

THE LATEST DEVELOPMENTS IN THE JUDICIAL PRACTICES OF SPECIAL DEPARTMENTS OF MEDICAL MALPRACTICE LITIGATION IN JAPANESE COURTS

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I. INTRODUCTION

This article describes the latest developments in the judicial practices of special departments of medical malpractice litigation in Japanese courts. I present mainly practices in the Tokyo District Court based on my experience as a judge. I worked in that capacity in one of the four special departments of medical malpractice litigation in the Tokyo District Court from 2008 to 2011. Medical malpractice litigation is one of the most difficult types of civil litigation because lawyers and judges are not experts in medical services or familiar with medical knowledge. These judicial decisions are of great interest to patients and physicians, and may affect the actual practice of medicine and future patients. Since proper and accurate judicial decisions based on medical knowledge are necessary, special judicial practices are needed to help lawyers and judges use medical knowledge in court. This might contribute to lengthy proceedings.

The number of new medical malpractice claims in Japanese district courts increased from 1992 to 1994, dropped slightly in 1995, and then increased dramatically from 1995 to 2004, before falling again. The average length of time between filing and the conclusion of medical malpractice cases in district courts was far longer than for other civil cases. When a physician-defendant is liable, it is necessary to compensate a patient-plaintiff as soon as possible. On the other hand, when a physician-defendant is not liable, it is necessary to release that defendant from the medical malpractice litigation as soon as possible, because the lawsuit interferes with a physician's work, affecting his/her patients and practice. To address these concerns, in 2001, the Tokyo District Court created special departments of medical malpractice litigation to achieve proper, accurate, and expeditious resolutions. Special departments of medical malpractice litigation have been playing an important role and developing innovative judicial practices in medical malpractice litigation.

Part II of this article provides statistics on medical malpractice and all civil litigation in Japanese courts. These statistics include: the number of new claims, the average length of time between filing and the conclusion of cases in district courts, the percentage of medical malpractice and all civil cases in which judge-appointed expert witnesses were used in district courts, and settlement and appeal rates.

Part III describes the substantive law of medical malpractice litigation, including contract law and tort law principles of duty of care, negligence, causation, and damages. It is necessary to understand the substantive law in order to grasp the fundamental framework of medical

malpractice litigation. The special departments of medical malpractice litigation have been developing innovative judicial practices, while taking into account the substantive law.

Part IV looks in detail at the latest developments in the judicial practices of special departments of medical malpractice litigation, which aim to achieve proper, accurate, and expeditious resolutions. These developments include: issue-centered practices, organized documentary evidence, the table of clinical treatment, concentrated and organized trials, judge-appointed expert witnesses, settlements, and symposiums for the medical and legal communities to better understand each other.

Part V concludes.

II. STATISTICS REGARDING MEDICAL MALPRACTICE AND ALL CIVIL LITIGATION IN JAPANESE COURTS

A. *The Number of New Claims*

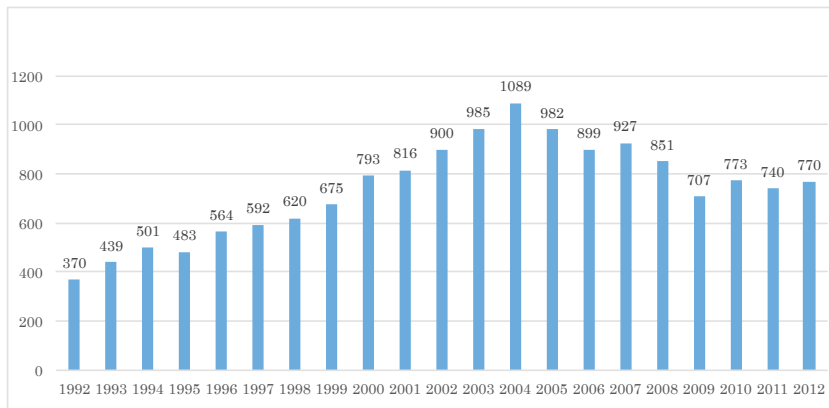
The number of new medical malpractice claims changed from 1992 to 2012, as illustrated in Table 1. That number increased from 1992 to 1994, dropped slightly in 1995, then increased dramatically from 1995 to 2004, before falling again. While the total numbers might be small, the rates of increase from 1992 to 2004 were not.¹ In 1992, there were only 370 new medical malpractice claims in district courts. By 2004, that number had increased to 1089. From 2004 to 2012, the number dropped to 770. Claims increased almost threefold from 1992 to 2004. As indicated below, the average length of time between the filing and conclusion of medical malpractice cases in district courts was far longer than for other civil cases: more than four times longer than for all civil cases in 1993 and 1994. Medical malpractice litigation is one of the most difficult types of civil litigation because lawyers and judges are not experts in medical services or familiar with medical knowledge. These judicial decisions are nevertheless of great interest to patients and physicians, and may affect the actual practice of medicine and future patients. Since proper and accurate judicial decisions based on medical knowledge are necessary, special judicial practices are needed to help lawyers and judges use medical knowledge in court. This might further contribute to lengthy proceedings. Under these circumstances, the Practice First Committee in the Tokyo District Court reviewed judicial practices in medical malpractice litigation, and issued a proposal in 1999 to help achieve proper, accurate, and expeditious resolutions.² The Practice First Committee proposed the use of issue-centered practic-

1. See Eric A. Feldman, *Law, Society, and Medical Malpractice Litigation in Japan*, 8 WASH. U. GLOBAL STUD. L. REV. 257-58 (2009) [hereinafter Feldman Medical Malpractice Litigation], originally published as Eric A. Feldman, *Suing Doctors in Japan: Structure, Culture, and the Rise of Malpractice Litigation*, FAULT LINES: TORT LAW AS CULTURAL PRACTICE 211-12 (David M. Engel & Michael McCann eds., 2009).

2. See Tokyo Chiho Saibansho Purakutisu Daiichi Inkaikai [the Practice First Committee in the Tokyo District Court], Iryo Kago Soshō no Un'ei ni tsuite [Medical Malpractice Litigation Practices], 1018 HANREI TAIMUZU [HANTA] 32 (2000).

es, organized documentary evidence using the table of clinical treatment, concentrated and organized trials, and organized judge-appointed expert witnesses. Following this proposal, four special departments of medical malpractice litigation (Iryo Shuchu Bu) were formed in the Tokyo District Court in 2001.³ Four of the fifty-one civil departments of the Tokyo District Court handle all medical malpractice cases in the court. In addition to the Tokyo District Court, other major district courts in the large cities of Osaka, Nagoya, Yokohama, Chiba, Saitama, Sapporo, Fukuoka, Hiroshima, and Sendai created special departments of medical malpractice litigation. The special departments of medical malpractice litigation in the Tokyo and Osaka district courts have published procedural guidelines for medical malpractice litigation.⁴ In the Tokyo District Court, there are also special departments of administrative, commercial, employment, intellectual property, and traffic litigation. In addition, there are special departments of mediation and construction litigation, provisional remedies, execution, and bankruptcy and civil rehabilitation.

Table 1: New Medical Malpractice Claims in District Courts⁵



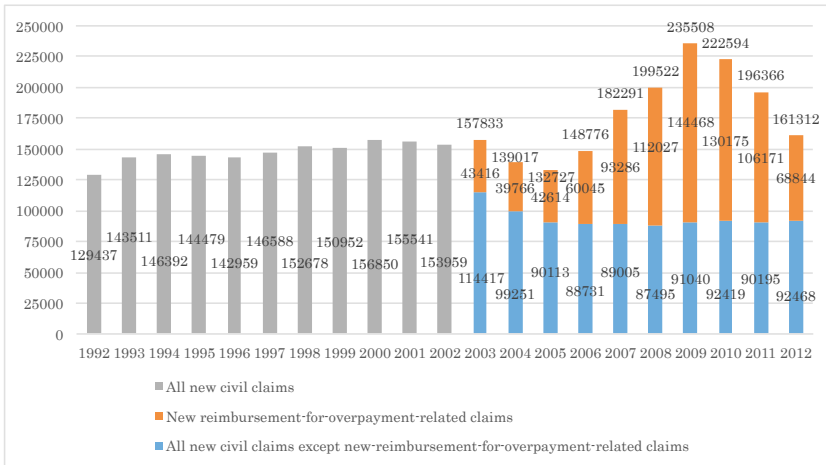
3. See Yuri Kamata, Tetsuya Yamada & Takatoshi Ogawa, *Tokyo Chisai Iryo Shuchu Bu ni okeru Jiken no Gaikyo* [General Conditions of Cases in Special Departments of Medical Malpractice Litigation in the Tokyo District Court], 213 MINJIHO JŌHŌ 17 (2004).

4. See Tokyo Chiho Saibansho Iryo Sosho Taisaku Inkai [the Committee of Medical Malpractice Litigation in the Tokyo District Court], *Iryo Sosho no Shinri Un'ei Shishin* [Procedural Guidelines for Medical Malpractice Litigation], 1237 HANREI TAIMUZU [HANTA] 67 (2007) [hereinafter Tokyo Guidelines]; Tokyo Chiho Saibansho Iryo Sosho Taisaku Inkai, *Iryo Sosho no Shinri Un'ei Shishin (Kaitei Ban)* [Procedural Guidelines for Medical Malpractice Litigation (Revised Edition)], 1389 HANREI TAIMUZU [HANTA] 5 (2013) [hereinafter Revised Tokyo Guidelines]; Osaka Chiho Saibansho Dai 17, Dai 19, Dai 20 Minji Bu [17th, 19th and 20th Civil Departments in the Osaka District Court], *Osaka Chiho Saibansho Iji Bu no Shinri Un'ei Shishin* [Procedural Guidelines in Special Departments of Medical Malpractice Litigation in the Osaka District Court], 1335 HANREI TAIMUZU [HANTA] 5 (2011) [hereinafter Osaka Guidelines].

5. See Saikō Saibansho [Sup. Ct. of Japan], *Saiban no Jinsokuka ni kakaru Kensho ni kansuru Hokokusho*, Dai 5 Kai, Gaikyohen [Fifth Report of the Review of

The number of all new civil claims changed from 1992 to 2012, as illustrated in Table 2. The trend in the number of all new civil claims is different from that of new medical malpractice claims. The number of all new civil claims changed slightly from 1992 to 2004, while new medical malpractice claims increased almost threefold in that same period. The number of all new civil claims had fluctuated dramatically and rapidly from 2005 to 2012, but this fluctuation was mostly based on the change in the number of reimbursement-for-overpayment (kabaraikin henkan) related cases. In reimbursement-for-overpayment cases, the Interest Rate Restriction Act (Risoku Seigen Hō) limits interest rates under loan contracts and invalidates the interest when rates exceed those limits; a debtor can then demand reimbursement for overpayment.⁶ There have been a large number of reimbursement-for-overpayment cases recently in Japan, which has contributed to a dramatic increase in the overall number of civil cases. In 2005, there were a total of 132,727 new civil claims in Japan. That number increased to 235,508 by 2009 and dropped to 161,312 by 2012. The number of new civil claims reflected a similar pattern in new reimbursement-for-overpayment-related claims from 2005 to 2012. In 2005, there were 42,614 new reimbursement-for-overpayment-related claims in Japan. That number increased to 144,468 by 2009 and dropped to 68,844 by 2012. The number of new civil claims apart from new reimbursement-for-overpayment-related claims remained nearly 90,000, almost unchanged from 2005 to 2012.

Table 2: All New Civil Claims and New Reimbursement-for-Overpayment-Related Claims in District Courts⁷



Expediting Trials, General Part] 68 (2013), available at http://www.courts.go.jp/vcms_lf/20524003.pdf (last visited Apr. 12, 2015) [hereinafter Court Report].

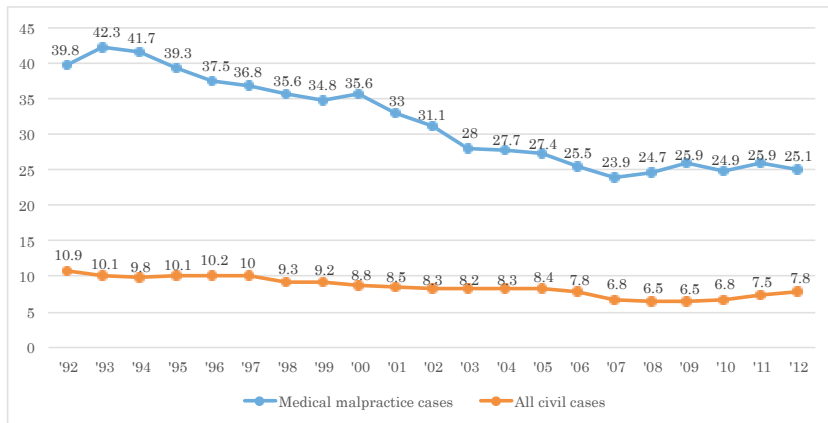
6. Risoku Seigen Hō [Interest Restriction Act], Law No. 100 of 1954, art. 1.

7. See Court Report, *supra* note 5, at 20-21; Saikō Saibansho [Sup. Ct.], Saibansho Deta Bukku 2014 [Court Data Book 2014] 35 (2014) [hereinafter Court Data Book].

B. *The Average Length of Time Between Filing and the Conclusion of Proceedings in District Courts*

The average length of time between filing and the conclusion of proceedings for medical malpractice cases in district courts was far longer than for all civil cases, as illustrated in Table 3. That average for medical malpractice cases was more than four times longer than for all civil cases in 1993 and 1994. However, the average length of time it took to resolve medical malpractice cases dropped dramatically from 1993 to 2007 relative to other cases. In 1993, the average length of time between filing and the conclusion of a medical malpractice case in district court was 42.3 months. That length of time was significantly reduced to 23.9 months by 2007. The total reductions in length and the rates of decrease from 1993 to 2007 were significantly greater than the reductions in all civil cases generally. The average length of time between filing and the conclusion of all civil cases fell from 1993 to 2007. In 1993, that average length of time was 10.1 months, which fell to 6.8 months by 2007. The Bureau for Medical Malpractice Litigation Commission (Ijikankei Soshō Inkaei) of the Supreme Court of Japan reported that the average length of time between filing and the conclusion of medical malpractice cases in special departments of medical malpractice litigation was almost 9 months shorter than the average length of time for medical malpractice cases in other district courts that did not have the special departments in 2011.⁸ Special judicial practices are needed for lawyers and judges to use medical knowledge in court and achieve expeditious resolutions. The special departments of medical malpractice litigation have been serving a very important function in reducing the length of time required to resolve cases.

Table 3: The Average Length of Time between Filing and the Conclusion of Medical Malpractice and All Civil Cases in District Courts (in months)⁹



8. Saikō Saibansho [Sup. Ct. of Japan] Ijikankei Soshō Inkaei Dai 24 Kai [The Twenty-Fourth Meeting of Medical Malpractice Litigation Commission], available at http://www.courts.go.jp/saikosai/iinkai/izikankei/yousi_024/index.html (last visited Apr. 12, 2015).

9. See Court Report, *supra* note 5, at 68; Court Data Book, *supra* note 7, at 71.

C. *Rates of Use of Judge-Appointed Expert Witnesses*

One important factor that has contributed to lengthy proceedings is the expert witness system in medical malpractice cases in Japan. Regarding that expert witness system, parties may use their own physicians as expert witnesses. However, when the physicians' expert opinions between parties are different, it is sometimes difficult for judges to determine which expert opinion is more reasonable, because judges are not experts in medical services. Judge-appointed expert witnesses (*kanteinin*) supplement the judges' medical knowledge to achieve proper and accurate resolutions. Parties may request these judge-appointed expert witnesses and when judges decide that they are necessary for the accuracy of resolutions, judges appoint their own expert witnesses. The judge-appointed expert witness system is effective in improving the accuracy of resolutions, but the process can be time consuming because the court needs to look for, select, and appoint qualified expert witnesses, and allow them time to prepare for trial. The average length of time between a decision to use judge-appointed expert witnesses and submission of the expert reports was 5.4 months in 2012.¹⁰ The special departments of medical malpractice litigation have developed some ways to increase efficiency and reduce the time needed to use the judge-appointed expert witness system. For example, the special departments in the Tokyo District Court started the conference style testimony by judge-appointed expert witnesses in 2003, as discussed below.

The percentage of medical malpractice cases that utilized judge-appointed expert witnesses among all medical malpractice cases fell rapidly from 2004 to 2012, but was still far higher than for other civil cases. In 2004, the percentage of medical malpractice cases in which judge-appointed expert witnesses were used in district courts was 22.4; that figure dropped to 12.9 by 2012, as illustrated in Table 4. The special judicial practices of issue-centered practices, organized documentary evidence, using the table of clinical treatment, and concentrated and organized trials made judge-appointed expert witnesses less necessary and contributed to less lengthy proceedings. On the other hand, the percentage of all civil cases in which judge-appointed expert witnesses were used in district courts was only 0.6 in 2012, as illustrated in Table 5. Judge-appointed expert witnesses were more necessary for medical malpractice cases than for other cases because the medical field itself is very difficult to understand. In addition, sometimes there are no clear medical standards, and lawyers and judges are not experts in medical services or familiar with medical knowledge.

10. See Court Report, *supra* note 5, at 73.

Table 4: Rates of Use of Judge-Appointed Expert Witnesses in Medical Malpractice Cases (%) in District Courts¹¹

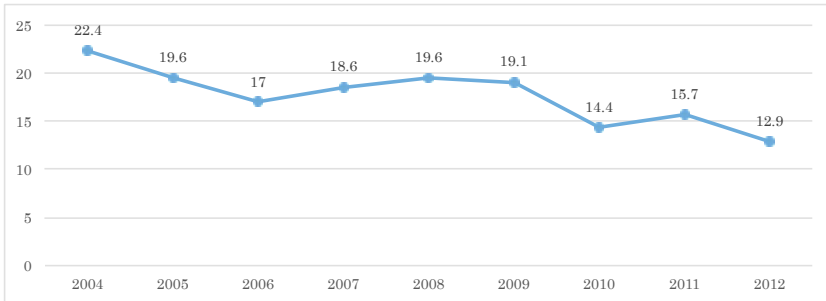
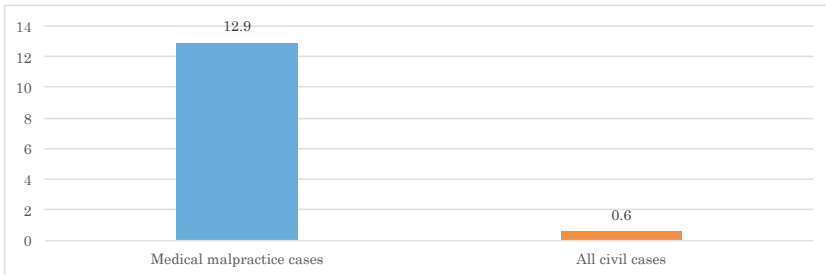


Table 5: Rates of Use of Judge-Appointed Expert Witnesses (%) in District Courts in 2012¹²



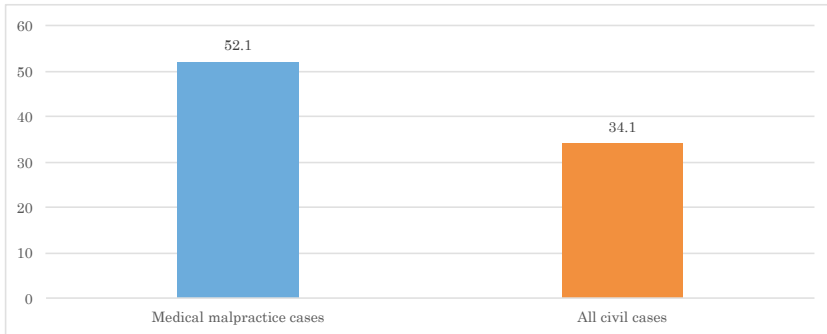
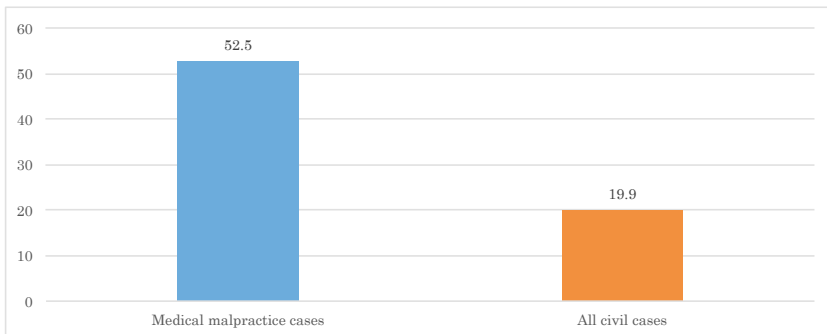
D. Settlement and Appeal Rates

The percentage of medical malpractice cases that were settled was higher than in other civil cases. In general, in medical malpractice cases compared to other cases, parties tend to settle rather than rely on judicial decisions. In 2012, the percentage of medical malpractice cases that were settled in district courts was 52.1, as illustrated in Table 6. In contrast, the percentage of all civil cases that were settled in district courts was 34.1. The special judicial practices contributed to the high settlement rates in medical malpractice cases, as indicated below.

Once a judicial panel makes a decision in a medical malpractice case, the parties are likely to appeal. In 2012, the percentage of medical malpractice cases in which parties appealed judicial decisions in district courts was 52.5, as illustrated in Table 7. The percentage of all civil cases in which parties appealed judicial decisions in district courts was 19.9. Many parties are less accepting of unfavorable judicial decisions in medical malpractice cases compared to other civil cases. There is sometimes high emotional tension between a patient and a physician because a patient thinks a physician betrayed him/her despite an initial feeling of trust. On the other hand, a physician thinks a patient unreasonably filed a lawsuit where medical treatment was pursued in the best way possible.

11. *Id.* at 72.

12. *Id.* at 42, 72.

Table 6: Settlement Rates (%) in District Courts in 2012¹³**Table 7: Appeal Rates (%) from District Courts in 2012¹⁴**

III. THE SUBSTANTIVE LAW OF MEDICAL MALPRACTICE LITIGATION

A. *Contract and Tort Liability*

When a plaintiff files a civil claim for wrongful death or medical injury against a medical facility or a physician, that plaintiff seeks contract and/or tort liability under the Civil Code.

Article 709 of the Civil Code provides for tort liability.¹⁵ Generally speaking, a plaintiff must show duty and negligence of a physician, causation, and damages under the article. Article 715 provides for employer liability.¹⁶ When a medical facility employs a physician, a plaintiff may seek tort liability from the facility based on the negligence of a physician who was engaging in the business of the hospital under that article.

Article 415 of the Civil Code provides for contract liability.¹⁷ Generally speaking, a plaintiff has to show nonperformance of a medical contract between a patient and a medical facility/physician, causation, and damages under article 415. Vicarious liability can also be applied. When

13. *Id.* at 69.

14. *Id.* at 74.

15. MINPŌ [CIV. C.] art. 709.

16. MINPŌ [CIV. C.] art. 715.

17. MINPŌ [CIV. C.] art. 415.

a medical facility employs a physician, nonperformance by that physician is considered as nonperformance by the medical facility, because the physician contributes to the performance of the facility.¹⁸ As a matter of practice, nonperformance of a medical contract is the same as negligence in tort, because a physician's breach of duty of care causes both nonperformance of the medical contract and negligence.¹⁹

Keep in mind that there are different rules regarding statutes of limitations, late charges, etc. for contract and tort liability. Regarding statutes of limitations, a claim of contract liability shall expire if not exercised for ten years from the time when it had become possible to exercise the right.²⁰ A claim of tort liability shall expire if not exercised for three years from the time when the victim or his/her legal representative comes to know of the damages and the identity of the tort-feasor; that claim shall also expire when twenty years have elapsed from the time of the tortious act.²¹ In terms of late charges, a defendant shall be responsible for delayed payment under contract law after a plaintiff makes a claim against said defendant.²² A defendant shall be responsible for delayed payment under tort law from the time of the tortious act.²³ Regarding statutes of limitations, the contract approach is usually favorable to a plaintiff. In terms of late charges, the tort approach is more favorable for a plaintiff.

B. *Duty of Care and Negligence*

The legal standard of a physician's duty of care is based on the medical standard in clinical practice at the time of treatment.²⁴ However, sometimes there are no clear medical standards. Parties use medical literature and physicians as expert witnesses to show medical standards. The medical standard for large, leading hospitals and their physicians in urban areas is different from the standard for small clinics lacking equivalent resources or expertise in rural areas.²⁵ When the court makes decisions based on a medical standard, it considers various circumstances including the hospital facilities and the quality of the region's medical resources. There are times when knowledge of new medical treatment is available to hospitals which to a considerable degree have similar facilities as the defendant-hospital and it is reasonable to expect the defendant-hospital to have the knowledge. That knowledge then becomes a part of the medical standard for the defendant-hospital unless there are

18. See Saikō Saibansho [Sup. Ct.] Jun. 9, 1995, 49 MINSHŪ 1499.

19. Norio Sekine, *Iryo Jiko no Hoteki Sekinin* [Legal Liability in Medical Malpractice], IRYO SOSHO [Medical Malpractice Litigation] 199 (Hitomi Akiyoshi ed., 2009) [hereinafter Akiyoshi Medical Malpractice Litigation].

20. MINPŌ [CIV. C.] art. 166, 167.

21. MINPŌ [CIV. C.] art. 724.

22. MINPŌ [CIV. C.] art. 412.

23. See Saikō Saibansho [Sup. Ct.] Sep. 4, 1962, 16 MINSHŪ 1834.

24. See Saikō Saibansho [Sup. Ct.] Mar. 30, 1982, 1039 HANREI JIHŌ [HANJI] 66.

25. See Robert B. Leflar, *The Law of Medical Misadventure in Japan*, 87 CHICAGO-KENT L. REV. 92 (2012).

special circumstances.²⁶ The initial burden of proof is on the plaintiff to provide facts that show negligence. When the plaintiff makes a showing of negligence, it is the defendant's burden to provide facts that negate negligence.²⁷

A hospital and a physician are sometimes unable to treat a patient properly because they lack sufficient resources or expertise. When they cannot meet medical standards for these reasons, they have a duty to consult and/or transfer the patient to a hospital or a physician who can offer adequate medical treatment.²⁸

When a physician performs an operation to treat a patient's disease, that physician also has a duty to explain to the patient the diagnosis, the elements of the planned operation, risk which is collateral to the operation, alternative medical treatments and their constituent elements, advantages and disadvantages, and recuperation, unless there are special circumstances.²⁹ This duty to explain arises from respect for patient autonomy and the patient-physician contractual relationship.³⁰ Consent by the patient after an explanation is called "informed consent." Failure to explain is an independent cause of action. The types of damages that are compensable will be detailed below.

C. Causation

Generally speaking, a plaintiff has to show causation between negligence and damages. As a matter of practice, causation consists of cause in fact (*jijitsuteki ingakankei*), and proximate or legal causation (*soto ingakankei*). Cause in fact is determined by a "but for test." If Y would not have occurred had X not occurred, then we can say X caused Y by using the "but for test." However, damages might expand infinitely if this were the only test, so a plaintiff has to show proximate or legal causation in addition to cause in fact. If the result and/or damages are very unusual and quite unexpected, a plaintiff will likely fail to prove causation because of a lack of proximate or legal cause. It is not necessary for a plaintiff to show proof by undisputed natural science, but it is necessary for a plaintiff to prove a high degree of probability (*kodo no gaizensei*) that the specific fact caused the specific result, by using a general rule and an examination of all evidence. It is necessary for reasonable persons to believe the truth firmly beyond a doubt to determine a high degree

26. See Saikō Saibansho [Sup. Ct.] Jun. 9, 1995, *supra* note 18, at 1499.

27. Tadashi Otsuka, *Shudan Saimu* [Operational Obligation], *YOKEN JIJITSU RON*, DAI 3 HAN [Issues Regarding Requisition Facts, 3d ed.] 421-22 (Wataru Murata & Akio Yamanome eds., 2012).

28. See Saikō Saibansho [Sup. Ct.] Nov. 11, 2003, 57 *MINSHŪ* 1466; Ryota Ozu, *Ten'i Sotan Gimu wo Meguru Mondai* [Issues Regarding Duty to Transfer and Consult], in Akiyoshi Medical Malpractice Litigation, *supra* note 19, at 318; Shigeyasu Nishioka, *Ten'i Gimu Ihan* [Breach of Duty to Transfer], *IRYO SOSHO NO JITSUMU* [Medical Malpractice Litigation Practices] 303 (Yuzuru Takahashi ed., 2013) [hereinafter Takahashi Medical Malpractice Litigation].

29. See Saikō Saibansho [Sup. Ct.] Nov. 27, 2001, 55 *MINSHŪ* 1154.

30. See Leflar, *supra* note 25, at 95-96.

of probability.³¹ The phrase “high degree of probability” suggests a level of confidence somewhat higher than the preponderance of the evidence standard prevailing in civil cases in common law jurisdictions.³² A judicial decision requires a sufficient basis for the decision, because it enables the enforcement of a compulsory remedy by public authorities in Japan.³³ It is necessary to reveal a medical mechanism to prove causation in medical malpractice litigation to the greatest extent possible.

Even if a plaintiff fails to prove causation (a high degree of probability), when a plaintiff proves with a considerable possibility (*soto teido no kanosei*) that a patient would have lived at the point of death if a physician had performed medical treatment meeting medical standards, the physician is liable under contract and/or tort law.³⁴ When a plaintiff proves with a considerable possibility that a patient would have avoided a severe and permanent injury if a physician had performed medical treatment meeting medical standards, the physician also has contract and/or tort liability.³⁵ However, damages due to infringement upon either a considerable possibility of continuing life or the avoidance of a severe and permanent injury are limited to damages from emotional harm. A plaintiff is compensated with attorneys’ fees to seek those damages. These damages are considerably lower than when a plaintiff proves a high degree of probability.³⁶

When a plaintiff proves causation between a physician’s breach of duty to explain and damages, the plaintiff is compensated for that breach as well as for other negligence under contract and/or tort law. There are times when a patient would have chosen the same medical treatment had it been adequately explained. In this case, the plaintiff fails to prove causation. But when the plaintiff proves breach of duty to explain, this breach of duty infringes on a patient’s autonomy. The physician also has contract and/or tort liability. Damages for infringement upon a patient’s autonomy are limited to damages from emotional harm. A plaintiff is compensated with attorneys’ fees to seek those damages. The amount of the damages is considerably lower than when a plaintiff proves a high degree of probability.³⁷

31. See Saikō Saibansho [Sup. Ct.] Oct. 24, 1975, 29 MINSHŪ 1417; Saikō Saibansho [Sup. Ct.] Jul. 18, 2000, 1724 HANREI JIHŌ [HANJI] 29.

32. See Leflar, *supra* note 25, at 93.

33. See Hiroshi Takahashi, *Shoko Shirabe* [Evidence Examination], JUTEN KOGI MINJI SOSHO HO, GE, DAI 2 HAN HOTEI HAN [Important Points Lecture on the Code of Civil Procedure, Second Volume.] 42-43 (2d ed., rev. ed. 2014).

34. See Saikō Saibansho [Sup. Ct.] Sep. 22, 2000, 54 MINSHŪ 2574; Saikō Saibansho [Sup. Ct.] Jan. 15, 2004, 1853 HANREI JIHŌ [HANJI] 85.

35. See Saikō Saibansho [Sup. Ct.] Nov. 11, 2003, *supra* note 28, at 1466; Saikō Saibansho [Sup. Ct.] Dec. 8, 2005, 1923 HANREI JIHŌ [HANJI] 26.

36. See Akira Ojima, *Seizon ni tsuite no Soto Teido no Kanosei* [Considerable Possibility of Living], in Takahashi Medical Malpractice Litigation, *supra* note 28, at 569-70.

37. See Yoshiaki Moritomi, *Setsumei Gimū Ihan* [Breach of Duty to Explain], in Takahashi Medical Malpractice Litigation, *supra* note 28, at 288.

D. Damages

There are no juries in civil cases in Japan, which eliminates some of the uncertainty experienced by parties to civil claims in the United States. Punitive damages are not permitted in Japan.³⁸ Medical malpractice litigation damages include active damages (*sekkyoku songai*), passive damages (*shokyoku songai*), and damages from emotional harm.³⁹ Active damages are damages that a patient initially has to pay because of medical malpractice. Active damages include the cost of medical treatment, hospitalization, sundries (which are associated with hospitalization), transportation for medical treatment, an attendant nurse, a wheelchair or an artificial leg, house modifications, and funerals. Passive damages are the loss of earnings that a patient would gain but for the malpractice. There are also damages from emotional harm. There are damages guidelines in traffic accident cases in Japan based on legal precedent, which are published in the “Red Book (Akai Hon)” and issued annually by lawyers in Tokyo.⁴⁰ The guidelines are not binding but contribute to predictability. It is common to refer to these guidelines and modify damages based on specific facts even in medical malpractice cases in the Tokyo District Court. The guidelines suppose that healthy persons are injured in traffic accidents. However, in medical malpractice litigation, plaintiffs typically already have pre-existing conditions before the malpractice. Even if the medical treatment meets all the medical standards, plaintiffs sometimes cannot recover a state of perfect health due to a pre-existing condition. It is necessary to consider the specific facts of a medical malpractice litigation in this way to determine damages. Medical malpractice damages are more predictable in Japan than in the United States, in large part due to the absence of juries and punitive damages in Japan.

IV. THE LATEST DEVELOPMENTS IN THE JUDICIAL PRACTICES OF SPECIAL DEPARTMENTS OF MEDICAL MALPRACTICE LITIGATION IN JAPANESE COURTS

A. *Special Departments of Medical Malpractice Litigation*

As indicated earlier, the number of new medical malpractice claims increased from 1992 to 1994, dropped slightly in 1995, then increased dramatically from 1995 to 2004. The average length of time that it took to resolve medical malpractice cases had been far longer than for other civil cases. Under these circumstances, the Practice First Committee in the Tokyo District Court reviewed the judicial practices in medical malpractice

38. See Feldman Medical Malpractice Litigation, *supra* note 1, at 265-66.

39. See Takashi Omine, *Songai* [Damages], in Akiyoshi Medical Malpractice Litigation, *supra* note 19, at 448.

40. NICHIBENREN KOTSU JIKO SODAN SENTA, TOKYO SHIBU [The Japan Federation of Bar Associations, Traffic Accident Consultation Center, Tokyo Branch], MINJI KOTSU JIKO SOSHO SONGAI BAISHO GAKU SANTEI KIJUN [Damages Guidelines in Civil Traffic Accident Litigation] (2015).

litigation to achieve proper, accurate, and expeditious resolutions, and issued a proposal for judicial practices in medical malpractice litigation in 1999. The Practice First Committee proposed issue-centered practices, organized documentary evidence using the table of clinical treatment, concentrated and organized trials, organized judge-appointed expert witnesses, and more. Following this proposal, four special departments of medical malpractice litigation were formed in the Tokyo District Court in 2001. In addition to the Tokyo District Court, other major district courts in the cities of Osaka, Nagoya, Yokohama, Chiba, Saitama, Sapporo, Fukuoka, Hiroshima and Sendai also created special departments of medical malpractice litigation. The special departments of medical malpractice litigation in the Tokyo and Osaka district courts have published procedural guidelines for medical malpractice litigation. The special judicial practices such as issue-centered practices, organized documentary evidence using the table of clinical treatment, and concentrated and organized trials that the special departments developed have become widespread among most of the other district courts. I present mainly the judicial practices of special departments of medical malpractice litigation in the Tokyo District Court in the following text, because I worked in one of the four special departments in the Tokyo District Court.

B. *Issue-Centered Practices*

In order to achieve proper, accurate, and expeditious resolutions, it is necessary to distinguish disputed from undisputed facts between parties, and to understand the essential issues by referring to medical knowledge.⁴¹ These are called issue-centered practices. Major issues in medical malpractice are usually duty of care, negligence, causation, and damages. Plaintiffs have to recognize that they have the burden to prove facts which demonstrate duty of care, negligence, causation, and damages; they are also required to understand actual clinical treatment, obtain the necessary medical knowledge, and prepare for trial. On the other hand, the defendants are requested to allege facts, submit documentary evidence, and prepare for trial actively regardless of the burden of proof. This is because medical treatment evidence and medical information are unevenly distributed among defendant-hospitals. Judges are required to encourage parties to act properly.

When a plaintiff alleges a physician's duty of care and negligence, that plaintiff should recognize and show actual clinical treatment by analyzing a patient's medical records, X-rays, CT (computerized tomography) and MRI (magnetic resonance imaging) records, echo images, etc. A plaintiff has to provide concrete facts which show a physician's duty of care and negligence. For example, a patient's status and the results of medical examinations, a physician's actions such as a diagnosis and an operation, and medical knowledge which shows duty of care and negligence

41. See Wataru Murata, *Soten Seiri 1* [Organizing Issue 1], in Takahashi Medical Malpractice Litigation, *supra* note 28, at 79.

at the time of medical treatment in cooperation with other physicians and medical literature.

A plaintiff should consider whether negligence caused damages or not. Generally speaking, even if a plaintiff proves duty of care and negligence, when a plaintiff fails to prove causation between negligence and damages, i.e., a high degree of probability or considerable possibility, that negligence is meaningless. Therefore, a plaintiff should consider actual results and damages, a medical mechanism that caused negative results and damages, and specify negligence in medical treatment that caused the results and damages at first, then allege meaningful negligence that caused the results, causation, and damages. Medical knowledge plays an important role when judges determine negligence and causation in medical malpractice litigation. In addition to facts, it is necessary for parties and judges to distinguish disputed from undisputed medical knowledge between parties such as the definition of a disease, operations and medical treatment, and the medical reference value for medical examinations. Then they can understand the essential issues to achieve proper, accurate, and expeditious resolutions.

Here are the typical steps taken in a medical malpractice suit. First, a plaintiff submits a complaint about clinical treatment, a physician's duty of care and negligence, causation, and damages. Second, a defendant submits an answer to the complaint which clarifies whether there is a dispute between the parties and includes a specific counterargument; a defendant also submits the table of clinical treatment and documentary evidence such as medical records which are discussed below. Third, a plaintiff submits a reply to the answer and may amend the complaint and specify duty of care and negligence, may submit medical literature, and may reply to the table by denying facts that a defendant alleged or by adding new facts. Fourth, parties continue to reply to the opposing party's allegations and the table of clinical treatment, and submit medical literature including physicians' expert reports. Judges are required to encourage parties to act properly, to clarify unclear points in the parties' allegations, and to recognize the essential issues. Finally, parties prepare for the concentrated and organized trials that issue-centered practices enable.

C. *Documentary Evidence*

A defendant is requested to submit documentary evidence including a patient's medical records, X-rays, CT (computerized tomography) and MRI (magnetic resonance imaging) records, echo images, medical literature, and physicians' expert reports, regardless of burden of proof, because medical treatment evidence and medical information are unevenly distributed among defendant-hospitals. A plaintiff also has to submit medical literature, etc. to prove a physician's duty of care and negligence, causation, and damages.⁴² There are no juries or hearsay ev-

42. See Tomonao Mitsui, *Shosho* [Documentary Evidence], in Akiyoshi Medical Malpractice Litigation, *supra* note 19, at 111.

idence rules in civil cases in Japan, so judges have to review substantial documentary evidence that is organized by the parties.⁴³ Documentary evidence in medical malpractice litigation is divided into three categories: A, B, and C. Documentary evidence of medical treatment, such as a patient's medical records, X-rays, CT and MRI records, echo images, and video tapes of operations, are classified into category A. Documentary evidence of medical knowledge, such as medical literature, clinical practice guidelines, package inserts, and physicians' expert reports, are classified into category B. Documentary evidence of damages, such as receipts of expenditures for medical treatment, hospitalization, transportation for medical treatment, an attendant nurse, a wheelchair, an artificial leg, house modifications, and tax-income certificates that prove a loss of earnings, are classified into category C.

Clinical practice guidelines play an important role at the time of medical treatment and also during medical malpractice litigation. They are defined as systematically developed statements that assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.⁴⁴ However, even if statements are known as guidelines, their nature and purpose differ from one another. It is necessary to know the following about any guidelines: who created those guidelines, their purpose, how they were arrived at, their bases, to what extent they recommend specific medical treatment, what kind of facilities and resources they assume, how well they are known to physicians, and their reputation. It is also necessary to examine whether or not they influenced medical standards at the time of medical treatment.⁴⁵

Physicians' expert reports also play an important role in medical malpractice litigation. These reports are necessary for the opposing party to prepare for the cross-examination of physicians. The reports should include career records, specialties, certificates, clinical experience, and facts of medical treatment (i.e., patient's status, elements of the diagnosis, operations, and physicians' explanations). They also should include facts and medical knowledge related to duty of care, negligence, and causation, such as the evaluation of a patient's status, the bases of the diagnosis, the appropriateness of the medical treatment, and any medical mechanism related to negative results. It is worth noting that sometimes physicians submit expert reports that are not within their specialty and in areas in which they have no clinical experience.

D. *The Table of Clinical Treatment*

As indicated earlier, the table of clinical treatment plays an important role in medical malpractice litigation. Lengthy clinical treatment

43. See Saikō Saibansho [Sup. Ct.] Feb. 1, 1949, 3 MINSHŪ 21.

44. See INSTITUTE OF MEDICINE, CLINICAL PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM 38 (Marilyn J. Field & Kathleen N. Lohr eds., 1990).

45. See Nozomu Hirano, *Chumoku Saibanrei Kenkyu, Iji* [Research of a Remarkable Medical Malpractice Case], MINJI HANREI II [Civil Cases II] 170 (Gendai Minji Hanrei Kenkyukai ed. [Current Civil Cases Research Team], 2011).

and hospitalization, and numerous medical records make medical malpractice litigation even more difficult for lawyers and judges to understand. The table of clinical treatment helps parties and judges address medical malpractice litigation and achieve proper, accurate, and expeditious resolutions.

The table of clinical treatment consists of both a defendant's and a plaintiff's section. The steps to create the table of clinical treatment are as follows. First, a defendant submits a first draft of the table, because a defendant handles medical treatment and generates medical records, so a defendant knows more about the details of a patient's treatment and can more easily produce the table than a plaintiff.⁴⁶ The table of clinical treatment includes time (hour, day, month, and year), clinical treatment (a patient's subjective and objective status and voiced complaints while in medical facilities, assessment, plans, operations, physicians' explanations, etc.), and evidence that proves clinical treatment. Second, a plaintiff reviews and replies to the first draft of the defendant's table, and submits a second draft. A plaintiff may deny facts of clinical treatment which a defendant alleged in the table, may add new facts of clinical treatment which a defendant did not allege in the table, may take notes of evidence, and may submit a second draft of the table. Third, a defendant reviews and replies to the second draft of the table, and then submits a third draft. A defendant may modify only his/her own facts of clinical treatment based on a plaintiff's allegations. Parties then repeat the process of replying to the table of clinical treatment of the opposing party. It is necessary to distinguish facts of clinical treatment from legal issues such as duty of care, negligence, and causation. Parties should not write down legal issues on the table of clinical treatment, because it prevents parties and judges from recognizing the facts of clinical treatment. Parties may allege legal issues outside of the table. On the other hand, the table of clinical treatment should not include facts irrelevant to legal issues of cases. When parties complete the table of clinical treatment, they allege facts in the table in court. This helps judges to distinguish disputed from undisputed facts of clinical treatment between parties and to understand the essential issues of facts of clinical treatment. The table of clinical treatment contributes to concentrated and organized trials to achieve proper, accurate, and expeditious resolutions.

E. *Concentrated and Organized Trials*

As mentioned before, issue-centered practices, organized documentary evidence, and the table of clinical treatment enable concentrated and organized trials of medical malpractice litigation, which play an important role in achieving proper, accurate, and expeditious resolutions. As a matter of practice, these procedures are connected closely in Japan.

46. See Tomomasa Kawashima, *Shinri Jujitsu no tameno Shohosaku* [Methods to Achieve Organized Trials], in Akiyoshi Medical Malpractice Litigation, *supra* note 19, at 43.

Issue-centered practices and the table of clinical treatment help parties and judges distinguish disputed from undisputed facts of clinical treatment between parties, and understand the essential issues of the facts of clinical treatment. Organized documentary evidence helps parties and judges understand the facts of clinical treatment and medical knowledge. Physicians' expert reports enable the opposing party to prepare for the cross-examination of physicians. Special departments' guidelines for medical malpractice litigation in the Tokyo and Osaka district courts propose that, as a general rule, parties should complete their examination of all physicians as expert witnesses in a single day. This does not include judge-appointed expert witnesses.⁴⁷ Completing the examination of all physicians as expert witnesses in a single day helps parties and judges compare different expert opinions about medical standards, confirm the bases of differences of expert opinions, and review the reasonableness of each expert opinion. Judges may grant re-examination of a physician after examination of another physician to compare different expert opinions further. Completing the examination of all physicians as expert witnesses in a single day allows that re-examination. Also, parties can review the reasonableness of each expert opinion and may recognize the essential elements of cases, which contributes to high settlement rates in medical malpractice suits.

In the examination of physicians as expert witnesses, generally speaking, a party that requests a physician as an expert witness examines the physician first, the opposing party cross-examines the physician next, and the first party redirects the physician. Judges may examine the physician supplementally as is true for other civil cases in Japan.

It is necessary to consider whether general medical knowledge applies to the specific case or not. For example, regarding clinical practice guidelines, because the guidelines assume a standard medical treatment for average patients, physicians may provide other medical treatment if patients have another condition, i.e., they are not typical and the medical treatment which the guidelines recommend is difficult to apply, it is urgent to provide other medical treatment, or treatment which physicians decide is reasonable according to the patients' specific status based on other medical evidence. Parties should examine the physicians as expert witnesses about that matter.

When parties examine physicians as expert witnesses, they may use X-rays, CT and MRI records, but special equipment is necessary to view such evidence. Parties should confirm whether the court has that special equipment. If not, parties should provide it.

47. See Tokyo Guidelines, *supra* note 4, at 78; Revised Tokyo Guidelines, *supra* note 4, at 20; Osaka Guidelines, *supra* note 4, at 17; Nozomu Hirano, *Ninsho Shirabe* [Witness Examination], *Iryo Sosho* [Medical Malpractice Litigation] 193 (Takahisa Fukuda, Yuzuru Takahashi & Yasushi Nakamura eds. 2014).

F. *Judge-Appointed Expert Witnesses*

It is sometimes difficult for judges to determine the medical standards of clinical practice at the time of medical treatment and the medical mechanisms that are necessary to determine duty of care, negligence, and causation, because judges are not experts in medical services. Parties may use their own physicians as expert witnesses. However, when physicians' expert opinions between parties are different, it is sometimes difficult for judges to determine which expert opinion is more reasonable. Judge-appointed expert witnesses supplement judges' medical knowledge to achieve proper and accurate resolutions. Parties may request judge-appointed expert witnesses (*kantei*), and when judges deem that they are necessary for the accuracy of resolutions, judges appoint those witnesses. Generally speaking, physicians are usually available to a defendant, but it might not be easy for a plaintiff to find qualified physicians as expert witnesses in Japan. Though a plaintiff may request judge-appointed expert witnesses, a plaintiff should seek his/her own physicians as expert witnesses, and use medical literature to the greatest extent possible. After special departments of medical malpractice litigation were formed, the percentage of medical malpractice cases in which judge-appointed expert witnesses were used dramatically decreased, as illustrated in Table 4. The judge-appointed expert witness system is effective for the accuracy of resolutions, but it takes much time because the court needs to look for qualified physicians as expert witnesses, judges need to appoint the expert witnesses, and those witnesses need to prepare for trial as indicated earlier. The special departments of medical malpractice litigation have developed some ways to improve efficiency and reduce the length of the judge-appointed expert witness process.

The special departments of medical malpractice litigation in the Tokyo District Court started the conference style testimony by judge-appointed expert witnesses (*kanfarensu kantei*) in 2003. With this conference style testimony, as a general rule, three judge-appointed physicians submit expert reports as expert witnesses, convene at an open trial, and testify orally. Judges and parties then ask questions of the judge-appointed expert witnesses. Thirteen schools of medicine in Tokyo, i.e., the University of Tokyo, Tokyo Medical and Dental University, Keio University, Juntendo University, Kyorin University, Showa University, Teikyo University, Tokyo Medical University, the Jikei University, Tokyo Women's Medical University, Toho University, Nippon Medical School and Nihon University, recommend candidates as judge-appointed expert witnesses under a rotation system, which enables the court to look for qualified physicians as expert witnesses more easily than before. The three appointed expert witnesses examine and discuss the same case together, which can address and correct any misunderstandings, achieve accurate resolutions, and reduce the burden on each expert witness.⁴⁸ This system

48. See Hitomi Akiyoshi, Yoshito Kuroda & Nozomu Hirano, *Minji Soshō to*

was an innovative change and led to symposiums for the medical and legal communities to better understand each other, as indicated below.

G. *Settlements*

As indicated above, the percentage of medical malpractice cases that are settled is higher than in other civil cases. Generally speaking, in medical malpractice cases, parties do not want to rely on judicial decisions. There is sometimes high emotional tension between a patient and a physician. This is because a patient thinks a physician betrayed him/her despite an initial feeling of trust, but on the other hand, a physician thinks a patient unreasonably filed a lawsuit though medical treatment was pursued in the best way possible. However, parties can recognize the facts of clinical treatment and the basis of a physician's decisions, medical knowledge, medical standards, and then review the reasonableness of the decisions and/or operations, and may recognize the essential elements of cases via procedures indicated earlier, which leads to a high settlement percentage among medical malpractice suits. Predictable damages of medical malpractice litigation indicated earlier also results in a high settlement percentage. When a defendant agrees to settle, the insurance company usually provides compensation and the solvency of a defendant is not problematic unlike in other civil cases. This further contributes to a high settlement percentage among medical malpractice suits. Article 89 of the Code of Civil Procedure provides that the court may attempt to arrange a settlement at any stage of the procedures.⁴⁹ Parties may agree to various clauses of a settlement, which can achieve more of a flexible resolution than in judicial decisions. For example, parties may agree to a defendant's apology clause to a plaintiff. Other clauses might include that parties will not reveal the contents of the settlement to others unless there are justifiable reasons, or that a plaintiff will not claim civil, criminal, or administrative liability of a defendant and physicians who engage in the business of the defendant to protect from future lawsuits against them.⁵⁰

H. *Symposiums for the Medical and Legal Communities to Better Understand Each Other*

The special departments of medical malpractice litigation in the Tokyo District Court have operated the conference style testimony by

Kanfarensu Kantei [Civil Litigation and the Conference Style Testimony by Judge-Appointed Expert Witnesses], 50 *SHONIKAI* [Pediatrics of Japan] 773 (2009); Tokyo Chiho Saibansho Iryo Soshō Taisaku Inkai, Tokyo Chiho Saibansho Iryo Shuchu Bu ni okeru Kantei no Jitsujō to Sono Kenshō, Jo, Ge [The Current Situation and Review of the Judge-Appointed Expert Witnesses System in Special Departments of Medical Malpractice Litigation in the Tokyo District Court, First and Second Volume], 1963 *HANREI JIHŌ* [HANJI] 3 (2007), 1964 *HANREI JIHŌ* [HANJI] 3 (2007).

49. *MINSHŌ* [C. CIV. PRO.] art. 89.

50. See Hideki Hama, *Hanketsu Wakai Chotei* [Judgment, Settlements and Mediation], in *Akiyoshi Medical Malpractice Litigation*, *supra* note 19, at 158.

judge-appointed expert witnesses with the cooperation of thirteen schools of medicine in Tokyo as listed above. They have reviewed the conference style testimony system, and continue to discuss better schemes for medical malpractice litigation with physicians from the thirteen schools of medicine and lawyers from the three Tokyo bar associations. In these situations, differences in the way of thinking and understanding of terms between physicians, lawyers, and judges were indicated, though they sometimes use similar terms such as “case,” “complaint,” “examination,” “procedure,” and “evidence.”⁵¹ The general consensus was that it is necessary for physicians and lawyers to understand each other and create a common basis to achieve more accurate resolutions. Therefore, with the cooperation of the thirteen schools of medicine and the three Tokyo bar associations, in 2008, the special departments of medical malpractice litigation started holding annual symposiums for the medical and legal communities to better understand each other. At the first symposium, judges explained the fundamental concepts and civil procedures of medical malpractice litigation and introduced a specific case in which causation between negligence and damages was disputable; physicians and lawyers then discussed causation in that case.⁵² At the second symposium in 2009, a physician first introduced a specific case in which the duty of care and negligence were disputable and then followed with the facts of clinical treatment chronologically; physicians and lawyers then discussed the duty of care and negligence at several points.⁵³ At the third symposium in 2010, physicians and lawyers discussed how package inserts and clinical practice guidelines relate to medical standards and the legal duty of care and negligence by using a specific case.⁵⁴ At the fourth symposium in 2011, a lawyer who represents patients presented pre-complaint preparatory work for subsequent medical malpractice litigation; a lawyer who represents physicians then presented qualified expert reports, and a discussion among physicians and lawyers followed.⁵⁵ At the fifth symposium in 2012, judges explained the legal duty of physicians’ explanations by using specific cases, both a patient’s and a physician’s lawyer commented, followed by a discussion among physicians and lawyers.⁵⁶

51. See NORIO HIGUCHI, *IRYO TO HO WO KANGAERU* [Consideration of Medicine and Law], at i (2007).

52. *Iryo Kai to Hosokai no Sogo Rikai no Tameno Shinpojiumu Dai 1 Kai* [The First Symposium for the Medical and Legal Communities to Better Understand Each Other], 1326 HANREI TAIMUZU [HANTA] 5 (2010).

53. *Iryo Kai to Hosokai no Sogo Rikai no Tameno Shinpojiumu Dai 2 Kai* [The Second Symposium for the Medical and Legal Communities to Better Understand Each Other], 1328 HANREI TAIMUZU [HANTA] 5 (2010).

54. *Iryo Kai to Hosokai no Sogo Rikai no Tameno Shinpojiumu Dai 3 Kai* [The Third Symposium for the Medical and Legal Communities to Better Understand Each Other], 1355 HANREI TAIMUZU [HANTA] 4 (2011).

55. *Iryo Kai to Hosokai no Sogo Rikai no Tameno Shinpojiumu Dai 4 Kai* [The Fourth Symposium for the Medical and Legal Communities to Better Understand Each Other], 1374 HANREI TAIMUZU [HANTA] 56 (2012).

56. *Iryo Kai to Hosokai no Sogo Rikai no Tameno Shinpojiumu Dai 5 Kai* [The

At the sixth symposium in 2013, a physician introduced a specific case in which the difference between negligence and an inevitable complication was disputable, and explained practices of the Safety Management Committee in a hospital, followed by a discussion among physicians and lawyers.⁵⁷ There might not be clear conclusions so far, but many physicians, lawyers, and judges, involved in medical malpractice litigation, feel that it is necessary to understand each other for proper, accurate, and expeditious resolutions.

V. CONCLUSION

The number of medical malpractice suits increased from 1992 to 1994, dropped slightly in 1995, increased dramatically from 1995 to 2004, and then fell again. Medical malpractice litigation is one of the most difficult types of civil litigation in Japan, because most lawyers and judges are not experts in medical services or familiar with medical knowledge. However, judicial decisions in medical malpractice litigation are of great interest to patients and physicians; furthermore such decisions might change the actual practice of medicine, which affects future patients, so proper and accurate judicial decisions are necessary. The average length of time between filing and the conclusion of medical malpractice cases in district courts was far longer than for other civil cases, but an expeditious resolution is necessary to try to make a plaintiff whole or to release a defendant from medical malpractice litigation as soon as possible. Toward this end, major district courts in Japan created special departments of medical malpractice litigation. These departments have developed judicial practices such as issue-centered practices, organized documentary evidence using the table of clinical treatment, concentrated and organized trials, judge-appointed expert witnesses, settlements, and symposiums for the medical and legal communities to better understand each other. They took into account the substantive law with respect to contract and tort law providing duty of care, negligence, causation, and damages. These practices can achieve proper and accurate resolutions and a shorter average length of time for medical malpractice lawsuits. The medical and legal communities are continuing to discuss better schemes for medical malpractice litigation in Japan.

Fifth Symposium for the Medical and Legal Communities to Better Understand Each Other], 1391 HANREI TAIMUZU [HANTA] 48 (2014).

57. Iryo Kai to Hosokai no Sogo Rikai no tameno Shinpojiumu Dai 6 Kai [The Sixth Symposium for the Medical and Legal Communities to Better Understand Each Other], 1404 HANREI TAIMUZU [HANTA] 5 (2014).