2006).

58. A long-standing debate exists among scholars of Japanese law over the reasons why the litigation rate is low in Japan compared with the United States. Some contend that the reasons are chiefly found in cultural differences between the two nations. See, e.g., Takeyoshi Kawashima, *Dispute Resolution in Contemporary Japan*, in LAW IN JAPAN: THE LEGAL ORDER IN A CHANGING SOCIETY 41, 42–50 (Arthur Taylor von Mehren ed., 1963). Others argue that the better explanations focus on differences in institutional structures, legal doctrine, or availability of information about the facts of injury. For brief summaries of this debate, see JOHN OWEN HALEY, *AUTHORITY WITHOUT POWER: LAW AND THE JAPANESE PARADOX* 108–11 (1991); RAMSEYER & NAKAZATO, *supra* note 34, at 91–92; Robert B Leflar, *Law and Patient Safety in the United States and Japan*, in READINGS IN COMPARATIVE HEALTH LAW & BIOETHICS 124, 124–26 (Timothy Stoltzfus Jost ed., 2d ed. 2007). Professor Ramseyer, the leading proponent of law-and-economics explanations for Japanese institutional behavior, contends that none of these explanations work. The main reason for the relative lack of medical malpractice litigation in Japan, according to Ramseyer, is price controls on medical services and products. Ramseyer, *supra* note 54, at 676–77. One might observe that it is the United States, not Japan, that is the outlier, as other participants in this conference have noted. In few other countries does the litigation rate even approach that of the United States.

The scale of damage awards is similar in Japan and the United States, and may be somewhat higher on average in Japan.⁵⁹ There are three main differences between the two countries with regard to damages. First, in Japan damage awards are standardized with reference to injury severity levels as set out in the traffic accident compensation system.⁶⁰ The wide variations in damage awards for similar injuries evident in American litigation are nowhere to be found in Japan. Second, *isharyō* (solatium) damages may be awarded in Japan to compensate for dignitary or emotional injury even in the absence of physical harm, for example, by violation of a patient's right of informed consent⁶¹—a result rare in American jurisdictions, which typically require plaintiffs to prove that better information for the patient would likely have led to a better outcome.⁶² Third, punitive damages are not awarded in Japanese courts.⁶³

B. Health Care Specialty Courts and Other Litigation Reforms

Public dissatisfaction with the judicial system's handling of civil claims for medical injury grew during the 1990s, as mounting case loads and inefficient trial procedures resulted in clogged dockets and serious delays in case resolution. Trials in Japan take place in sequential hearings over a period of months or years, and medical malpractice trials consume more time than most. Statistics on the duration of cases from filing to resolution are far worse for medical injury cases than the average for all civil cases.⁶⁴ Moreover, difficulties interfering with plaintiffs' access to factual information, such as the lack of a broad discovery process in Japanese civil procedure and the allegedly widespread alteration of medical charts by physi-

59. See Leflar & Iwata, *supra* note 4, at 200; Ramseyer, *supra* note 54, at 653.

60. See RAMSEYER & NAKAZATO, *supra* note 34, at 90-99.

61. See, e.g., Supreme Court Feb. 29, 2000, 54 MINSHŪ 582 (awarding damages to Jehovah's Witness for performing blood transfusion contrary to patient's prior refusal, despite transfusion's medical benefit). For English translations of the Tokyo High Court and Supreme Court decisions in the case, see CURTIS J. MILHAUPT ET AL., *THE JAPANESE LEGAL SYSTEM: CASES, CODES AND COMMENTARY* 347-356 (2006).

62. See Aaron Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 1988 U. ILL. L. REV. 607, 608 (1988).

63. RAMSEYER & NAKAZATO, *supra* note 34, at 89.

64. See Eric Feldman, *Suing Doctors in Japan: Structure, Culture, and the Rise of Malpractice Litigation*, in *FAULT LINES: TORT LAW AS CULTURAL PRACTICE* 211, 219-21 (David M. Engel & Michael McCann eds., 2006) (setting out statistics on case duration).

cians to cover up mistakes,⁶⁵ have undercut public faith in the efficacy and even-handedness of the judicial process. These concerns were heightened at the turn of the twenty-first century because of intensified media coverage of the notorious series of medical errors at major hospitals.⁶⁶

To address criticisms and improve the efficiency and accuracy of malpractice litigation, the Supreme Court's administrative office initiated measures to reform the procedures by which medical injury trials are conducted and to sharpen the capability of the judges who conduct them. Procedural reforms included setting and enforcing clearly delineated trial timelines with a concentrated evidence-gathering process, and the expansion of a system for employment of judge-appointed expert witnesses. A key reform in judicial administration was the institution of health care divisions (*iryō shūchūbu*) of district courts in several metropolitan areas with heavy civil case-loads.⁶⁷

The health care court reform was launched in 2001, shortly after the number of medical injury cases began its rapid upswing (see Figure 1 above). The reform created health care divisions of district courts in Tokyo, Osaka, Nagoya, and several other metropolitan areas and assigned these divisions all medical malpractice cases filed in those districts. These divisions are staffed by regular career judges who serve in the health care divisions for assignments of typically three to five years.⁶⁸ The goals of the system are speedy, well-informed, consistent adjudication.⁶⁹

Notable features of the health care divisions include: (a) training for judges both in medical issues and in the efficient handling of medical cases; (b) the use of court-appointed experts; and (c) concentrated efforts at promoting settlements.⁷⁰ Each division has developed its own particular styles and customs of adjudication, so

65. See, e.g., HIROTOSHI ISHIKAWA, *KARUTE KAIZAN WA NAZE OKIRU* [WHY MEDICAL RECORDS ARE FALSIFIED] (2006) (setting out plaintiffs' attorney's claims that chart falsification is common).

66. See *supra* notes 4–13 and accompanying text.

67. For a description of these measures and a partial critique of their efficacy, see Feldman, *supra* note 64, at 223–24.

68. Feldman, *supra* note 44, at 273 n.53.

69. Interview with Chief Judge Wataru Murata and Judge Nozomu Hirano, Tokyo Dist. Ct., 34th Div. (Aug. 10, 2010) [hereinafter Tokyo Judges' 2010 Interview].

70. Feldman, *supra* note 44, at 273; Tokyo Judges' 2010 Interview, *supra* note 69.

specific practices vary significantly. But the three features mentioned above are common to the divisions whose judges the author has interviewed.⁷¹

Training and seminars for judges in the health care divisions are carried out both by judges experienced in medical cases and by faculty at medical universities.⁷² The practice of holding seminars at hospitals under the tutelage of medical faculty initially aroused some suspicion on the part of plaintiffs' attorneys who feared judges' perspectives might absorb something of the coloration of their medical hosts. Such concerns appear to have diminished over time.⁷³

Court-appointed experts assist different health care divisions in different ways.⁷⁴ Some divisions, such as Yokohama's, employ "expert commissioners" (*senmon iin*) to assist in sorting out the issues at an early stage of a case, to advise judges in the evaluation of evidence, and to help facilitate settlements.⁷⁵ The Tokyo health care divisions, by contrast, have developed a "conference of experts" (*kanfuarensu kantei*) system for use at the later stages of litigation. Under this arrangement, three or four specialists in the area of medicine pertinent to a case are selected from cooperating medical faculties in the Tokyo area. After the parties have gathered and submitted the medical evidence and opinions from their own medical experts, and after the issues in the case have been sorted and refined by the judges and parties, the court-appointed experts each submit a brief written opinion on those issues. A conference then takes place (typically at the court in the Tokyo divisions, sometimes by videoconference in other divisions such as Chiba) at which the experts

71. Tokyo Judges' 2010 Interview, *supra* note 69; Interview with Chief Judge Makoto Kaiami and Judge Yūko Mizuno, Tokyo Dist. Ct., 14th Div. (May 23, 2006) [hereinafter Tokyo Judges' 2006 Interview]; Interview with Chief Judge Takeo Koiso and his colleagues, Chiba Dist. Ct. (Aug. 1, 2006) [hereinafter Chiba Judges' Interview]; Interview with Judge Toshitsugu Nakamoto and colleagues, Osaka Dist. Ct., 17th Div. (May 16, 2006) [hereinafter Osaka Judges' Interview]; Interview with Judge Jirō Yasuda, Tokyo Dist. Ct., 8th Div. (Aug. 10, 2010) [hereinafter Yasuda Interview]; Interview with Chief Judge Junji Maeda, Nara Dist. Ct., in Tokyo (Feb. 3, 2007) [hereinafter Maeda Interview]; Interview with retired judge Yoshiro Kusano, in Tokyo (July 3, 2006) [hereinafter Kusano Interview].

72. Tokyo Judges' 2010 Interview, *supra* note 69.

73. Interview with Yoshio Katō, in Nagoya, July 26, 2010; interview with Toshihiro Suzuki, in Tokyo, Aug. 2, 2010. Both Katō and Suzuki are noted plaintiffs' attorneys.

74. The use of court-appointed experts in medical cases is not confined to the health care divisions. However, these divisions have become particularly adept in using experts, each division in its own way.

75. See Feldman, *supra* note 64, at 222-23 (describing "expert commissioner" system).

give their opinions orally. First, the judges (two or three judges sit on each case)⁷⁶ and then the parties' attorneys question the experts on the points raised.⁷⁷

According to Chief Judge Wataru Murata of the Tokyo District Court and Chief Judge Takeo Koiso of the Chiba District Court, several factors are critical to a smoothly working "conference of experts" system. Obtaining the cooperation of experts in relevant fields is essential. To this end, good working relationships must be cultivated between the court and the region's medical university faculties. Utilizing several experts in each case, rather than just one, is helpful because the court obtains more perspectives on the case and no expert feels that he or she has sole responsibility for the outcome. No cross-examination of the experts by the attorneys is allowed, removing a major deterrent to participation by the experts.⁷⁸ It is a judge-initiated, "inquisitorial" style of evidence gathering, rather than an adversarial style under the attorneys' control.

Judges in the health care divisions take an active part in promoting the settlement of cases rather than having them litigated to final judgment.⁷⁹ Rapid case resolution benefits not only the parties, but also the judges. This is so partly because it decreases their workload (final judgments require written opinions) and partly because judges' career advancement hinges in some measure on their record of docket control and case resolution efficiency. A judge perceived by the Administrative Office of the Courts to be a dawdler may well next receive a posting to a family court in some obscure rural district.⁸⁰

The "conference of experts" system is helpful in promoting settlements, particularly when the court-appointed experts are unanimous in their opinions because both parties see clearly where they stand.⁸¹ Judges use this understanding as leverage to encourage the parties to agree. This is often done in *ex parte* meetings between the judges and one party in the case. As Chief Judge Murata put it, "We

76. Yasuda Interview, *supra* note 71.

77. Chiba Judges' Interview, *supra* note 71; Tokyo Judges' 2010 Interview, *supra* note 69.

78. Tokyo Judges' 2010 Interview, *supra* note 69; Chiba Judges' Interview, *supra* note 71.

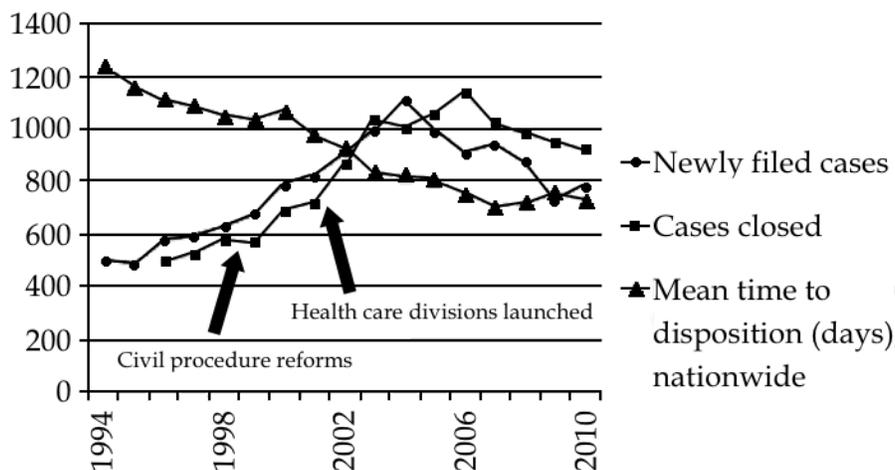
79. Osaka Judges' Interview, *supra* note 71; Tokyo Judges' 2010 Interview, *supra* note 69; Chiba Judges' Interview, *supra* note 71; Kusano Interview, *supra* note 71.

80. See J. MARK RAMSEYER & ERIC B. RASMUSEN, MEASURING JUDICIAL INDEPENDENCE: THE POLITICAL ECONOMY OF JUDGING IN JAPAN 122-168 (2003).

81. Tokyo Judges' 2006 Interview, *supra* note 71.

give the same message to both sides, but we might place a different emphasis in each conversation. To the plaintiff's attorney we might say, 'You've got a strong case on negligence, but your plaintiff was already so sick that better treatment probably wouldn't have made much difference. You'd better settle.' To the defense attorney, we would say, 'Your proof on no causation is fairly convincing, but the quality of care your doctor provided was terrible. You'd better settle.'"⁸² In fact, the health care divisions are successful in promoting settlements: a considerably higher proportion of medical cases are settled in the Tokyo health care division, for example, than in the nation as a whole.⁸³ (Similar efficiencies have been observed in analogous health care courts instituted in New York state.⁸⁴)

FIGURE 2: Disposition of Japanese Medical Malpractice Civil Cases Filed in Court, 1994–2010⁸⁵



It is difficult to ascertain whether the quality of adjudication has improved as a result of these various reforms, although commentary by judges with experience in the health care divisions has generally

82. Tokyo Judges' 2010 Interview, *supra* note 69.

83. *Id.*; Tokio Ikeda et al., *Iji Kankei Soshō ni okeru Shinri Tetsuzuki no Genjō to Kadai* [Issues in Trial Procedures for Medical Litigation], 1331 HANREI TAIMUZU [HANTA] 5, 16 (2010) (part 2) (remarks of Chief Judge Murata).

84. See Michelle Andrews, *Judge Devises Model for Resolving Medical Malpractice Cases More Quickly*, WASH. POST, Nov. 21, 2011, available at http://washingtonpost.com/national/health-science/judge-devises-model-for-resolving-medical-malpractice-cases-more-quickly/2011/11/16/gIQAT0EthN_story.html.

85. *Supreme Court Medical Malpractice Case Statistics*, *supra* note 47.

been favorable.⁸⁶ Without question, since the institution of the divisions, the duration of medical trials has continued its downward trend.⁸⁷

It is hard to say how much of this speeding-up of medical litigation is due to implementation of the health care divisions, other procedural reforms, or a mere continuation of prior tendencies. But it is clear from the author's interviews with judges of varying seniority that the judges take pride in getting cases resolved and off the docket—and their careers can benefit from a track record of speedy case resolution.

V. THE OBSTETRICAL INJURY NO-FAULT COMPENSATION SYSTEM

Public and quasi-public injury compensation systems have partially displaced private law in several areas of social concern in Japan (e.g., environmental pollution, asbestos-related disease, adverse drug reactions, and infections from blood transfusions).⁸⁸ The most recent of these quasi-public programs is the obstetrical injury no-fault compensation system launched in 2009.

Leaders of the Japanese medical establishment have long favored a no-fault compensation system for patients with medically caused injuries. For example, Dr. Tarō Takemi, the long-serving, iron-fisted, and politically indomitable president of the Japan Medical Association (JMA), expressed his support of such a system as early as the 1970s, and the JMA maintains that position to this day.⁸⁹

86. See Tokio Ikeda et al., *Iji Kankei Soshō ni okeru Shinri Tetsuzuki no Genjō to Kadai* [Issues in Trial Procedures for Medical Litigation], 1330 HANREI TAIMUZU 5 (2010) (part 1); Ikeda et al., *supra* note 83 (part 2) (panel discussions among judges in health care divisions of Tokyo and Osaka district courts).

87. The mean time from filing to disposition of medical malpractice cases declined nationwide from 1242 days in 1994 to 978 days in 2001 (when the health care courts were launched) to 756 in 2009. *Supreme Court Medical Malpractice Case Statistics*, *supra* note 47. The Tokyo health care division was more efficient than the average of all district courts, disposing of its cases within a range of 537 days to 604 days in 2003–2005. Tokyo Judges' 2006 Interview, *supra* note 71. The Osaka health care division was even speedier, with a mean duration in 2005 of 441 days. T. Nakamoto, *Osaka Chihō Saibansho no Iryō Shūchūbu* [The Osaka District Court's Medical Division], 832 NBL 1, 56–57 (2006).

88. For a listing of these programs, see Eri Osaka, *Reevaluating the Role of the Tort Liability System in Japan*, 26 ARIZ. J. INT'L & COMP. L. 393, 400 (2009).

89. See, e.g., "Bunben ni kan-suru Nōsei Mahi ni tai-suru Shōgai Hoshō Seido" no Sōki Jitsugen o [Toward Prompt Institution of an "Injury Compensation System for Birth-Related Cerebral Palsy"], 1080 NICH-I NYŪSU 1 (Sept. 5, 2006), available at <http://www.med.or.jp/nichinews/n180905a.html> (JMA publication quoting Dr. Takemi as favoring no-fault compensation for medical injury in 1972); Japan Med. Ass'n, *Iryō Jiko Chōsa Seido no Sōsetsu ni Muketa Kihon-*

The uproar within the medical profession over the perceived abuse of power by prosecutors in the arrest, detention, and trial of Dr. Katō, the obstetrician at Ohno Hospital, lent a specific recent impetus to that stance.⁹⁰ Anxieties over possible criminal prosecution for errors in small hospitals lacking facilities and backup, combined with changes in residency posting practices which contribute to an ever greater concentration of young physicians in metropolitan areas, have resulted in a shortage of obstetricians—particularly in rural prefectures. To relieve these anxieties to some extent by providing protective shelter for obstetrical practice, the Japan Medical Association, the Japan Society of Obstetrics & Gynecology, and their political allies in the then-governing Liberal Democratic Party persuaded the health ministry to initiate a no-fault compensation system for a defined class of obstetrical injuries.

The system is administered by the quasi-public Japan Council for Quality Health Care. It is financed by a levy of ¥30,000 (US \$375) on each birth in Japan, ultimately paid by the social insurance system to private insurance companies that cover the liability for compensation payments.⁹¹ Parents of severely injured children who meet the rather strict requirements for compensation receive a standard 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.⁹² The system is voluntary—no childbirth facility is required to participate, although virtually all of them do.⁹³ Parents' legal right to sue for birth-related injuries on theories of negligence and breach of contract remains unchanged.⁹⁴ No legislation was needed, therefore,

teki Teigen ni tsuite [Basic Proposal for the Establishment of a Medical Accident Investigation System] 15-16 (2011), available at http://dl.med.or.jp/dl-med/teireikaiken/20110713_2.pdf (favoring no-fault compensation system).

90. See *supra* notes 31-36 and accompanying text.

91. For a more detailed explanation of the workings of the system, see Leflar, *supra* note 2.

92. Ministry of Health, Labor & Welfare, *Sanka Iryō Hoshō Seido ni tsuite* [The Obstetrical Compensation System], available at <http://www.mhlw.go.jp/topics/bukyoku/isei/i-anzen/sanka-iryō/index.html> (last visited Dec. 7, 2011).

93. See Taro Tomizuka & Ryozo Matsuda, *Introduction of No-Fault Obstetric Compensation*, HEALTH POL'Y MONITOR (2009), available at <http://hpm.org/survey/jp/a14/4>. See also the compensation system participation statistics provided in *Dai-8-kai Sanka Iryō Hoshō Seido Un'ei linkai Shidai* [Agenda for 8th Meeting of Obstetrical Compensation System Management Committee] 3 (2011) [hereinafter *Compensation Committee Agenda*], available at http://www.sankahp.jcqh.or.jp/pdf/obstrics_meeting_08.pdf (table in agenda materials).

94. Tomizuka & Matsuda, *supra* note 93.

to launch the new system; it merely required a Cabinet Order to fund it.⁹⁵

Although it is too soon to pronounce judgment on the merits of the obstetrical injury compensation program, a few points are already apparent. First, the program is popular with providers of childbirth services: 99.7% of childbirth facilities in the nation have signed up to participate.⁹⁶ Second, the program has so far been a financial boon to the insurance companies responsible for paying compensation to families of injured infants; far more has been collected in premiums than is owed to families for the infants certified to date.⁹⁷ What the effects may be on the quality of obstetrical care and on malpractice claims and litigation is unclear.

If the obstetrical compensation proves successful, it may provide an impetus for the extension of no-fault principles beyond injuries suffered by infants in childbirth. The Ministry of Health, Labor & Welfare has recently initiated a Commission for the Study of No-Fault Compensation Systems Conducive to Health Care Quality Improvement, with a membership representing most major affected interest groups as well as academia.⁹⁸ Although a seismic shift away from the current fault-based civil law system is not to be expected any time soon, rumbling portents of future change are beginning to register.

VI. SUMMARY AND CONCLUSIONS

Japanese legal structures addressing health care-related deaths and injuries rely somewhat more on public law institutions and

95. *Id.*

96. *Compensation Committee Agenda*, *supra* note 93.

97. *Id.* During the first two years of its operation (2009–2010), the system had accepted compensation claims for ninety-nine births occurring in 2009, incurring payment obligations over twenty years totaling about ¥3 billion (US \$32 million). During 2009, the system collected premiums amounting to ¥31.5 billion, more than ten times as much as the amount owed. *Id.* at 17. Because of the cost of these premiums to the social insurance system at a time of severe budget deficits and tremendous public expenses associated with the rebuilding of regions of northeast Japan devastated by the 2011 earthquake, tsunami, and nuclear meltdown, one would expect the per-birth levy to be lowered in the future.

98. *Iryō no Shitsu no Kōjō ni Shi-suru Mukashitsu Hoshō Seido-tō no Arikata ni kan-suru Kentōkai* [Commission for the Study of No-Fault Compensation Systems Conducive to Health Care Quality Improvement], *Sankō shiryō* [Reference materials] (5th meeting, Oct. 31, 2011), available at <http://www.mhlw.go.jp/stf/shingi/2r9852000001trjp-att/2r9852000001trt0.pdf>.

rules than do the common-law North American jurisdictions, where private law adjudication is overwhelmingly predominant.

This article has explored four developments in health care law in twenty-first century Japan. The first two are in the public law sphere: the highly publicized criminal prosecutions of health care personnel accused of medical errors, and the health ministry-sponsored Model Project for the Investigation and Analysis of Medical Practice-Associated Deaths at hospitals in selected regions. The article then outlined an innovation to improve the operation of private law: the institution of health care divisions of trial courts in several metropolitan areas. Finally, the article introduced Japan's new no-fault program for compensating birth-related obstetrical injuries, a quasi-public system that aims to partially displace private law adjudication in a limited but costly set of cases.

Briefly summarizing the author's perspectives on each of these four developments:

(1) The importance of criminal law as a force for improving medical quality seems likely to diminish. Prosecutorial overreaching in the Ohno Hospital case and other recent medical trials have created an atmosphere in which considerable prosecutorial restraint is likely for the foreseeable future.

(2) The Model Project reflects a welcome increase in emphasis on objective peer review of adverse events in hospitals, and in transparency to patients, families, and the public about events leading to health care harm. However, the Model Project is limited in scope and the likelihood of widespread adoption of its method of reviews by experts outside of the hospital at which the adverse event took place remains problematic.

(3) The track record of trial courts' health care divisions shortening clogged court dockets is encouraging. The employment of court-appointed experts not beholden to the parties is an intriguing exercise, but one perhaps more easily accommodated by continental legal systems of an inquisitorial nature than by common-law systems based on adversarial principles.

(4) The new no-fault obstetrical compensation system is off to a promising start, although premiums are being collected at a level that far outstrips compensation obligations recognized to date. If the obstetrical compensation system proves successful, the possibility exists that Japan will take a close look at extending no-fault principles to redress a wider range of health care harms.