In fact, events in Japan proceeded in a rather different fashion. The family has not, as of this writing, brought a malpractice action or even engaged an attorney. But police, who learned of the case from an anonymous whistle-blower, arrested the three surgeons for criminal negligence resulting in death, and filed papers with the prosecutor charging the supervising physician with the same crime. A dozen investigators spread out over the hospital confiscating evidence, including the video of the thirteen-hour operation. Ultimately two of the three surgeons pleaded guilty. Criminal charges were dropped against the supervising physician for lack of sufficient evidence, but his medical license was suspended (along with those of the two who pleaded guilty) by the Ministry of Health, Labor and Welfare's Medical Ethics Council—apparently the first license suspension for a failure of supervision in the Council's history. The story was national front page news when the surgeons were arrested, and since then the case has received steady continuing coverage by Japan's major newspapers. A leading urologist has already published a book calling attention to how the various errors committed and system flaws demonstrated in the case are manifestations of deep-seated infirmities in the structure of Japanese medicine.

Nor is the case unique. It is one of a series of recent high-profile medical mishaps to which the media have given intensive coverage: cases stunning in their quotidian banality, many of them followed by a cover-up and deception of patients and families suffering harm. Often the events come to light only because a whistle-blower within the hospital—perhaps a nurse chafing under an arrogant surgeon's abuse—contacts a journalist or the police. Among the many recent cases, three besides the Aoto Hospital case have attained representative significance: the heart and lung patients' mixup at Yokohama City University Hospital in 1999, the Tokyo Hiron General Hospital fatal injection in 2000, and the Tokyo Women's Medical University heart-lung machine blunder in 2001.

In the United States, errant physicians and hospitals fear the malpractice lawyers. In Japan, their greater concerns are the whistleblowers, the media, and the police.

In the United States, what brought the problem of medical error to the forefront of public attention was epidemiological studies of hospital injury, drawn together in compelling fashion with insights from behavioral science in the Institute of Medicine report, To Err Is Human. Those epidemiological studies were sparked by the medical malpractice liability crises of the 1970s and 1980s, which impelled the funding of the studies. Certainly, the media have also played an important role in publicizing the patient safety issue, as well as in illustrating a few particular cases of malpractice. But in essence, the interaction of malpractice law with liability insurance drove epidemiological science, and science has driven policy.

In Japan, by contrast, no epidemiological studies have delineated the overall extent of medical error. As will be seen in the next section, neither civil malpractice liability nor liability insurance has been a factor powerful enough to launch research programs or to move health bureaucracies to act. The salience of the topic of patient safety as a problem for national health policy must be attributed instead chiefly to the extensive media treatment given to cases such as those noted above. The widely remarked appearance of To Err Is Human not long after the first of the cases, the Yokohama City University Hospital heart and lung patients' mixup, magnified the newsworthiness of the medical error problem, enabling the media to portray it as a matter of international rather than merely local significance.

The upsurge of public concern in Japan about patient safety must be viewed against the background of a society moving away from traditional hierarchy and secrecy, especially prevalent within the medical world, towards greater openness, transparency, and citizen participation. The Diet recently passed a national medical information law, following the lead of prefectures around the country. Informed consent in medicine, a concept virtually unheard of until the late 1980s, has become widespread in clinical practice (albeit with a Japanese coloration and ample opportunity for abuse, as in the Aoto Hospital case). Public demand for information about hospital quality is high, as witnessed by brisk sales of popular publications purporting to rank hospitals in various fields of medicine by reputation, by volume of procedures performed, etc.

In this environment of increased public expectations for openness, traditional practices of deception and secrecy are increasingly met with stony disapproval. And malpractice actions, once rare, are on the rise.

III. Malpractice Law, Self-critical Analysis, and Policies of Candor

A. Litigation Volume, Damages, and Liability Insurance

Without question, Americans file far more medical malpractice claims, in court and out, than Japanese do. Claims incidence figures are not directly comparable, since the best available U.S. statistics count claims closed annually, while the only available Japanese statistics count claims filed annually, and do not include all claims made outside the judicial system. Nevertheless, in the face of the vast disparity between the claims figures, differences in counting methods are trivial. For example, in 1997 there were 110,754 medical malpractice claims closed in the United States, compared with a total of 1,089 claims filed in the Japanese courts and with the Japan and Osaka Medical Associations. Given that the population of the United States is about 2.2 times that of Japan, an American in 1997 was as much as forty to fifty times more likely (as an upper-bound estimate) to have filed a medical malpractice claim than was a Japanese.

In Japan, by contrast, no epidemiological studies have delineated the overall extent of medical error. As will be seen in the next section, neither civil malpractice liability nor liability insurance has been a factor powerful enough to launch research programs or to move health bureaucracies to act. The salience of the topic of patient safety as a problem for national health policy must be attributed instead chiefly to the extensive media treatment given to cases such as those noted above. The widely remarked appearance of To Err Is Human not long after the first of the cases, the Yokohama City University Hospital heart and lung patients' mixup, magnified the newsworthiness of the medical error problem, enabling the media to portray it as a matter of international rather than merely local significance.

Damage awards to successful medical malpractice plaintiffs in Japan are more standardized and predictable than awards in the United States. Awards in Japanese malpractice cases are usually based chiefly on guidelines used by courts for injuries in traffic accident cases. Under these guidelines, for example, in death cases, pain-and-suffering awards range from 20–28 million (US$ 180,000–$ 250,000), to which would be added funeral expenses and lost earnings to the presumptive retirement age of sixty-seven discounted to present value, from which latter amount thirty to fifty percent is subtracted for presumptive living expenses not incurred. Punitive damages are never awarded in Japanese civil cases, eliminating a source of some variation in United States awards. Comparison of the magnitude of awards in Japan and the United States is difficult, because of the diversity of U.S. judicial forums and the lack of nationwide statistics; but mean and median awards in U.S. wrongful death cases, at least, seem not to diverge radically from the Japanese scale of damages.

Medical malpractice premiums in Japan, which could be considered a very rough, hewn proxy for liability payouts in the long term, are but a small fraction of those charged in the United States. The premium paid by a physician member of the Japan Medical Association liability insurance program in 2000 was 55,000 (US$ 500). General hospitals insured by Yasuda Fire & Marine Company paid 16,130 (US$ 150) annually per bed in 2000. By contrast, American
Overall levels of claims and premiums tell only part of the story, however. Trends, and perceptions of trends, are also significant. The quantity of civil malpractice cases filed in Japanese courts is accelerating, as Figure 1 illustrates, and at a rate that outstrips increases in most other categories of litigation.

The plaintiff’s malpractice bar is increasing in number and sophistication. Of greatest significance is the media attention devoted to medical cases. Though the number of litigated cases is small in comparison with the United States, media coverage—equally of cases that would be deemed so common by major American papers as to be without news value—magnifies their impact on the public and the medical profession. With adverse publicity comes damage to reputation. Civil malpractice litigation has a sentinel effect out of proportion to its quantity.

In the United States, a standard component of the rhetoric of medical tort reform is that liability premiums for physicians in high-risk specialties, such as obstetricians, neurosurgeons, and orthopedists, have risen to unsustainable levels, particularly in geographic areas where large liability awards are common. However, as Mark Geistfeld and William Sage have recently observed, this phenomenon is in large part an artifact of American medical liability insurers’ conventional practice of basing premiums on a physician’s specialty and geographic location—a practice that “is not preordained, and in fact is socially counterproductive.” Risk class segregation practice results in volatile risk pools composed of small numbers of physicians, justifying spikes in premiums due to a few large liability payouts in a particular specialty or locality.

A major difference between Japan and the United States in this respect is that medical malpractice liability premiums in Japan do not vary depending on the physician’s specialty or geographical area of practice. Essentially, the risk pool is the nation’s doctors. Overall payouts should therefore be far more predictable than in the United States, and in fact premiums were stable throughout the 1990s. It is true that the Japan Medical Association indemnity insurance system has suffered substantial red ink in recent years and found it necessary to increase annual premiums from 55,000 (US $500) to 70,000 (US $640) in 2003. Nevertheless, these amounts are still incomparable by American standards. From the standpoint of efficiency, cost spreading, and stability, there is much to be said for the Japanese medical liability insurance approach.

B. Self-Critical Analysis and the Law

As pioneers in the field of medical system safety have long pointed out, and as To Err Is Human stressed, essential to a hospital’s project of creating a “culture of safety” is self-critical analysis: the gathering and study of reliable information on preventable mistakes and the implementation of corrective measures. Since 2001, JCAH0 has made the conduct of “thorough and credible root cause analyses” of all sentinel events a subject for hospitals’ triennial inspections. Since 2003, the Department of Health and Human Services (DHHS) has required all hospitals participating in the Medicare and Medicaid programs to develop and maintain a quality assessment and performance improvement program, incorporating self-critical analyses as part of the process. So thoroughly has this concept penetrated the hospital administration world, in fact, that the Institution of In-hospital systems for producing self-critical analyses of accidents and near misses may be considered to have become an established standard for American health care institutions.

Many physicians and hospital administrators, cautioned by defense counsel, fear that these self-critical analyses, in the hands of plaintiffs’ attorneys, will serve as weapons for infliction of legal liability and professional embarrassment. It is often claimed that this fear deteres honest, thorough reviews of adverse events, hindering quality improvement efforts. Whether the fear of disclosure of self-critical analyses in fact stifles efforts at error reduction is empirically unproven, and in any case the fear may be considerably overblown in the light of state-law peer review privileges rendering hospital deliberations about incidents relating to the quality of care nondisclosable and inadmissible as evidence in civil trials. Still, uncertainties persist about the scope of the peer review privilege, which varies a bit from state to state and which is not recognized in some federal courts. So caution on the part of some medical providers about the legal consequences of conducting self-critical analyses is not without reason.

This concern, against the background of the heated debate over medical tort reform, impelled Congress to enact the Patient Safety and Quality Improvement Act of 2005. The new law, discussed more fully elsewhere in this issue, creates a voluntary system for providers to report medical errors to DHHS-certified Patient Safety Organizations; it makes the reports confidential, shielding them from use in civil and criminal proceedings. Original medical information such as patient charts and incident reports will still be available to litigants as under existing state law, but evaluative information transmitted to a Patient Safety Organization will be protected.

Unlike U.S. hospitals, Japanese hospitals are not required to perform self-critical analyses by hospital accreditation authority or by government reimbursement policy. Nevertheless, many Japanese hospitals are beginning to do self-critical analyses, spurred in part by recommendations from the National University Hospital Presidents’ Conference and by guidance from the Ministry of Health, Labor, and Welfare (MHLW) following the well-publicized medical misadventures noted above. These recommendations have met resistance, not only due to institutional inertia and lack of comfort with the disruption of traditional practices. Part of the resistance is attributable to concerns by Japanese medical leaders, similar to those voiced in the United States, about the possibility that such analyses could be used to medical defendants’ detriment in civil malpractice actions or in criminal proceedings.

Four separate sources of legal obligation are of concern to Japanese hospitals and physicians in this respect: (1) national and local Freedom of Information rules applicable to public hospitals; (2) the liberalized discovery rules under Article 220 of the civil procedure law; (3) an asserted contractual obligation, recognized in recent cases, to investigate hospital accidents and report the results to patients; and (4) the requirement for reporting to police of “unusual deaths” in Article 21 of the Physicians’ Law. The first three sets of rules, relating to civil cases, are discussed in this section of the article; the fourth, violation of which is grounds for criminal prosecution, is discussed in Part IV on criminal law.
Under the national information disclosure law, enacted in 1999, records kept by public hospitals are potentially subject to disclosure unless an exception applies, for example, to protect individual patients' privacy. However, the privacy exception does not necessarily protect the names of individual physicians. For example, in response to an Asahi Shim bun journalist's request for information on an accident at a public hospital, the Cabinet's Information Disclosure Review Board, which handles administrative appeals under the law, called for the disclosure of the names of attending physicians, the minutes of internal hospital committees investigating the accident, and other content of apology letters to patients and families. Although such disclosures are apparently uncommon, they contain the potential for considerable embarrassment to medical personnel.

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The recent liberalization of the previously restrictive discovery rules of the Japanese civil procedure code has opened up the possibility that hospital incident reports and internal analyses of adverse events might become generally available to plaintiffs' attorneys. (Unlike the information disclosure law, the civil procedure law applies not only to public entities, but to any potential party in a civil case.) Article 220 of the civil procedure law now recognizes a new general principle of discoverability of specifically identified documents, but contains several exceptions. The Supreme Court in its 1999 Fuji Bank decision recognized that "documents produced solely for internal use" (naiju bunsho) are exempt from discovery, under one of these exceptions. Hospitals' internal reports arguably fall within this "internal use" exception.

Applying the principles of the Fuji Bank case to the hospital setting, the Tokyo High Court in 2003 ruled that a hospital's internal report concerning a patient's death was disclosable. In part, to attorneys for the patient's family. In its Saltana Medical University decision, that court drew a distinction between the portion of the report containing fact-gathering interviews with hospital personnel, on the one hand, and the portion containing "objective" conclusions about the patient's course, the causes of her death, proposed corrective measures and accident prevention strategies, on the other. The court held the fact-gathering section of the report non-disclosable on the grounds that disclosure would interfere with a protectable interest that the court characterized as "free formation of ideas" (jy na ishi keisei) on the part of the medical personnel, and that the fact-gathering was solely for internal use. However, the court ruled that the portion of the report containing factual conclusions and quality improvement strategies was disclosable. Although this portion of the report was, in part, for internal use, it was also the basis for the hospital's report on the case to prefectural health authorities, and it contained an apology to the family and a prayer for the eternal repose of the departed patient-factors that took this portion of the report out of the "internal use" exception.

The Tokyo High Court's decision applied a disclosure principle somewhat broader than that generally employed under American state-law peer review statutes, which typically call for disclosure of incident reports but protect from [*208]* disclosure all documents with evaluative content. This broader disclosure principle may have wide-ranging impact, due to a mandatory accident reporting requirement recently adopted by the MHLW and applied to a class of larger hospitals. This reporting requirement, under the rationale of the court's decision, may vitiate the force of the "internal use" exception to the new general discovery principle, as explained below.

Similar to the controversy over accident reporting in the United States, a major issue facing MHLW in structuring its patient safety programs has been the choice of a system to implement for the reporting and analysis of medical errors. The ministry has wobbled somewhat on the issue. MHLW initially required tokuten klin by in (an administrative category comprising about eighty-one advanced-level hospitals) to establish safety management systems incorporating systems for internal reporting to hospital patient safety committees of accidents involving injury. Fearing provider resistance, MHLW originally required neither tokuten klin by in nor general hospitals to submit any external reports, either of accidents involving injury or of "near misses" in which an error did not result in harm. The ministry encouraged all hospitals, however, to send in reports of "near misses" on a voluntary basis.

MHLW's original reporting program was not a success. The "near miss" reports, which ministry officials had hoped would contain virtually as much information useful in identifying specific problems as reports of actual accidents might contain, were entered into a rigid, unhelpful coding system that made root cause analysis difficult. Few staffers were available to read and analyze the reports and give feedback; the lack of feedback in turn discouraged conscientious reporting. Vast variations appeared in the thoroughness with which tokuten klin by in conducted their internal reporting systems for accidents involving injury. The upshot was that the ministry had no reliable information on the actual extent of medically caused injury in Japan.

In 2003, acting on an advisory committee report, MHLW changed course and determined that accidents causing harm to patients, in addition to "near miss" events, would be the focus of the redesigned reporting system. Since 2004, reporting of accidents causing harm has become mandatory, rather than voluntary, for a class of 275 larger and specialized facilities, including national and university hospitals. Reports are made not to any governmental entity with enforcement powers, such as MHLW, but rather to an independent quasi-public entity whose purpose is the collection and analysis of medical accident data and the formulation and dissemination of corrective measures—a structure somewhat analogous to the air safety reporting system in the United States. Although reporting is required, no penalty is assessed for failure to report—a compromise policy aimed at simultaneously mollifying media and patients' groups' criticisms of the previous voluntary reporting system, and appeasing [*210]* Japan Medical Association opposition to strictly enforced mandatory accident reporting.

The newly mandatory nature of medical accident reporting to a quasi-public outside entity, analogous to the prefectural authority that received the hospital report in the Saitama Medical University decision and may well be more closely related to the reporting requirements under the "internal use" exception of Article 220 of the revised civil procedure code, discussed above. It may be that the rationale of the Tokyo High Court's decision in that case (if accepted by other courts) would require hospitals subject to the mandatory reporting requirement to disclose to plaintiffs' attorneys, as a routine matter, the "objective" parts of the internal accident investigations upon which their accident reports are based.

Not long ago, Japanese civil procedure law was criticized as too restrictive in its evidence-gathering rules, to the prejudice of the quality of justice, and U.S. discovery procedures were heralded by critics of the old code as providing a freer flow of relevant information to the judicial process. Now, at least with regard to this aspect of medical malpractice litigation, if the principle of the Saitama Medical University decision is broadly applied, the tables may well have turned on the law, in that more information disclosure in the judicial process. The possible effects on self-critical analysis in Japanese hospitals remain to be seen.

C. Policies of Candor

Legal compulsion, of course, is not the only means by which information about hospital accidents may be disclosed to affected patients, families, and the public. Some hospitals have
adopted policies of rather thoroughgoing voluntary disclosure. For example, after its nationally publicized heart and lung surgery patient mix-up and other misadventures, Yokohama City University Hospital implemented a policy of public disclosure of all cases of malpractice resulting in death, serious injury, or lesser injury, where hospital safety practices are called into question. The national university hospitals' organization has also announced a similar policy calling for prompt public disclosure of individual cases of malpractice involving death or serious injury, and periodic public compilations of cases involving lesser fault and lesser harm.

Regardless of whether a hospital discloses its mistakes to the general public, or its self-critical analyses are made available to plaintiffs' attorneys, in the United States a consensus has formed that errors resulting in harm to patients must be disclosed to the patient and family as a matter of medical ethics. Medical mistakes must not be covered up. This ethical duty of truth telling about error may not be universally observed—in fact, in actual practice it may be disregarded as often as not—but the duty is made clear in the American Medical Association's Code of Medical Ethics. And the JCAHO hospital accreditation process now reinforces that ethical principle as an accreditation requirement.

Neither the Japan Medical Association's code of ethics nor the hospital accreditation criteria of the Japan Council for Quality Health Care contain any provisions concerning error disclosure to patients corresponding to the stances of the American Medical Association and the JCAHO. We are unaware of any studies on the extent of error disclosure to Japanese patients and families. On the one hand, the importance of sincere apology as an essential element in dispute resolution in Japan suggests that candidness should be at a premium. On the other hand, there are gradations of candor, and frequent is the case in which a "sincere apology" is extracted only after the harm-causer is driven into a corner by exposure of the facts. It is apparent that a great deal of the distrust in physicians that the Japanese public has come to harbor is a consequence of the medical world's blanket of secrecy.

However, recent judicial decisions have recognized that hospitals have a legal duty to investigate the causes of medical accidents and to report the conclusions faithfully to the patient. Both the Kyoto District Court and the Tokyo District Court have held that this duty to investigate and report on accidents arises out of the hospital-patient contract, in which the medical provider undertakes an implied obligation to explain the nature and course of treatment and its results. Reinforcing the autonomy principle recognized in recent Japanese medical jurisprudence, these decisions should help lay the groundwork for greater candor toward injured patients. The decisions also suggest avenues worth exploring in American litigation over medical accidents in which medical providers have been duplicitous or evasive about adverse outcomes.

Access by medical error victims and the general public to reports of patient safety hazards through the civil justice system, administrative mechanisms, and voluntary private initiatives is not the only means by which the principle of public accountability for medical error can be vindicated. In Japan, far more than in the United States, a significant locus for the accountability function is the criminal justice system, amplified by the power of the media.

IV. Patient Safety and the Criminal Justice System

Criminal prosecutions of medical personnel for medical acts resulting in harm to patients are rare in both Japan and the United States. Barriers to successful criminal prosecution are high, and properly so. Nevertheless, the criminal law is available in both nations (as it is in European legal systems) as a restraint on patient-endangering acts of uncommon turpitude.

In this section of the article we compare the frequency of criminal prosecutions for medical acts in the two nations and the relative significance of the prospect of prosecution to medical personnel, finding that the criminal law casts a longer shadow in Japan. We set out the chief legal grounds for prosecuting medical acts, grounds generally unavailable to American prosecutors. We note that in the years since the spotlight has begun to shine on prosecutions of medical personnel, hospitals' reports to police of medical accidents have increased.

We describe the considerations prosecutors say they take into account in bringing medical cases in Japan, and speculate that a reason Japanese medical error victims appear more likely than their American counterparts to seek prosecutions of erring medical providers may be a greater convergence of objectives between prosecutors and victims in Japan than in the United States.

A. Prosecutions for Medical Acts in the United States

In the United States, it has been estimated that two recent decades have seen perhaps twenty-five to thirty-five cases of criminal prosecutions for medical negligence. These cases were typically brought, and convictions sometimes obtained, on the basis of the defendants' reckless disregard for patients' safety—a standard considerably stricter than the negligence standard applied in civil cases. The rarity of these prosecutions is at least partly explained by the factual complexity typical of medical cases and the need for expertise regarding matters such as causation and professional standards of care, the discretion afforded physicians in matters of medical judgment, the high burden of proof beyond a reasonable doubt, and the fact that responsibility for prosecution decisions typically falls on busy local prosecutors' offices lacking ready access to medical expertise. These factors together make the prosecution of medical personnel a costly and difficult endeavor.

Accordingly, in comparison with the relative frequency of civil medical malpractice actions, the threat of criminal prosecution does not loom large as a concern of American physicians and hospitals. Injured patients and their families seldom seek to have a harm-causing physician indicted; the private law remedy is vastly preferred.

B. Medical Prosecutions in Japan

1. Significance to Medical Personnel

A major source of concern to Japanese hospitals and physicians is the prospect of a police investigation and criminal prosecution. This concern is not shared in the United States, though it is to an extent in some European nations. Even before the recent surge of public attention to the problem of medical error, an average of two to three prosecutions per year were brought in medical cases in Japan—per capita frequency considerably higher than that reported in the American literature.
More important than the absolute number of prosecutions is the level of media coverage. The front-page publicity accorded to prosecutions for recent medical disasters has set the medical profession on notice. Public pressure has helped create a public expectation that sorts that police and prosecutors have a routine role to play in sorting out medical mishaps. This expectation is evident in the actions of medical malpractice attorneys. Attorneys experienced in representing Japanese medical malpractise plaintiffs report that patients and families sufficiently indignant about medical injuries to consult an attorney frequently also seek police investigations, and want to see medical wrongdoers prosecuted. This sense of indignity is due in part, but only in part, to anger over providers' not uncommon practice of deceit about harm suffered in the hospital, and falsification of patients' medical records.

2. Legal Grounds for Criminal Prosecutions; Reporting of Medical Accidents to Police

Japanese prosecutors employ several legal weapons in medical cases that are not part of American prosecutors' usual arsenal. Most importantly, the standard charge brought against medical personnel under the Japanese Criminal Code is "professional negligence causing death or injury" -a crime not found in U.S. statute books. (As noted above, few convictions in recent years in American medical cases almost always involve charges of recklessness or intent-a higher level of mens rea than negligence.) Additional sanctions are available in the Criminal Code for attempts to cover up medical wrongdoing by altering patients' charts, which plaintiffs' attorneys charge is a common practice, and under the Physicians' Law for failing to report "unusual deaths" (j sh) to police. Japanese prosecutors may be reluctant to bring medical crime cases for various reasons including the factual difficulties, but as these provisions demonstrate, their statutory obligation to protect the public certainly extends into medical facilities.

The crime under Article 21 of the Physicians' Law of failing to report an "unusual death," though infrequently prosecuted, is causing considerable controversy within Japanese medical circles. Disagreement exists about whether this ambiguous provision of the Physicians' Law requires only the reporting of deaths in which ordinary non-medical criminal activities might be suspected-the traditional interpretation-or whether the provision extends to cover deaths in which professional negligence might be involved.

The issue exemplifies the tension between the goals of patient safety and public accountability. Like the prospect of being named a defendant in a civil malpractice action in the United States, the possibility of criminal sanctions and adverse reputational consequences could create, in the minds of medical personnel, the incentive to cover up medical mishaps. Thus, the opportunity for analysis and correction of errors would be lost-a point that has escaped the notice of neither scholars nor medical practitioners. Accountability considerations, however, demand that circumstances raising suspicions of medical error be communicated to some competent, neutral entity outside the hospital, rather than being kept under wraps in the usual fashion. At present, there are few external entities capable of effective response to such communications, except the media (to whom whistleblowers within the hospitals have increasingly turned) and the police. So, despite the limitations of police in terms of medical expertise, it is understandable that some might favor a structure encouraging reporting to the police as a public accountability mechanism. Indeed, leaders of the medical world, attentive to shifts in public attitudes, recognize the social importance of a functioning accountability mechanism as a way of regaining the public's shaken trust in their profession.

Since the well-publicized arrest and conviction of the director of Hiroo General Hospital in Tokyo for failure to report a malpractice-related death, and the affirmation of the conviction by the

Supreme Court of Japan, many physicians and hospitals have chosen to err on the side of caution and have filed "unusual death" reports whenever a patient dies in circumstances raising the possibility of professional negligence. The number of reports to police has increased six-fold since the Hiroo Hospital case became public (Figure 2).

[See Figure 2 in Original]

This jump in Japanese medical providers' reports to police may have implications for the debate in the United States over the proper extent of legal protection for self-critical analyses. The statistics on increased reporting indicate that the threat of legal sanction does not invariably lead medical providers to conceal evidence about adverse events. Economic incentives derived from reputational loss constitute a significant counterweight. When a hospital's cover-up is revealed, public distrust of the hospital is magnified, and the hospital's patient base and revenues drop precipitously. The prospect of avoiding that disquieting possibility has apparently reinforced hospitals' inclination to make a clean breast of hospital deaths that may be medically related.

As noted above, MHLW recently adopted a mandatory reporting system for adverse events, with reports to be submitted by a subset of hospitals to an independent entity without enforcement powers. As this new system gains traction, the accountability-based pressure for reporting to police is likely to diminish. Whether the lodging of a part of the public accountability function in the new reporting system will affect the interpretation of the ambiguity in the Physicians' Law remains to be seen.

3. Prosecutorial Considerations

According to Tokyo prosecutors experienced in medical cases, several factors are most important in decisions about whether to prosecute. Factors supporting prosecution are (1) the bringing of a complaint by the patient or family, (2) the seriousness of the harm, (3) the egregiousness of the medical personnel's acts or omissions, (4) the clarity of proof of negligence, and (5) failure by the medical personnel involved to have provided compensation and apologies to the injured. Other relevant considerations include the extent of media coverage, the current wellness of professional disciplinary sanctions within medicine, and perhaps, the deterrent effect of prosecution on other harm-causing behavior. Few cases meet these criteria, but those that do, when they become public, have enormous impact.

4. Why a Greater Role for Criminal Law in Japan? A Conjecture

Criminal law plays a far greater role in the public regulation of medical error in Japan than in the United States. Japanese aggrieved by perceived medical error have a greater tendency to call for police and prosecutorial involvement than Americans. The lack of other accountability mechanisms in medicine-for example, the weakness of peer review and professional discipline structures, the current wellness of the hospital accreditation, the absence of objective hospital-by-hospital statistics on outcomes of medical treatment, and the relative infrequency of civil malpractice litigation-enhances the social importance of the criminal law as a way of increasing transparency in the medical world.
Various theories have been offered for the tendency of Japanese to rely on police and prosecutors in cases of medical harm. One explanation draws on a traditional predilection among Japanese to look to public authorities to resolve disputes. 138 Another explanation emphasizes the practical difficulties and delays in obtaining civil law remedies through malpractice actions, impelling victims to turn instead to public officials who are more accessible and may be more likely to act.

One other conjectural explanation, drawing on the work of David Johnson, focuses on a comparison between the goals of medical error and the goals of prosecutors. Recent scholarship on medical error victims’ experiences and goals, 136 and victims’ own accounts, indicate that their objectives include compensation, a sincere apology, knowledge of the truth about what happened, sometimes revenge, and the institution of measures to avoid similar injuries in the future.

Prosecutorial objectives in Japan are rather well aligned with those of medical error victims. As Johnson demonstrates, Japanese prosecutorial culture emphasizes establishing the exact facts of each case, taking victims’ wishes into account when deciding to dispose of cases, and pursuing defendants’ rehabilitation by encouraging remorse. Prosecutors’ considerations in the charging decision include whether the victim has received compensation and apology. It is reasonable to suppose that prosecutorial priorities are known to the public, at least in a general way. It is not surprising, then, that Japanese medical error victims should turn to prosecutors for assistance.

By contrast, American prosecutors are typically far busier than their Japanese counterparts and generally less exacting about determining the precise facts of each case, particularly with regard to non-violent crimes. They lack the high regard for the import of remorse and apology that is a part of the Japanese prosecutorial culture. By contrast, American attorneys are in some sense a source of potential assistance to those suffering from medical error than are private attorneys specializing in personal injury. In short, the prosecutor is less appealing as an ally to injured patients and families in the United States than in Japan.

V. The Health Ministry “Model Project” on Investigation of Medical Accidents

Keenly aware of the criticisms of the extent of the criminal justice system’s involvement in the patient safety arena but attempting to work within existing legal and institutional structures, the Ministry of Health, Labor and Welfare launched a “model project” in the autumn of 2005 to try to move the system in a different direction. Four medical specialty societies helped launch the “model project,” viewing it in part as a possible alternative accountability mechanism that could ultimately displace some of the emphasis heretofore placed on criminal prosecutions. The project, initiated in Tokyo, Osaka, Nagoya, and Kobe, will work as follows.

When a patient dies in a hospital under circumstances indicating the possibility of medical error, an independent, third-party investigation by medical specialists can be undertaken with the agreement of both the patient’s family and the hospital. An autopsy would be conducted. Autopsies have seldom been performed in Japan, largely for cultural reasons, but pathologists and forensic medicine specialists are eager to raise their professional profile, and both the pathology and the forensic medicine specialty societies are participating in the experiment.

Specialists from the relevant medical disciplines will review the patient’s chart and interview the attending physician and other hospital personnel. An evaluation of evidence and information will be submitted and a report on the cause of death and on needed preventive measures both to the hospital and to the family. Then the report, with identifiers redacted, will be made public.

This third-party mechanism will have nothing to do, as a formal matter, with the question of compensation for the family. But as a practical matter, no doubt its conclusions will carry considerable weight in negotiations between the family and the hospital. Where negligence is inferable by the facts found by the investigators, given their prestige and standing, it would most likely lead quickly to apologies and formal expressions of remorse by the hospital and physicians, attention to needed preventive measures, and agreement for compensation to the family within standard amounts. The process could therefore serve as a speedy substitute for the civil malpractice action, although it would not preclude the possibility of an action. The effect of the process would probably also be to buffer providers from the draconian criminal law.

If this experiment works well and the process it envisions takes root in Japan, one of its promising aspects is that it would help bring external peer review into Japanese medicine. It would not be secret peer review; rather, the mechanism would have accountability built into it, by providing the facts and the experts’ conclusions to the family, the profession, and the general public.

The aim of the “model project” is to obtain the medical facts and conclusions in much more timely, less expensive, and perhaps more accurate, objective fashion than the civil law malpractice system currently allows. It is an experiment well worth monitoring. If it succeeds, reformers seeking to link patient safety and improvement of the American medicolegal dispute resolution system may find its conclusions instructive.

VI. Conclusion

Both Japan and the United States are coming to realize that reduction of the human toll from medical error is a social objective of the first importance. Leaders in both nations recognize that accurate information on the nature, frequency, and causes of medical errors is essential to any successful quality improvement program. Both nations are grappling with the problem that obtaining accurate information through programs of self-critical analysis in medical facilities may create serious tension between the goals of patient safety and public accountability.

Differences in the two societies’ legal structures, however, have forced efforts to resolve this tension into somewhat different trajectories. In the United States, battles over the rules of civil malpractice litigation are fierce, and tort law occupies center stage in the debate. The hospital accreditation process plays a critical role in medical quality control, and peer review is relatively well developed, so a major issue (resolved to some extent by the Patient Safety and Quality Improvement Act of 2005) has been protecting from plaintiffs’ attorneys internal hospital information developed for purposes of quality improvement and accreditation requirements. In Japan, although the volume of medical malpractice cases is increasing, malpractice premiums (stabilized by nationwide risk pooling without regard to medical specialty) do not pinch the medical profession to a comparable degree. Pressures on hospitals from civil litigation and from hospital accreditors are much less stringent, and peer review and professional discipline are weak. The debate in Japan focuses to a larger extent on the proper role of the criminal justice
It is possible that the threat of criminal prosecution and accompanying adverse publicity may undercut sorely needed initiatives within Japanese hospitals to perform self-critical analyses, although statistics demonstrating a recent substantial increase in reporting of medical accidents to police cast some doubt on the extent of this potential patient safety problem. In any case, few would contend that police and prosecutors are ideally suited for the medical quality control role that has been thrust upon them. Nonetheless, democratic societies demand public accountability, and the relative weakness of other social structures [*2255] regulating medicine in Japan has made the criminal justice system (together with the media) into an accountability mechanism of last resort.

With regard to two important points, however, the involvement of the criminal justice system in the medical error arena offers Japan unqualified benefits. First, it has helped motivate the medical profession to undertake internal system improvements 148 and to cooperate in the health ministry's innovative "model project" for neutral expert investigation of medical accidents. Second, under the criminal law's looming presence, the entrenched practice of systematic deception of patients about medical harm cannot long endure. Whistleblowers within hospitals have uncovered these deceptions, prosecutors are not inclined to tolerate them, criminal sanctions as well as civil damage judgments have ensued, and the media are unforgiving. Thanks in part to the criminal justice system, the practice of medical dishonesty by doctors and hospitals seeking to cover up their mistakes is likely on the wane.

Legal Topics:
For related research and practice materials, see the following legal topics:
Healthcare Law > Business Administration & Organization > Accreditation
Torts > Malpractice & Professional Liability > Attorneys
Torts > Malpractice & Professional Liability > Healthcare Providers

FOOTNOTES:


[2] See infra notes 45-48 and accompanying text, and Figure 1.


[4] Campbell & Ikegami, supra note 3, at 188 (noting that "few hospitals have quality assurance programs" and that "[i]n conducting peer reviews is usually technically not possible because the state of medical records is so poor that they may be incomprehensible even to the writer.").

[5] Interview with officials in the Ministry of Health, Labor, and Welfare's patient safety office, Tokyo (Aug. 6, 2004) [hereinafter MHLW Aug. 2004 Interview]. These officials noted that the Medical Ethics Council, which operates under health ministry auspices, embarked on a new policy in late 2002 whereby serious malpractice could be the basis of an administrative sanction. However, information about incidents of malpractice is hard to come by. The ministry's patient safety office is staffed with only eight people, who have a multiplicity of other tasks besides investigating malpractice incidents. Moreover, unlike the police, health ministry officials lack the subpoena power, and some hospital administrators have refused their requests for documents. Id.


[7] JCQHC surveys, unlike their JCAHO counterparts, do not check whether hospitals carry out self-critical analyses of adverse events. Interview with Hitashi michi, director, JCQHC, Tokyo (July 31, 2003) [hereinafter michi Interview].

[8] The account given here was compiled from interviews with government sources, attorneys, and physicians, and from the following news stories: "By in ni ni na kekan: 3 ishi taio de ichi ra ga kaiken ["Major Problems at This Hospital," Director Says of Arrest of 3 Doctors], Yomiuri Shimbun, Sept. 25, 2003; Three Urologists Held over Mistreatment of Patients Read from Manual While Performing Surgery, Japan Times, Sept. 26, 2003; Taiho no Niki idai by in ishi, Rini-I no shin nor otorai shujutsu [3 Jikei Medical U. Docs Arrested; Operated Without Ethics Committee OK], Yomiuri Shimbun, Sept. 26, 2003; 3-nin dake no shi de oshikuri- Jikeikai by in no jiken [Jikei Hospital Case: Surgeons Insisted on Team of Only 3], Yomiuri Shimbun, Sept. 26, 2003; Jikei idai by in no shujutsu rando no tsuishutsu, ishi no b s kaimeri e [Jikei Hospital Tums Over Surgery Video; Will It Explain Docs' Surgical Joyride?] Yomiuri Shimbun, Sept. 28, 2003; Jikei idai by in no shujutsu rando, 2 hikouki to moto shinryu buch o ch kaikou [Jikei Medical U. Hospital Surgical Error: 2 Defendants and Ex-Supervisor Sacked], Yomiuri Shimbun, Dec. 26, 2003; Jikei Medical School Fires Three Doctors Standing Trial for Malpractice Death, Japan Times, Dec. 27, 2003; Moto Jikei idai Aoto by in 2-ishi ni gy mu teishii 2- nen: Id shin [Medical Ethics Board Gives 2 Former Aoto Hospital Docs 2-year License Suspensions], Yomiuri Shimbun, Mar. 17, 2004; Panel Floats Suspension for Surgeons, Japan Times, Mar. 18, 2004; Jikei idai Aoto by in jiken [Jikei Medical U. Hospital Case], Yomiuri Shimbun, June 18, 2005.


See Paul C. Weiler, Medical Malpractice on Trial 13 (1991) (summarizing HMPs finding of only one tort payment for three potential tort claims involving the most serious or costly injuries); Paul C. Weiler, A Measure of Malpractice: Medical Injury, Malpractice Litigation, and Patient Compensation 70 (1993) (describing HMPs finding of one tort claim for every 7.6 negligently caused injuries). Factors suppressing the filing of malpractice actions when negligence is proven include the lack of information available to injured patients and their families concerning the facts regarding patient care; potential plaintiffs' disinclination to undergo the rigors of obtaining and cooperating with legal counsel in the preparation and trial of a lawsuit; and the practical difficulties to plaintiffs' attorneys of obtaining and marshalling proof of negligence and causation of injury in a cost-effective manner.

The hospital may have offered compensation to the family on a private, informal basis; we are unsure whether that is the case.

The youngest of the three urologists, who acted only as a surgical assistant, pleaded innocent. The hospital suspended him from work for ten days. As of this writing his criminal trial continues.

See supra note 8.

Hideki Komatsu, Jikel Idal Aoto By In jiken: Iry no k z to Jissenteki rint [Practical Ethics and the Structure of Health Care: The Jikel Medical U. Aoto Hospital Case] (2004).

This phenomenon has received sporadic international attention. See, e.g., Yuriko Ono, In Japan, a Doctor Shakes Up Medicine in Malpractice Case, Wall St. J., June 10, 2002, at A1 (physician's negligence action against hospital in which her daughter died).

A heart patient had part of his lung removed, and a lung patient with a similar name had part of his heart valve excised. The mistake was not discovered until the evening after the operations. Three doctors and two nurses were found criminally liable for professional negligence. 1087 Hannrei Taizyu 296 (Yokohama Dist. Ct., Sept. 20, 2001). See Court Fines Medical Staff for Heart, Lung Mixup, Japan Times, Sept. 21, 2001.

A patient died after a nurse injected her with what the nurse believed to be a heparin solution. In fact the syringe contained a disinfectant, and had been left on the cart by another nurse. The two nurses were convicted of the crime of professional negligence causing death or injury. The hospital director was convicted of forging a death certificate containing a false cause of death, and of failing to report the case to the police. 1771 Hannrei Jih 156 (Tokyo Dist. Ct., Aug. 30, 2001); see also Coverup of Patient's Death Gets Director Suspended Temp, Japan Times, Aug. 31, 2001; Nurses Get Suspended Sentences in Hiroo Malpractice Case, Japan Times, Dec. 28, 2000. The Supreme Court affirmed the hospital director's conviction. 58(4) Koei 247 (Sup. Ct. Apr. 13, 2004) (Hiroo Hospital case).

Improper operation of a heart lung machine by one doctor during heart surgery led to a decreased blood flow to the brain of the twelve-year-old patient, who later died. Another doctor, who was in charge of the surgery, falsified data on the patient's chart in a coverup attempt. Two Doctors Arrested in Malpractice Death, Int'l Herald Tribune/Asahi Shimbun, June 29, 2002, at 1. The first doctor was arrested and indicted for professional negligence causing death, the second for destruction of evidence. 2 Doctors Indicted for Girl's Death, Int'l Herald Tribune/Asahi Shimbun, July 20-21, 2002, at 22. The hospital was stripped of its prestigious and remunerative status as a tokeultin by in (an administrative category of advanced-level hospitals). An external investigative committee later found that one of the doctors had not "acquired the basic knowledge required for heart surgery," and that three other patients had died in the past several years. "The hospital operated on 5,000 patients last year, and acted on information from confidential patient private settlements. By contrast, in the case of media reports and official acts by police and prosecutors (which become matters of public record and typically are pounced upon by the media), reputational damage is inevitable. We do not mean to minimize reputational concerns among hospitals in the United States. As patient safety specialists Robert Wachter and Kaveh Shojania have noted with reference to North American medical providers, 'fear of media exposure runs neck-and-neck with fear of lawsuits in reasons for 'failure to disclose' by caregivers and hospitals.' Wachter & Shojania, supra note 9, at 266. See generally William M. Sage, Reputation, Malpractice Liability, and Medical Error, in Accountability: Patient Safety and Policy Reform 159-83 (Virginia A. Sharp ed., 2004). Our claims are rather that civil liability occupies a relatively less prominent position in Japan than in the United States, and that criminal liability plays a more important role in the Japanese system than in the North American systems.


Institute of Medicine, To Err Is Human: Building a Safer Health System (2000) [hereinafter To Err Is Human].


Media exposés, in particular the Boston Globe's 1995 account of the death of one of its columnists at the Dana Farber Cancer Institute due to medication mistakes, drew attention to the scientific evidence of the widespread incidence of medical error and helped spark the national debate over the issue. See Michael L. Millenson, Moral Hazard vs. Real Hazard: Quality of Care Post-Arrow, 26 J. Health Pol'y Pol'y & L. 1069, 1074 (2001).

There have been a few studies of error within particular medical disciplines. See, e.g., Ken Nagaya et al., Causes of Maternal Mortality in Japan, 283 JAMA 2661 (2000) (finding an association between maternal mortality and "[i]nadequate obstetric and anesthetic services and laboratory facilities"); Y. Kowashima et al., Annual Study of Perioperative Mortality and Morbidity for the Year of 1999 in Japan: The Outlines-Report of the Japan Society of Anesthesiologists Committee Operating Room Safety, 50 Jap. J. Anesthes. 1260 (2001) (in Japanese with English abstract). A health ministry official explained, perhaps somewhat disingenuously, why no quantitative studies of the overall incidence of medical error have been undertaken to date. "This is impossible. Our ministry is not equipped with the National Center for Health Statistics." Tetsuya Fujimori, M.D., Deputy Director, MHLW General Affairs Division, Health Policy Bureau, Tokyo (Apr. 12, 2001). Since that time, the health ministry has begun a pilot study, led by Dr. Hideto Sakai, to estimate the extent of medical accidents at a group of larger hospitals. Preliminary results of as of early 2005 estimated that 6.4% of hospitalizations resulted in some kind of injury. MHLW, Iris ky o zen kokushitei hassi ni kansuru kenkyu [The Nationwide Frequency of Medical Accidents], summarized at http://web.kyoto- inet.or.jp/ok/hoken- syukan/pages/200503/sf00003 3.html. This is a rate not inconsequent with North American findings, although methodological differences make direct comparisons problematic.

See supra note 17.

Gy se1 ikkan no hoy - suru j h no k kai ni kansuru h itsu [Law Concerning Access to Information Held by Administrative Organs], Law No. 102 of 1999.


Best's Aggregates and Averages, Property-Casualty 78 (2003). The figure includes all insurance claims files opened, whether the claims were filed in the judicial system or not.

Annual statistics on claims filed in court are published by the Supreme Court of Japan's Administrative Office. T h e y a r e a v a i l a b l e a t http://courtadmin2.courts.go.jp/shanyou nsf/0258b7 c1650a828294256476004875a6c8c638bc9660a65049257013000a1ed2 (2005) OpenDocument, and in hard copy in Yutaka Tejima, Ijih Ny mon [A Primer on Medical Law] 137 (2005). In 1997, 597 medical injury claims were filed in court.

See Kazue Nakajima et al., Medical Malpractice and Legal Resolution Systems in Japan, 285 JAMA 1632, 1633, 1638 (2001). These statistics represent claims filed with the nationwide nonjudicial dispute resolution system under the auspices of the Japan Medical Association liability insurance program, which covers forty-three percent of Japanese physicians, and with its second largest local chapter. Claims filed with the JMA - 321 in 1997 - encompassed the larger claims (1 million or more). Those filed with the local chapter - 171 in 1997 - represented the smaller claims. Id. at 1634, 1637-38. It would be incorrect to take the number of lawsuits that are not permissible to enumerate. The number of medical malpractice claims in Japan is a whole. About eight percent of the claims filed in the JMA system are also filed in court. See id. at 1635; the Osaka claims represent only a fraction, albeit a substantial one, of all the small claims filed with local medical associations; other nonjudicial dispute resolution systems exist outside the medical associations; some other medical injury claims are filed only with the special compensation system for drug-related adverse events; and an unknown number of other potential claims are settled by other informal means. See infra note 35. Ramseyer and Nakazato, relying on earlier data but using a method similar to that employed here, estimated ranges for malpractice claims of about 800 to 3,700 for Japan and 70,000 for the United States. J. Mark Ramseyer & Minoru Nakazato, Japanese Law: An Economic Approach 69 (1999).


Given the census figures in supra note 34, the Best estimate of U.S. claims, Best, supra note 31 and accompanying text, yields a U.S. claims rate per 100,000 population of roughly forty. A simple summing of Japanese court filings, JMA and Osaka Medical Association claims, yields a claims rate per 100,000 of roughly 0.9 - a "minimum estimate" for the denominator of the United States/Japan ratio for the reasons given in supra note 33. So the forty-to-0.9 ratio should be considered an "upper bound" estimate. The "lower bound" estimate of this ratio remains obscure. One should revise the ratio's denominator upward to reflect the small number of claims filed with medical associations in the other 46 prefectures. One might simply extrapolate from Osaka figures to arrive at a national estimate for these claims. But Osaka, with its well-developed plaintiff-side medical malpractice bar, probably has a higher-than-average medical injury litigation rate. See Ramseyer & Nakazato, supra note 33, at 68-69 (indicating substantially higher claims rates for Osaka than for two other nearby urban prefectures, Hyogo and Kyoto). So, such an extrapolation would be problematic. The denominator should also be revised upward to reflect claims settled by informal mechanisms, paid by liability insurers or from medical providers' personal resources, and not captured by any database available to the authors. The number and amounts of such payments by liability insurers is held in strict confidence, and determined by individual providers are impossible to enumerate. Well-informed defense attorneys have suggested to one of the authors that the number of payments by liability insurers might well be characterized as "the sunken part of the iceberg" - perhaps eight or ten times the number of claims recorded in the judicial system. Interview with Tatsuo Kuryuyangai and Yasushi Kodama, Naha, Okinawa, Feb. 25, 2006.


Osaka benshogishiki k ts jiko linkai [Osaka Bar Ass'n Traffic Accident Comm.], K ts jiko songai baish gaku santoku no shiori [Guide to Calculating Traffic Accident Damages] 11 (2005) [hereinafter Traffic Accident Damages Guide]. Pain- and-suffering damages (ishay) in death cases include awards to surviving family members for their grief, and may be adjusted up or down for unusual circumstances. Id.

Oshida, Kodama & Suzuki, supra note 36, at 21; Traffic Accident Damages Guide, supra note 37, at 10-11 (2005); Interview with Prof. Hisanaga Kuroki, Osaka University, (Nov. 27, 2005) (forty percent typically subtracted for a lack of earnings lost in typical net lost earnings awards by age and sex, ranging from 21-48 million (US $ 190,000-$ 440,000) for males and 11-27 million (US $ 100,000-$ 250,000) for females, see Ramseyer & Nakazato, supra note 33, at 90, Table 4.1.

Ramseyer & Nakazato, supra note 33, at 89 n.53.

Neil Vidmar and colleagues, in their study of Florida medical malpractice awards from 1990 to 2003, found that for 5,552 death claims paid, the median payment per claim was $ 194,835 and plus the claim cap of $ 2 million. U.S. Vidmar's "Invisible" Profile of Medical Malpractice Litigation: Insights from Florida, 54 DePaul L. Rev. 315, 340 Table 7 (2005). These amounts are not incomensurate with, and may well be lower than, the sum of pain-and-suffering, lost earnings, and funeral expenses available under the Japanese damages scale. See supra notes 37-38 and accompanying text.

See Baker, supra note 23, at 402-06 & Figure 2. As Baker explains, however, the existence of the underwriting cycle, together with the long liability tail characteristic of medical malpractice insurance and various other behavioral and institutional factors, make the relationship between premiums and payouts quite imprecise.

Nakajima, supra note 33, at 1633, Table 1. The amount of the annual premium increased to 70,000 (US $ 640) in 2003. See infra note 52.

Nakajima, supra note 33, at 1633, Table 1.


See David A. Hyman & Charles Silver, The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution? 90 Cornell L. Rev. 893, 914-17 (2005) (arguing that "[n]o study has shown that exposure to liability has a statistically significant negative effect on the frequency of error reports"); Lucian L. Leape, Reporting of Adverse Events, 347 New Eng. J. Med. 1633, 1635 (2002) ("No link between [error] reporting and litigation has ever been demonstrated.").


For example, there is sometimes a grey area between original medical records and factual "incident reports," both of which are typically discoverable and admissible in evidence, and the reports that hospitals and other health care providers have prepared for their own review. This leads hospital attorneys to counsel deposing incident report forms so as to provide only minimal information, devoid of evaluative content, and thereby potentially less useful for patient safety-oriented analysis.


The House of Representatives passed HR. 5, the controversial bill according various protections to medical providers and medical product suppliers, the day before President Bush signed the Patient Safety and Quality Improvement Act. Health Care - Damages: House Approves Medical Malpractice Bill with $250,000 Noneconomic Damages Cap, 74 U.S.L.W. 2059 (2005).


Some commentators have disparaged the likely effectiveness of the Patient Safety and Quality Improvement Act in developing useful information, citing a lack of sufficient proposed appropriations to fund the Act's adverse events analysis efforts and a lack of incentives for medical personnel to report errors to Patient Safety Organizations. E.g., Hyman & Silver, supra note 58, at 988.

See michi Interview, supra note 7.


An implicit admission of the inadequacy of the original coding system is found in a 2003 report by the official in charge of MHLW's patient safety office, setting out the ministry's activities and plans in the field. See Kazuhiro Araki, Iryo anzen suishin g-tai sakai ni tsuite [General Measures for the Promotion of Medical Safety], 18 tij h gaku [J. Med. L.] 60, 65 (2003) (noting revisions in coding system).

For example, Kitasato University Hospital conscientiously reported about 3,000 incidents - a fifth of the total reported nationwide. By contrast, neither Ashikaga Medical College Hospital nor Hamamatsu University Hospital reported a single incident. Medical Accident Tally at 15,000, International Herald Tribune/Asahi Shimbun, Apr. 24, 2002. Kitasato University Hospital is said to have suffered a decrease in patient census when the story came out.

Interview, supra note 75.

This function is performed by the Japan Council for Quality Health Care (Nihon iry kin kaku, see supra notes 6-7 and accompanying text).

Interview with Yasushi Kodama, an attorney/physician who has served on MHLW advisory committees on patient safety (Aug. 1, 2003). In fact, initial compliance with the reporting requirement has been low. In the first nine months of the system's operation, only 889 reports of medically related harm, including 108 reports of deaths, were submitted. 125 of the 275 reporting facilities submitted scarcely credible reports stating "zero accidents." Moreover, forty percent of the reports of deaths contained no usable information, rendering the reports unhelpful for safety improvement purposes. Iryo shib jiko h kagetsu de 108-ken [Fatal Medical Accidents: 108 in 9 Months], Nihon keizai shimbun, July 29, 2005. Of course, underreporting is expected when any new reporting system is set up. Nor is Japan unique with respect to underreporting of medical accidents. See, e.g., Richard Perez-Pena, Audit Finds Hospitals Failed to Report Hundreds of Mistakes, N.Y. Times, Sept. 29, 2004, at A23; Hospital Infections 'Seriously Underreported,' JCAHO Says, Announcing New Advisory Panel, 11 BNA's Health Care Poly Rep. 132 (2003).

See supra notes 76-80 and accompanying text.

3 It is possible, however, that courts might develop and apply some other basis for an exception to the general disclosure principle, for example in the nature of a privilege to protect medical personnel's privacy or to encourage self-critical analysis.

See Ota, supra note 76, at 569-70; Mochizuki, supra note 76, at 285-294.

See supra note 17.

Yokohama shiritsu daigaku by in kaikaku inkan [Yokohama City U. Hospital Reform Comm.], Iryo no kekyo [Standards for Public Disclosure of Medical Accidents] (2001) (on file with the authors). The policy, adopted at the instigation of city government, requires patients' or
families' consent before public disclosure, to protect their privacy. Incidents not involving harm to patients, in principle, are not to be disclosed. Some private hospitals not subject to information disclosure ordinances have adopted similar policies, despite extensive media coverage about such cases. Interview with Dr. Mori Mori, President, Ishikai Yaa General Hospital, Osaka (July 8, 2001) (describing hospital policies).


†708 See Thomas H. Gallagher & Wendy Levinson, Disclosing Harmful Medical Errors to Patients: A Time for Professional Action, 165 Archives Internal Med. 1819 (2005); Kathleen M. Mazer et al., Communicating with Patients About Medical Errors: A Review of the Literature, 164 Archives Internal Med. 1690 (2004); Rae M. Lamb et al., Hospital Disclosure Practices: Results of a National Survey, Health Aff., March/April 2003, at 73.


†711 See Nihon Ishikai [Japan Medical Ass’n], Ishi no shokury riri shishin [Physicians’ professional ethics guide] §§ 2(1), 2(2), 2(7) (2004) (recognizing, subject to exceptions, physicians’ duties to explain patient’s medical condition to patient and to disclose medical records, but not addressing issue of explanation of errors).

†712 McGZ inter, supra note 7.


†714 See Hanele Yaa Jhih 112, 124-25 (Kyoto Dist. Ct., July 12, 2005) (K no v. Jinchinski case). In a civil action 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 coverup 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 $2 million (US $9,000) for breach of the contract duty to investigate and report faithfully.

†715 1907 Hanele Yaa Jhih 112, 124-25 (Kyoto Dist. Ct., July 12, 2005) (K no v. Jinchinski case). In a civil action 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 coverup 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 $2 million (US $9,000) for breach of the contract duty to investigate and report faithfully.

†716 See, e.g., 54(2) Minsh 582, 1710 Hanele Yaa Jhih 97, 1031 Hanele Yaa Jhih 158 (Sup. Ct. Flb. 29, 2000) (Takeda case) (recognizing Jehovah’s Witness’s right to truthful information about possibility of receiving blood transfusion, in connection with patient’s right of self-determination). See also supra note 29 and accompanying text.

†717 We exclude from consideration criminal acts committed by medical personnel outside the course of usual medical care, such as billing fraud, assaults on patients, violations of controlled drug laws, euthanasia, and physician-assisted suicide, and acts constituting the unlicensed practice of medicine. However, prosecutions under some of these headings, selectively targeted, can have the effect of deterring patient-endangering practices, as Associate U.S. Attorney Jim Sheehan emphasizes. E.g., James G. Sheehan, Symposium on Regulating for Patient Safety: Current Patient Safety Enforcement, Widener University School of Law (Oct. 15, 2004).


†719 See James A. Felkins, "With No Evil Intent": The Criminal Prosecution of Physicians for Medical Negligence, 22 J. Legal Med. 467, 471-72 n.51 & 53 (2001) (describing nine appellate cases, and estimating from "fifteen or so" to "perhaps two dozen" more non-appellate cases over the twenty-year period). Based on a Westlaw database search and a coW of other studies). The actual number of prosecutions may be somewhat higher than Felkins’ estimate, because the cases are not recorded in any systematic way and the Westlaw database Felkins searched is incomplete. See also George J. Annis, Medicine, Death, and the Criminal Law, 33 New Eng. J. Med. 527, 527 (1995) (criminal prosecution under the Felkins case, "extraordinarily rare"). By comparison, one writer has enumerated twenty-three criminal cases brought against twenty-eight doctors in the United Kingdom from 1990 to 2003. Jon Holbrook, The Criminalization of Fatal Medical Mistakes, 327 BMJ 1118, 1118-19 n.5-9 (2003) (editorial citing reports by R. E. Fenner and C. Dyer).

†720 See Felkins, supra note 109, at 475-90. Felkins’ review of modem appellate cases reports convictions upheld for reckless or intentional acts in Com. v. Youngkin, 427 A.2d 1356 (Pa. Super. Ct. 1981) (involuntary manslaughter); People v. Einaugler, 618 N.Y.S.2d 414 (N.Y. App. Div. 1995) (involuntary manslaughter); United States v. Chapman, (noted in discussion in Felkins, note 109 at 477-78); and People v. Kxana, 15 Cal. Rptr. 2d 512 (Cal. App. 1992) (second-degree murder). In all these cases, recklessness or conscious disregard for a known risk to life was proven. Physicians have occasionally been prosecuted for crimes with mens rea less than recklessness, for example negligent homicide (under a concept of negligence stricter than that applied in civil cases). E.g., State v. Warden, 813 P.2d 1146 (Utah 1991). But in the modem cases except for Warden, they were either found not guilty, or their convictions were overturned. See U.S. v. Billig, 26 M.J. 744 (1988) (military case); People v. Verbrugge, 998 P.2d 43 (Colo. Ct. App. 1999). In an earlier era, negligent homicide cases against physicians were somewhat successful. Donald C. Barnett, Annotation, Homicide Predicated on Improper Treatment of Disease or Injury, 45 A.L.R.3d 114, §3(e) (1972). However, the modem cases typically require intent or recklessness. See Kara M. Courier, Note, Doing Time for Criminal Crime: The Incompetence of Incompetent Physicians as an Additional Mechanism to Ensure Quality Health Care, 28 Seton Hall L. Rev. 569, 607-13 (1997).

†721 See supra note 20.

†722 See, e.g., Jost, supra note 108, at 85-86 n.29 (observing that in Germany "[e]ven today there are probably many as criminal as civil complaints brought against doctors"); Holbrook,
supra note 109, at 1118 (noting increase in prosecutions for medical manslaughter in the United Kingdom).

†n113 According to one recent report, seventy-three prosecutions were brought in medical cases over the period 1974- 1999 - a rate of two to three per year. "Shohotei nisuru": Iryo kago y hatsu keijii saiban 73-ken, Ky dal shoo bunseki ["Elementary Mistakes": 73 Criminal Cases Triggered by Medical Malpractice, Kyushu U. Researcher Finds], Nishi Nippon Shimbum, Aug. 25, 2003, http://www.nnishinpon.co.jp/media/news/news- today/20030825/morning/news01.html (reporting study by Dr. Sh Ichi Maeda). This study found twenty-one prosecutions during the 1970s, twenty-two during the 1980s, and twenty-seven during the 1990s. This rate appears not to have varied much in the fifty years following the end of World War II. See Hideo Iida & Isei Yamaguchi, Keijo Iryo kago [Criminal Medical Malpractice] 1 (2001) (reporting 137 prosecutions brought in the fifty years following the end of World War II).

†n114 Filkins's estimate, based on incomplete data, puts the U.S. prosecution rate at slightly more than one per year - less than half the pre-2000 Japanese rate, though the U.S. population is more than four times Japan's. See Filkins, supra note 109. In light of this, and the impression of Filkins's estimate preclude anything approaching statistically accurate comparisons with Japan. Nevertheless, one may obtain a rough measure of the relative frequency of criminal versus civil medical malpractice litigation in the two countries by comparing the ratio of each country's criminal cases brought per 100,000 population to civil cases brought per 100,000 population. Cf. supra note 35 and accompanying text (comparing civil malpractice litigation rates). That ratio is more than two orders of magnitude higher for Japan than for the United States, suggesting the greater relative importance of criminal law in the medical injury field in Japan.

†n115 Keih art. 211 (Gy muj kashitsu chishish - t - zai), providing a prison sentence of up to five years and a fine of up to 500,000 (US $ 4500). This crime is most commonly charged in connection with traffic offenses. Articles 209 and 210 also criminalize negligence causing injury and negligence causing death respectively, but they are seldom used in medical prosecutions. Medical personnel convicted under Article 211 typically receive fines and often suspended sentences, but they rarely serve prison time. See Iida & Yamaguchi, supra note 113, at 435-82 (collecting cases; summary chart on file with the authors).

†n116 See supra note 110 and accompanying text.

†n117 Keih art. 104 (Sh ko inmetsu). This provision formed the basis for the indictment of one of the physicians in the recent Tokyo Women's Medical University case. See supra note 19 and accompanying text.

†n118 See, e.g., Kanute kaizan 103-ken: Iryo kago sosh no bengoshi ch sa [109 Cases of Altering Patient Charts - Survey by Medical Malpractice Attorneys], Yomuri shimbun (Osaka edition), July 7, 2004, at 1; Tokyo Women's Medical University case, supra note 19; Leflar, supra note 3, at 35 & n.127.

†n119 Ishih [Physicians' Law] art. 21.

†n120 The most well-known Article 21 prosecution involved a charge brought against the director of Hiroo General Hospital in Tokyo for failing to report a patient's accidental death. See supra note 18 and accompanying text. The administrator was convicted, and his conviction was affirmed by the Supreme Court. 58(4) Keish 247 (Sup. Ct. April 13, 2004) (rejecting argument that criminal conviction for failing to make required report violated constitutional protection against self- incrimination). The authors are aware of only three other prosecutions under this provision: Judgment of Tokyo Summary Ct. (Sept. 5, 2001); judgments of Morioka Summary Ct. (Dec. 27, 2002) (2 cases).


†n123 In fact, the Japan Surgical Society [Nihon geka gakkai] issued a position paper contesting the idea that Article 21 of the Physicians' Law requires the reporting to police of deaths potentially connected to medical error, but nevertheless calling on its members to voluntarily report to police both deaths and serious injuries resulting from clear breaches of the standard of medical care, as a matter of medical ethics. Nihon Geka Gakkai, Shinry k i ni kannen shita kannja no shib, sh ga no hoku no tsuite [Reporting to Police of Patients' Deaths and Injuries Connected with Medical Acts], reprinted in Horiyuki K , Iryo jiko e no hoku no mondai no tsute [Issues with Reporting Medical Accidents to Police], 1249 Jurisuto 69, 70-71 (2005), and Furukawa, supra note 121, at 16-18. This position, like the position paper of the National University Hospitals Presidents' Conference which preceded it, supra note 68, in effect, acknowledges the importance of reporting to a public entity as an accountability mechanism in a system of shaken public confidence in physicians' skill and candor. Interview with attorney/physician Toshiharu Furukawa, Tokyo (July 16, 2003). Similarly, the prestigious Science Council of Japan recently issued a report opining that deaths clearly the result of medical negligence must be reported to police, even if doing so would disadvantage medical providers, in order to promote the transparency in health care that the public expects. With regard to deaths whose cause is unknown or is less clear, the Council suggested a process of expert review before determining whether a report must be submitted to the police. Nihon gakujutsu kaigi [Science Council of Japan], I-j i shi tsute: Nihon gakujutsu kaigi no kenn (Unusual Deaths: Opinion and Proposal of the Science Council of Japan) 6-7 (2005).

†n124 See supra note 120.

†n125 Iryo jiko, jiken todokawa 200-ken toppa - Kelsatsuchu matome, sakunen 35 z [Reports of Medical Accidents, Incidents] Top 200, 35% Increase from Last Year - Police Agency Study], Nihon keish 1129 (2004). These figures include reports of injuries as well as deaths. The number of investigations (rikken) of medical incidents that police opened on the basis of these reports increased dramatically from 1999 (twenty-one) to 2000 (seventy-one), but has fallen off since then.

†n126 We are indebted for this latter point to Prof. Norio Higuchi and Dr. Sakai Iwaski.

†n127 See supra notes 88-90 and accompanying text.

†n128 Interview with Sh J Iwamura, Takayuki Aonuma, and Atsushi Sat , Tokyo District Prosecutor's Office (July 25, 2001) (hereinafter Prosecutors' Interview).

†n129 See Futoshii Itawa, Kashitsu ni yoru iryo kago ni taisuru keijitke kisei: Nichibei hikaku-k [Regulation of Medical Malpractice through Criminal Negligence Actions: Japan- U.S. Comparative Research], in In anzen suishin ni kansuru h teki mondai ni kansuru kenkyu : Heisei 14- nendo kenkyu sekia h kokusho [Research Report on Legal Problems in the Promotion of Medical Safety] 6 (Yasushi Kodama ed., 2003) (on file with authors). The prosecutors whom we interviewed said that they consider such as the deterrence of medical error formed part of their motivation for selecting cases. Prosecutors' Interview, supra note 128. But at least one of us found their restraint in this respect disingenuous.

†n130 See supra notes 3-5 and accompanying text.

†n131 See supra notes 6-7 and accompanying text.

†n132 See supra notes 31-44 and accompanying text.

The mean duration from filing of a medical malpractice case to its conclusion by trial judgment or settlement in 2002 was about two and a half years, compared to 8.3 months for civil cases generally. Administrative Office of the Supreme Court, [上司裁判所年報] ([Supreme Court Annual Report], 2002) at 7. Although the latter is based on data from all civil cases, it is likely to be underestimates for medical malpractice cases, which tend to be longer and more complex.


An important study of the significance to patients of candor, apology, and willingness to undertake safety corrections is Steven S. Kraman & Ginny Hamm, Risk Management: Extreme Honesty May Be the Best Policy, 131 Annals Internal Med. 963 (1999) (describing Lexington, Ky. Veterans Administration Hospital's successful policy of openness toward patients and apology in cases of error); see also Cohen, supra note 108 at 8 (same; legal analysis); Cherri Holbrook et al., Parental Preferences for Error Disclosure, Reporting, and Legal Action after Medical Error in the Care of Their Children, 116 Pediatrics 1276 (2005) (questionnaire survey).


See supra note 128 and accompanying text.

Although law enforcement officials have recently been criticized for inattention to victims' needs, see, e.g., Higashina no tachiba ni tatta shi h: Hihienie jiko de musuko o nakashte [Toward a Justice System That Stands on the Victims' Side: Son Lost in Hit-and-Run], 2 Gekkan shi kaikaku 15-17 (1999), available at http://www2.tky.3web.ne.jp/norhn/katayama.html, prosecutors claim to be responding to these criticisms.

See Johnson, supra note 135, at 21-27.


The ready availability of personal injury lawyers throughout the United States, whose advertising is ubiquitous and who populate almost every county courthouse, stands in sharp contrast to the paucity of similarly motivated attorneys in Japan. Although the number of private attorneys doing medical malpractice work in Japan has been rising, see supra note 46, it is still far smaller on a per capita basis than the corresponding number of medical malpractice attorneys in the United States.

See, e.g., "Iry kanren-shi" hatsu no kai jissi - Tokyo-to-nai no dalgabu by in de [First

"Medically-Related Death" Autopsy - Tokyo-Area University Hospital, Asahi shimbun, Nov. 13, 2005 (reporting first case investigation under "model project," and setting out the project's goals).


The medical specialty societies are the Japan Surgical Society (Nihon geka gakkai), the Japanese Society of Internal Medicine (Nihon ni seike gakkai), the Japanese Society of Pathology (Nihon raku gakkai), and the Japanese Society of Legal Medicine (Nihon h i gakkai).

This description of the project is taken from MHLW Model Project, supra note 145; MHLW Aug. 2004 Interview, supra note 5; and Iry -naka no shi, dai-3-sha kensh - Senmon-i ga bunseki, k hy [3rd-Party Investigations of Deaths During Medical Treatment - Specialists to Analyze, Report Publicly], Asahi Shim bun, Aug. 22, 2004.

See supra notes 68-69 and accompanying text.
Strength of the Political Groups in the House of Representatives

(as of April 30, 2014)

<table>
<thead>
<tr>
<th>Political Groups in the House</th>
<th>Number of Members</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liberal Democratic Party</td>
<td>114 (17)</td>
<td>LDP</td>
</tr>
<tr>
<td>The Democratic Party and The Shin-Ryokufukai</td>
<td>58 (9)</td>
<td>DP-SR</td>
</tr>
<tr>
<td>New Komeito</td>
<td>20 (3)</td>
<td>NK</td>
</tr>
<tr>
<td>Japan Restoration Party and Unity Party</td>
<td>14 (1)</td>
<td>JRP-UP</td>
</tr>
<tr>
<td>Your Party</td>
<td>13 (2)</td>
<td>YP</td>
</tr>
<tr>
<td>Japanese Communist Party</td>
<td>11 (4)</td>
<td>JCP</td>
</tr>
<tr>
<td>People's Life Party</td>
<td>7 (2)</td>
<td></td>
</tr>
<tr>
<td>Social Democratic Party</td>
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<td></td>
</tr>
<tr>
<td>Independents</td>
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<td></td>
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<tr>
<td><strong>INCUMBENTS</strong></td>
<td><strong>480 (39)</strong></td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>MEMBERSHIP</strong></td>
<td><strong>480</strong></td>
<td></td>
</tr>
</tbody>
</table>

Notes: Figures in parentheses show the number of women members.

Strength of the Political Groups in the House of Councillors

(As of May 9, 2014)

<table>
<thead>
<tr>
<th>Political Groups in the House</th>
<th>Number of Members</th>
<th>Abbreviation</th>
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</thead>
<tbody>
<tr>
<td>People's Life Party</td>
<td>2 (1)</td>
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<tr>
<td>Independents</td>
<td>4 (1)</td>
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<tr>
<td>INCUMBENTS</td>
<td>242 (39)</td>
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<td>Vacancies</td>
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<tr>
<td><strong>MEMBERSHIP</strong></td>
<td><strong>242</strong></td>
<td></td>
</tr>
</tbody>
</table>

Notes: Figures in parentheses show the number of women members.

Most house members belong to political groups, which is formed based on their political parties. On this website, the names of the political groups are abbreviated as listed above for layout reasons. These abbreviations are not the official abbreviations for the various political groups.

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Profile of the Prime Minister

Shinzo Abe

Prime Minister

Date of Birth: September 21, 1954
Place of Birth: Tokyo
Member of the House of Representatives (Elected 7 times)
Constituency: Yamaguchi 4th district (Shimonoseki and Miasato cities)

Education
1977 Graduated from the Department of Political Science, the Faculty of Law, Seikei University

Career
2012 President of LDP
Prime Minister
2007 Resigned Prime Minister
2006 President of LDP
Prime Minister
2005 Chief Cabinet Secretary
(Third Koizumi Cabinet (Restuffed))
2004 Acting Secretary General and Chairman of Reform Promotion Headquarters, LDP
2003 Secretary General, LDP
2002 Deputy Chief Cabinet Secretary
(First Koizumi Cabinet (1st reshuffled))
2001 Deputy Chief Cabinet Secretary
(First Koizumi Cabinet (1st reshuffled))
2000 Deputy Chief Cabinet Secretary
(Second Mori Cabinet (Reshuffled))
1999 Trustee, Committee on Health and Welfare
Director, Social Affairs Division, Liberal Democratic Party (LDP)
1993 Elected as Member of the House of Representatives
1989 Executed Assistant to the Minister for Foreign Affairs
1979 Joined Kobe Steel, Ltd.
Abe Cabinet (Formed December 26, 2012)

Dec. 28, 12

Prime Minister
Shinzo Abe

Deputy Prime Minister
Taro Aso

Finance Minister
Yamamoto Taro

Communications Minister
Yoshitake Shindo

Justice Minister
Sadakazu Tanigaki

Foreign Minister
Fumio Kishida

Education, Culture, Sports, Science and Technology Minister
Hakubun Shimomura

Health, Labor and Welfare Minister
Norihisa Tamura

Agriculture, Forestry and Fisheries Minister
Yoshimizu Kogata

Economy, Trade and Industry Minister
Takashina Hideto


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Overview of the Judicial System in Japan

JUDICIAL POWER IN THE STATE

The Constitution (promulgated on November 3, 1946, and put into force on May 3, 1947) provides the democratic foundation for the separation of state powers. To be more precise, legislative power is vested in the Diet; executive power is vested in the Cabinet, the members of which are collectively responsible to the Diet in the exercise of this power. The Diet is empowered to designate the Prime Minister, the head of the Cabinet, from among the members of the Diet; and the whole judicial power is vested in the Supreme Court and lower courts established by law. The courts are the final adjudicators of all legal disputes, including those arising out of administrative actions between citizens and the state.

As shown in the chart below, the judicial system of Japan is composed of the following five types of courts: the Supreme Court, high courts, district courts, family courts, and summary courts. The respective courts have their own jurisdictions as provided for in law.

(As of 2010)

SUPREME COURT
Judicial Function

The Supreme Court is the highest court in the state and is composed of the Chief Justice and fourteen Justices. The Supreme Court exercises appellate jurisdiction of final appeal and appeals against a ruling as provided specifically in the codes of procedure. In addition, it has original and final jurisdiction in the proceedings involving the impeachment of commissioners of the National Personnel Authority. A final appeal to the Supreme Court is permissible in the following instances: (1) an appeal lodged against a judgment rendered in the first or second instance by a high court; (2) a direct appeal sought against a judgment rendered by a district court or a family court, or a judgment in criminal cases rendered by a summary court as a court of first instance; (3) an appeal filed with a high court and transferred to the Supreme Court for a special reason; (4) a special appeal to the court of the last resort made against a judgment in a civil case rendered by a high court as the final appellate court; and (5) an extraordinary appeal to the court of the last resort lodged by the Prosecutor-General against a final and binding judgment of a criminal case.

An appeal against a ruling to the Supreme Court is permissible in the following instances: (1) an appeal filed against a ruling in a civil case or a domestic relations case either on the grounds of violation of the Constitution or with the permission of the high court; (2) an appeal against the decision of the Constitution or with the permission of the high court; (3) an appeal against an order, etc., of an intermediate appellate court in a juvenile case, on the grounds of violation of the Constitution and or for the reason of a conflict with judicial precedents. In civil and administrative cases, a final appeal to the Supreme Court may be lodged on the grounds of violation of the Constitution and grave contraventions of provisions regarding the procedure of the lower courts, which are listed in the Code of Civil Procedure as the absolute reasons for the final appeal. The Supreme Court, however, may accept a case when the Court deems that it involves a case when the Court deems that it involves an important issue concerning the construction of laws and regulations, as the final appellate court upon a petition to do so. Oral arguments and decisions in the Supreme Court are made either by the Grand Bench composed of all fifteen Justices sitting together or by one of the three Petty Benches, each composed of five Justices. Nine or more Justices on the Grand Bench and three or more Justices on each Petty Bench shall constitute a quorum to hear and determine cases.

The proceedings in the Supreme Court commence with the filing of a petition of final appeal by a party dissatisfied with the judgment of a lower court, generally of a high court. Since the Supreme Court primarily determines the question of law, it renders a decision, as a rule, after an examination of documents alone (appeal briefs and records of the lower courts). Where an appeal is groundless, the Supreme Court may dismiss the appeal without proceeding to oral arguments. If the Supreme Court finds it well-grounded, however, a judgment will be rendered after the oral argument is heard.

Every case on appeal is first assigned to one of the three Petty Benches. If a case proves to involve a constitutional issue, namely, an issue of the constitutionality of any law, order, rule, or disposition, except when there is a precedent upon the same issue, the Grand Bench inquires and adjudicates on it.

To assist the Justices of the Supreme Court in their judicial work, there are a certain number of Judicial Research Officials in the Supreme Court.

Judicial Administration

In addition to the primary function of exercising judicial power, the Supreme Court is vested with rule-making power and the highest authority of judicial administration. In its conduct of those administrative affairs, the Supreme Court acts upon the resolutions of the Judicial Assembly, which consists of the fifteen Justices and is presided over by the Chief Justice.

The Judicial Assembly is held for deliberation and determination of matters of rule-making and judicial administration.

With the rule-making power, the Supreme Court may establish the rules of judicial procedure, and of matters relating to attorneys, the internal discipline of the courts, and the administration of judicial affairs.

In establishing rules on important matters, the Supreme Court, in order to establish them with deliberation, consults the Advisory Committee on Rule-Making, which is composed of judges, public prosecutors, attorneys, officers from related institutions, and persons with relevant knowledge and experience, to inquire of the necessary matters to establish rules. Then the Judicial Assembly deliberates and approves the proposed rules formulated on the basis of the Committee's report.

The designation of the Chief Justice of the Supreme Court and appointment of other Supreme Court Justices and judges of lower courts are within the purview of the Cabinet. However, the nomination of candidates of lower court judges from among whom the Cabinet appoints, including the Presidents of the high courts, and the appointment of judges to a specific court are reserved for the Supreme Court, which exercises the authority through the resolutions of the Judicial Assembly, provided that, as a rule, the nomination of candidates of lower court judges requires advice of the Advisory Committee for the Nomination of Lower Court Judges. In addition, such matters as the appointment and dismissal of court officials other than judges are within the purview of the judicial administration of the Supreme Court.

As for the budget of the courts, the Supreme Court, upon the resolution of the Judicial Assembly, submits annual estimates of revenues and expenditures directly to the Cabinet. If the Cabinet reduces the Courts' estimated expenditures, the Supreme Court may request the Cabinet to raise the reduced amounts. In this case, the Cabinet shall attach the details of the reduction concerning the estimated expenditure to the revenue and expenditure budget and clearly state the necessary financial resources so that the Diet can amend the figure for its deliberation.

In order to carry out these administrative affairs, the Supreme Court has the General Secretariat as its internal organization for judicial administration, the Legal Training and Research Institute, the Training and Research Institute for Court Officials, and the Supreme Court Library. The chief staff of the General Secretariat may be selected from among the judges of lower courts with their consent.

Thus, the Supreme Court administers the whole judicial system independently, without any intervention by the executive branch or the legislative assembly.
HIGH COURTS

High courts are located in eight major cities in Japan: Tokyo, Osaka, Nagoya, Hiroshima, Fukuoka, Sendai, Sapporo, and Takamatsu. Each high court has its own territorial jurisdiction over one of eight parts of Japan. Some high courts have branches. There are six branches throughout Japan. In addition, in April 2006, the Intellectual Property High Court was newly established as a special branch of the Tokyo High Court, which handles cases relating to intellectual property only. Each high court consists of a President and other high court judges. High courts, except for the Intellectual Property High Court, have jurisdiction over appeals filed against judgments rendered by district courts in the first instance or family courts and appeals against rulings, except those over which the Supreme Court has jurisdiction as provided specifically in the codes of procedure. However, while appeals in criminal cases originating in summary courts come directly to high courts, appeals in civil cases originating in summary courts are usually brought first to district courts and then final appeals are lodged with high courts.

In addition, a high court has original jurisdiction over administrative cases on election, insurrection cases, etc. The Tokyo High Court also has exclusive original jurisdiction over cases to revoke determinations of quasi-judicial agencies as the Japan Marine Accident Tribunal.

The Intellectual Property High Court exclusively handles cases relating to intellectual property as appeals from district courts in civil cases relating to patent rights and actions against trial decisions made by the Japan Patent Office.

Cases in a high court are handled by a three-judge panel in principle. In addition, insurrection cases, judges’ disciplinary cases, etc. are handled by a five-judge panel.

There are 50 district courts in Japan having territorial jurisdiction over their respective districts, the area of which is identical to that of each prefecture (except Hokkaido, which is divided into four districts). The district courts have 203 branches in total. The district court is generally the court of first instance, except for matters specifically coming under the exclusive original jurisdiction of other types of court. It also has appellate jurisdiction over appeals in civil cases lodged against judgments of summary courts and appeals lodged against orders and directions made at summary courts.

In a district court, as a rule, cases are handled by a single judge, but a three-judge panel is required in the following instances:
(1) Cases in which a panel decides that "trial and decision (of this case) shall be made by a panel."
(2) Cases of crimes punishable by the death penalty or imprisonment with or without work for life or not less than one year. Exceptions, however, are provided in cases of robbery, quasi-robbery, attempts to commit these crimes, or crimes of habitual robbery and theft with repeated convictions under the Act for Prevention