Review Article

Healthcare Mediation in Japan

Current State, Issues, and Future Prospects

Ritsuko YOSHIMURA

Kyoto Women's University
Email: k5141201@kyoto-wu.ac.jp

ABSTRACT

As issues related to medical malpractice suits became exposed, such as significant financial or time losses and emotional distress suffered by affected parties, a more effective, timely, and lower-cost workaround with no trial was sought in many countries. Here in Japan, as in those countries, "alternative dispute resolution" (ADR) drew attention, and around 2003, several Japanese scholars and medical experts, nearly simultaneously, highlighted the need for healthcare mediation on the basis of the concept of ADR. In consequence, several communication programs of healthcare mediation were generated whose objectives were basically defined to give assistance to both medical professionals and patients (and/or their families) in information-sharing and promoting self-motivating fence-mending between them. A healthcare communication facilitator performs these tasks on a neutral and impartial ground. This paper describes the current state of healthcare mediation in Japan introducing the activities of two major organizations, the Japan Association of Healthcare Mediators (JAHM) and Kakehashi, and discusses issues and possible solutions to them.

Keywords: healthcare mediation, healthcare communication facilitator, ADR in healthcare, medical malpractice, neutrality, impartiality

Introduction

Since the close of the 20th century, efforts have been underway in several nations to reduce or replace courtroom-based malpractice cases, given losses in money and time as well as emotional distress the affected parties endure.[1] Part of this trend in Japan is "alternative dispute resolution" (ADR), which has gathered increased attention.[2] In Japan, several law scholars and medical experts then suggested the need for the ADR-based resolution that was well-adapted to the domestic medical context, and consequently, some training programs were developed for fostering healthcare communication facilitators.[3] Healthcare mediation is generally defined as follows: a healthcare communication facilitator intervenes between the patient and the medical professional sides, and provides support for them in promoting self-motivating information-sharing and dialog between them, so as to re-establish better relations.[3] Currently, several activity organizations work to promote healthcare mediation conducting periodic trainings and fostering specialists. In step with the aging of the Japanese population and advancement of medical care, the domestic medical setting will have an increased need for healthcare mediation, but at present, this kind of mediation is still unfamiliar or little known to the general public. In this study, the author first examines the current state of domestic healthcare mediation focusing on the activities of two major organizations. The author then detects issues from the results, and considers how those issues can be addressed for the patients' welfare and how the domestic healthcare mediation should be navigated from a clinical ethics perspective.

1. Spread of Healthcare Mediation in Japan

1.1 Historical background

When a conflict that occurred in a medical setting escalated to an out-of-control situation, the patient side, in most cases, would file a suit against the medical professional or medical facility. As the number of such cases increased, some trial-relevant problems became apparent, including significant losses of money and time, emotional distress suffered by both parties, and difficulty in judging medical problems in the courts.[1,2] In this context, a more effective, timely, and lower-cost workaround with no trial was sought, and consequently "alternative dispute resolution", or "ADR", drew attention in Western countries.[3] In the U.S., for example, the processes of ADR were introduced to healthcare in the 1990s, and several approaches have recently become well-known methods, such as arbitration, mediation, screening panels, and early neutral evaluation, all of which represent neutral third-party intervention.[4,5]

Here in Japan, as in Western countries, several ADR approaches came into use, near the end of the 20th century. Especially in 1999, when two serious medical malpractice cases, namely, the misidentification of patients at Yokohama City University Hospital and the incorrect injection of antiseptic solution at Tokyo Metropolitan Hiroo Hospital, occurred in succession,[6] ADR was highlighted as a replacement for a medical malpractice lawsuit, in point of mutual understanding between the medical profession side and the patient side through their face-to-face dialog. Further, in April 2007, the Act on Promotion of Use of Alternative Dispute Resolution was enforced, with a view to providing people easy access to ADR processes.[7] Although the number of medical lawsuits used to be considerably small compared to that in the U.S.,[8,9] since this legislation, ADR in healthcare has slowly but steadily become recognized as a workaround for medical lawsuits in Japan.[10] In fact, as of 2014, eleven bodies were accredited as agencies implementing healthcare ADR led by bar associations, medical societies, and NPOs, and the number of ADR applications accepted by those bodies is on the rise.[11] In the meantime, however, several problems have been pointed out in domestic healthcare ADR. For one thing, whether or not the bar associations or medical societies can be truly neutral and impartial third-parties completely apart from their primary professions, as lawyers or doctors [10]; and another, since the no-fault compensation system has not been brought into the domestic medical settings (except the field of gynecology and obstetrics), compensation may not be paid to the medical malpractice victims after the process of healthcare ADR, in some cases.[12]

Under these circumstances, several Japanese scholars and medical experts, nearly simultaneously, began to suggest the need for another resolution system, that is, in-hospital healthcare mediation. Pursuing their own activities based on this objective, they in common placed the highest importance on answering the requests from the patient-side, including "hunt for the truth" and "prevention of recurrence," and began to use a renewed manpower resource called a "healthcare communication facilitator." Although they had slightly different views respectively on the function of this new manpower resource, they shared a common definition: a well-trained person who impartially intervenes between two conflicting parties, listens to them equally with a sympathetic attitude, and facilitates their communication for fence-mending.[13] Around 2003, the development of two typical healthcare mediation programs was set in motion: one was the medical mediation model, which was co-developed by the Japan Council for Quality Health Care (hereafter referred to as "JCQHC"), Professor Yoshitaka Wada, Sociology of Law, Waseda University, and Associate Professor Yoshimi Nakanishi, General Medical Education Center, Yamagata University,[14,15] and the other, the Healthcare Communication Facilitator Training Program, developed by Professor Kazuto Inaba, Chukyo University Law School, and Ikuko Toyoda, Kakehashi (an authorized NPO).[16,17] As will be discussed later, the activities of the former group had a strong association with the revision of the medical fee addition system, used by the Health, Labor and Welfare Ministry, or "MHLW".[18] Inaba also played a key role in the establishment of the MHLW guidelines that defined the positions and

roles of healthcare communication facilitator and indicated the standards for creating healthcare mediation programs.[19] Both Wada and Inaba have often emphasized the importance of linkage between the no-fault compensation scheme and the healthcare mediation, as well as the effective use of healthcare communication facilitators in the medical malpractice checking system that started in October 2015.[19,20]

1.2 Activity organizations

This section introduces the two major activity organizations that domestically deploy healthcare mediation activities, namely, the Japan Association of Healthcare Mediators and Kakehashi.

(a) Japan Association of Healthcare Mediators (JAHM)

Wada, the major developer of the medical mediation model, came to a realization of the significance of the mediation approach in the lead-up to the development. Wada had already mastered Harvard-style mediation skills provided in the IPI and NBC models to be mentioned later in 2-1, during his study at Harvard Law School in 1982. In a subsequent study, he put forward the idea that the concept of conflict management was a key to the medical dispute settlement based on the problem-solving through collaborative dialog between the parties. Against this background, Wada devised the healthcare mediation model, in which they uniquely call the healthcare communication facilitator “medical mediator”, and started the development of the Medical Mediator Training Program, using this model at JCQHC, together with Nakanishi, who had credentials in human relations, and a family member of a medical malpractice victim. Since the Medical Mediator Training Program was first launched at JCQHC in 2003, the number of organizations that implemented this training program continued to rise, including major domestic hospital associations, local medical societies, and local municipalities. When this number reached around 30 in 2008, the Japan Association of Healthcare Mediators (JAHM) was founded for the purpose of establishing the qualification system and enhancing the abilities of healthcare communication facilitators.[14,15,21]

In Ehime Prefecture, which was among the first local municipalities to implement the Medical Mediator Training Program of JCQHC/JAHM, the number of medical disputes and medical malpractice cases leading to lawsuits was on a declining trend in the subsequent few years following adoption. Also, some similar reports were made by several other prefectures, and, reflecting on the trends and acknowledging these achievements, in 2012, the MHLW revised the medical fee addition system through which a medical facility becomes a recipient of additional medical payments, if it is satisfactorily equipped with some patient-support personnel, such as healthcare communication facilitator.[17,18]

The Medical Mediator Training Program was created within the guidelines approved by MHLW and was officially designated by JCQHC, the Japan Medical Society Association, or “JMA”, and JAHM. This training program has been implemented by the foregoing organizations across the country a hundred or more times on a yearly basis. Currently, JAHM is not only charged with certifying satisfactory trainees as healthcare communication facilitators and evaluating a newly-created program of healthcare mediation within the guidelines of MHLW, but also is committed to promoting public awareness of healthcare mediation and the collaboration with similar entities overseas.[14,19,21]

(b) Kakehashi

Toyoda, who lost her second son to a medical malpractice in 2003, started to work as a safety manager at Shin-Katsushika Hospital in Tokyo the following year.[16] Inaba, Professor at Chukyo University Law School, with a background as a municipal court judge, mastered the healthcare ADR mediation skills during his study in the U.S. in 1984, and entered the clinical safety exploratory working group of MHLW in 2004.[17] Toyoda, Inaba, and seven other members set up the training workshop for ADR in healthcare, aiming to improve the relations between the patient and the medical professional in 2006. These members, in turn, established another workshop of healthcare mediation to launch a training course for in-hospital patient supporters in 2008. [24,25] Toyoda, while being one of the organizers of this training course, participated in the educational sessions as a trainee. In her subsequent work experience, she continued to

serve concurrently as a hospital safety manager and a healthcare communication facilitator. Through this actual performance, Toyoda eventually demonstrated how effective and important it was to appoint a non-medical professional, such as a safety manager, to the position of healthcare communication facilitator.[26] In 2012, an authorized NPO, Kakehashi, was established with the above-mentioned workshop for healthcare mediation, as its parent organization. Their objectives were the following: to build a confidential relationship, to promote a communication between the medical professional and the patient, to enhance clinical safety, and to provide medical professionals and general citizens with opportunities for participating in study panels.[17,19] With a view to ensuring the position of healthcare communication facilitator, Inaba submitted the draft of the guidelines for operations and creation of training programs for healthcare communication facilitators to MHLW in 2012, and it was authoritatively approved the following year. These guidelines defined the scope of services provided by healthcare communication facilitators, the intended trainees, and basic skills to be mastered at healthcare mediation trainings. The Healthcare Communication Facilitator Training Program provided by Kakehashi was created within these guidelines approved by MHLW, and was designated as an official training program by JCQHC, JMA, and JAHM. This training program has been domestically implemented in four major cities a few times a year since 2005.[17,19] Furthermore, Kakehashi organizes practical debriefing meetings for healthcare communication facilitators and participatory symposia for advocating healthcare mediation for the public. Kakehashi has also adopted a consultation service for medical professionals who are in charge of handling claims from patients.[25,27]

2. Overview of Healthcare Mediation Programs

This section provides summaries of the two Japanese training programs of healthcare mediation whose developers were described in earlier sections.

2.1 Medical Mediator Training Program

The Medical Mediator Training Program uses the medical mediation model developed by JCQHC, Wada, and Nakanishi. In this model, healthcare mediation is defined in the following way: to support information-sharing and fence-mending between the patient (and/or family) and the medical professional so as to prevent the clinical issue from leading to a lawsuit.[25] This model is built upon the concept of conflict management that addresses problems arising between the parties, including emotional issues. In other words, during the process of healthcare mediation in which the parties start a face-to-face communication, share information and bring themselves to improve their deteriorated relationship, the healthcare communication facilitator equally demonstrates empathy to both parties and provides support for fence-mending.[28] This program is expected to be applicable to various kinds of clinical practices, ranging from initial measures to end-of-life care.[14,15]

(a) Theoretical basis of the medical mediation model

The medical mediation model has two theoretical bases, namely, social constructivism and narrative. Social constructivism incorporates the idea that what one sees and hears takes on meaning only when interpreted from a viewpoint that is acquired or familiar to everyone. This perspective is generally called “cognition framing”. On the other hand, narrative is based on the concept that although the output from cognition framing varies from person to person, it may be recursively reflected and finally transformed in each person’s view. In the medical mediation model, this can be restated in the following manner: a conflict occurs between a patient and a medical professional on the medical treatment, due to a difference in the way of thinking, but the intervention of a healthcare communication facilitator promotes self-motivating dialog between both, which will have them become aware of each other’s needs or viewpoints, and reach a mutual understanding.[14,15]

(b) Methods of the medical mediation model

In the early stages after the occurrence of conflict, the healthcare communication facilitator first interviews each party individually and presents them an opportunity for tri-polar dialog. During the tri-polar dialog, both parties are to be open, share information with each other, and attempt to restore the deteriorated relationship. The healthcare communication facilitator, to advance this process, intervenes in between maintaining impartiality, enters a position of trust through attentive listening to both parties, and provides support for their fence-mending.[26] Furthermore, the healthcare communication facilitator proceeds with the above-mentioned process by returning to each step of fact disclosure, medical indication, judgment, and event verification as needed.[14,15] This model is derived from the NBC (naming, blaming, claiming) and IPI (issue, position, interest) models developed by Harvard Law School to which some revisions were made by Wada and his colleagues, in order to adapt these to the Japanese healthcare environment.[14,15,28]

(c) Basic stances and behavioral ethics of healthcare communication facilitator

The basic stances of a healthcare communication facilitator are the following: 1) to maintain fairness and impartiality between parties, 2) not to provide support to one side in a prejudiced way, 3) to establish a party-centered communication.[14] The behavioral ethics of a healthcare communication facilitator are the following: 1) not to conduct fact-finding, not to make judgment, not to perform evaluation, and/or not to provide verbal intermediacy, 2) to discern both parties' feelings based on an ethic of care, 3) to provide them support for information-sharing and fence-mending.

(d) Contents of Medical Mediator Training Program

The curriculum of the Medical Mediator Training Program includes the following:[15]

-Basic Course
Theory and methods of the medical mediation model:
introduction of specific methods, understanding of the whole context through skill practice and role-playing
Practice of IPI analysis (Follow-up training):
staged deployment of IPI model, application in routine care or ethical judgment, application in medical care security

-Intermediate Course
Practical procedures of conflict management in healthcare settings:
case-based practices of theory and methods

-Advanced Course
Simulative hands-on training of healthcare mediation:
case-based practices of skills used in emotional aspects, application of experiences in medical malpractice analysis to healthcare mediation

(e) Training-related data

The following data were reported as to the Medical Mediator Training Program co-hosted by JCQHC and JAHM:[29,30]

-Total number of participants from commencing year to 2012: 11,769
-Total number of certified healthcare communication facilitators: 4,024 as of 2011
-Breakdown of participants: nurses, approximately 70%; doctors, approximately 20%; and the rest, medical social workers and non-medical students

(f) A case of healthcare mediation

The following is a case where a surgeon and the patient's family understood each other's interests and achieved fence-mending through healthcare mediation.[31] A pancreas cancer victim's family asserted that the patient developed pneumothorax during the treatment, due to the doctor's mistakes. On the other hand, the doctor claimed that it was just a complication, and he developed an attitude of evasiveness toward the family. The hospital safety manager then intervened between them as a healthcare communication facilitator. As he facilitated their self-motivating communication, the doctor began to apologize for the complication having resulted and for his evasive attitude toward the family. The patient-side softened their stance as well. At the same time, the IPI analysis implemented during healthcare mediation indicated that the doctors working at this hospital needed to develop the skill-sets similar to what are generally possessed by healthcare communication facilitators.

2.2 Healthcare Communication Facilitator Training Program (Kakehashi)

The authorized NPO Kakehashi defines a healthcare communication facilitator as follows: a person who works at the in-patient counseling counter, so that the patient (and/or family) can be confident of receiving medical treatment, the medical professionals can accomplish their original tasks, and communication between the patient and the medical professional can be successfully maintained.[32,33] The instructors of this training include family members of victims and medical professionals as perpetrators of medical malpractice. This training program places importance on emotional education, so that the participants can put themselves in the shoes of the affected parties, in particular, to listen attentively to the parties, to empathize with their concerns, and to respect them. Furthermore, the program is premised on the concept that a healthcare communication facilitator truly understands the patient and has the cognitive power to seriously create a partnership between the patient (and/or family) and the medical professionals.[25] The primary feature of its curriculum is a learning-by-doing teaching system that facilitates the fostering of work-ready human resources. In particular, versatile group-work training sessions and case-study workshops are given after the course work on the knowledge/skills needed for patient counseling.[34]

(a) Theoretical basis of the Healthcare Communication Facilitator Training Program

The Healthcare Communication Facilitator Training Program is a communication model based on the politeness strategy and information theory.[19] The politeness strategy is a communicative measure by which someone will think about the current feelings of his/her company, quickly sense his/her needs, and fulfill them as much as possible. Human needs generally fall into two types, namely, negative needs and positive needs, and it is considered effective to combine these concepts for improving the quality of medical care; for example, it is preferable to use respectful language with a patient who negatively holds the medical professional at arm's length, and in contrast, to talk like a friend with one who maintains a positive attitude toward the medical professional.[34,35] Information theory is based on the premise that misunderstanding, slip, or hearing wrong arises because the information sender converts a message into an entirely different signal, and in this context, information-sharing between them can be achieved through the process of first reframing (recapturing the substantial meaning of the message), next paraphrasing (re-expressing it to the company), and finally repeating them.[19]

(b) Qualifications desired for a healthcare communication facilitator

The qualifications that a healthcare communication facilitator should have are the following:[33]

- Empathetic listening skills: capability of listening to the parties with sincerity, being sensitive to their true needs, and continuing to facilitate their dialog in good faith,
- Sentiment imagination skills: capability of facilitating dialog from a standpoint of the parties, and adequately relating to their feelings and emotions,
- Limit-setting skills: capability of venturing to set a clear limit on his/her role and not dwelling on it, while feeling empathy for the parties, so as to fully carry out his/her duties, without causing autogenic inhibition,
- Skill in flexibly organizing communication: capability of organizing communication between the parties on a case-by-case basis in a timely manner, taking a comprehensive, panoramic view of the parties' situations and giving first priority to their feelings, and
- Non-adherence to impartiality: capability of taking a leap of faith to go to one side without clinging to impartiality when necessary, and in such a case, to get all information shared with the other party and eventually bring both close to each other.

(c) Basic stance of a healthcare communication facilitator

Kakehashi defines the basic stance of a healthcare communication facilitator as follows:[25,33]

- To be most concerned about the feelings of the parties and have a deep sense of empathy with them,
- To eagerly listen to the parties, not to give them

advice/proposals, and to share ideas with them to reach agreement,
- To respect the parties and to tune into them without managing their emotions,
- To have the courage to go over the impartiality borderline when needed; in such cases, to carefully and delicately give all attention to one party when deemed necessary and not to fail to share all information among the parties,
- Not to perform representative services for the parties, including apologizing, but to set an environment in which the parties can come face-to-face with each other,
- Not to engage in medical malpractice investigation, but to partner with commission members, and
- To build individual trust earned from the parties into strong credibility.

(d) Contents of the Healthcare Communication Facilitator Training Program

The curriculums of this training program contain not only comprehensive technical education necessary for healthcare communication, but also other wide-ranging contents, from handling of practical paperwork to fostering of hospital personnel, in particular as follows:[35]
- Basic skills for creating a support system for the patient (and/or family) and simulation training using these skills,
- Basic skills for healthcare communication, e.g., patient counseling and facilitation of dialog,
- Basic knowledge of medical care security, e.g., precautionary measures, and related acts/guidelines/systems,
- Basic skills for planning/operation of the Healthcare Communication Facilitator Training Program, and
- Comprehensive case examination and practical exercise, including information collection, countermeasure development, feedback and evaluation.

(e) Post-training outcome

The following is a case where a non-medical professional who doubled as a healthcare communication facilitator achieved a certain result after the Healthcare Communication Facilitator Training Program.[26] Toyoda, as previously mentioned, has been working as a (non-medical) hospital safety manager since 2004. Around 2006, when Toyoda and eight other members set up the training workshop for ADR in healthcare, there was a particular concern: whether or not the healthcare communication facilitator was able to maintain neutrality/impartiality during the mediation process, in case of a non-medical personnel being assigned to the position. Toyoda, while being one of the organizers of this workshop, participated in the educational sessions as a trainee and started to concurrently serve as a healthcare communication facilitator, and in consequence, received a glowing notice through positive reports from her co-workers and patients: “Toyoda, having comprehensive knowledge of in-hospital matters, resolved the miscommunication among medical professionals with comparative ease (reported by a nurse); she was a trustworthy consultee as she never confused me with technical expertise (reported by a patient); we can trust such personnel in her position to conduct patient counseling (reported by a doctor).” These reports demonstrated that it was effective at a certain level to have a non-medical safety manager concurrently serve as a healthcare communication facilitator, and also, her position as an in-hospital staff did not necessarily restrain the neutrality/impartiality to be maintained during the process of healthcare mediation.

(f) Implementation of Healthcare Communication Facilitator Training Program

Since 2010, the Healthcare Communication Facilitator Training Program (two days, 40 participants each) has been implemented in four cities: Tokyo, Osaka, Sapporo, and Nagoya.[32,33]

3. Issues and Considerations

This section creates a comparative table based on the preceding description of the two organizations of healthcare mediation activities and their training programs, and reviews the results. The latter part of the section summarizes other issues pointed out in the current state of the domestic healthcare mediation.

3.1 Comparative review of two activity organizations/training programs

The following are the findings from a comparative review of the two major domestic organizations of healthcare mediation activities and of their training programs:

-Similarity between the two organizations/programs:
For each program, a legal scholar was motivated by authentic pleas for help from the family of a medical malpractice victim who had suffered emotional distress in the courtroom and launched the building of a healthcare mediation model.[19,36] Since the persons concerned in the medical malpractice, such as nurses and the patient's family, are employed as instructors, both training programs can be said to be based on each party's perspective.

-Theoretical basis:
The medical mediation model of JAHM and the Healthcare Communication Facilitator Training Program of Kakehashi have different theoretical bases, respectively: the former, social constructivism and narrative; the latter, politeness strategy and information theory. However, what people see or hear is, in social constructivism and narrative, eventually recursively reflected and transformed after passing through a cognitive frame, and in information theory, what people see or hear is subjected to the action of reframing and paraphrasing. That is to say, what is differently understood by two people will undergo re-interpretation and then be transmitted to the addressee, which appears to be common to both concepts.

-Basic stance of a healthcare communication facilitator:
In JAHM's Medical Mediator Training Program, the basic stance of a healthcare communication facilitator is to maintain neutrality/impartiality as much as possible. In Kakehashi's Healthcare Communication Facilitator Training Program, however, trainees are taught to go to one side when necessary. In such a case, the healthcare communication facilitator intensively listens only to one party in question, but never fails to share all information with all parties concerned. In general, the roles of healthcare communication facilitator are fulfilled, when a good balance is kept between holding his/her respect and empathy for the parties and maintaining mental discipline. When the balance is lost between these two, it will be hard for them to acquire trust from the parties. For this reason, the above-mentioned basic stance of healthcare communication facilitator set by Kakehashi must be re-examined, specifically concerning the balance of holding a respect/empathy for the parties with maintaining mental discipline.

Table 1 Comparative Review of Two Activity Organizations

Program name / Item to be studied	Medical Mediator Training (JAHM)	Healthcare Communication Facilitator Training (Kakehashi)
Primary program developer	-law scholar -scholar of dispute resolution	-law scholar -patient's family (hospital safety manager)
Theoretical basis	-social constructivism -narrative (reflective transformation)	-politeness strategy -information theory (reframing, paraphrasing)
Facilitator's neutrality/impartiality	-to be neutral/mpartial on a steady basis	-not always to cling to neutrality/impartiality

3.2 Other issues in healthcare mediation in Japan

This section lists issues that have been pointed out regarding the domestic healthcare mediation, and goes through them citing a case of efforts:

- Question about whether or not an "in-hospital" staff is able to maintain neutrality/impartiality when assigned to the position of a healthcare communication facilitator[37,38]:
  As previously mentioned earlier in 2-2 (Post-training outcome), there was a positive report on the efforts made at Shin-Katsushika Hospital in Tokyo: a hospital safety manager who had been doubly assigned to the position of healthcare communication facilitator received a high evaluation of her performance, all the more for her position as a trusted insider.[26] JAHM advises that the role of the healthcare communication facilitator must be assigned to an in-hospital staff because expeditious handling of medical disputes needs to be entrusted to a knowledgeable insider, and such a personnel can maintain substantive neutrality/impartiality through earning trust from the parties during the process of healthcare mediation. Considering this advice by JAHM, together with the above positive report on healthcare mediation activities by Kakehashi, the response to the issue of "whether or not an in-hospital staff is able to maintain neutrality/impartiality" seems to have been shelved without any concrete suggestion at this moment. As remarked above, this is a matter of how a healthcare communication facilitator should control the balance of holding his/her respect/empathy for the parties with maintaining his/her mental discipline. Therefore, this issue obviously pertains to the major aspects of healthcare mediation, such as the methods and the basic stance of healthcare communication facilitator. Hence, as an issue common to all persons and/or all organizations involved, it must be fully re-addressed, not by an individual medical facility but by co-operative structures including JAHM and Kakehashi, and the scholars concerned.
- Insufficient understanding of healthcare mediation by hospital management, namely, unsatisfactory manpower costs of healthcare communication facilitators and overwork due to holding two positions concurrently:[39]
  At a hospital in Ehime Prefecture, the hospital top management members were encouraged to participate in the Medical Mediator Training Program to promote their understanding of healthcare mediation. After attending the training sessions, the top management members began to understand the significance of participation in the training, and in consequence, the quality of safety control was improved at that hospital. Encouragement of top management members to participate in the training seems to have had a positive effect on their understanding of healthcare mediation. However, this endeavor is not necessarily applicable to every medical facility throughout the country. For a positive nationwide expansion of healthcare mediation, it is vital to build a framework of co-operation among local governments, local medical associations and others.
- Need for co-operation between the medical malpractice checking system and healthcare mediation[19,20]:
  Prior to the start of the medical malpractice checking system in 2016, Toyoda, as a member of the related committee of MHLW, often made proposals on this system: particularly, how the apology and/or truth explanation to patients was to be made, who and what were to be surveyed, and how the public supplemental funds were to be paid.[40] MHLW has suggested that healthcare communication facilitators can be employed at the stage of initial-response immediately after a fatal accident,[33] but this is applicable only within the in-hospital investigation. To promote the fair use of this system, healthcare communication facilitators should be positioned at the stage of reporting to the victim's family, even after the investigation has been passed over to an external agency, so that they can understand and accept the situation. For further enhancement of this system, it is also expected that a person in a position similar to Toyoda's will continuously make proposals to the ministries or autonomous bodies, as a victim's family member, a safety manager, and a representative of the organization of healthcare mediation.
- Participation in training only for receiving additional medical payments:

Under the medical fee addition system revised by MHLW, in 2012, a medical facility becomes eligible for additional medical payments if it is accordingly equipped with a patient support personnel, such as a healthcare communication facilitator.[17,18] However, it has been reported that more and more hospital operators have come to encourage their staff to participate in the training sessions only for their financial benefit,.[41] In such cases, one could argue that the hospital management understands little about the significance of healthcare mediation or does not comprehend the importance of maintaining a trustful relationship with patients. This is because the accomplishment of healthcare mediation has not yet become well-known and its importance is therefore less well understood, even by medical professionals[41]. In order to fully publicize the idea in and out of facilities that healthcare mediation is an effective measure for building a relationship of trust with patients, it is imperative that intensive public relations be increasingly pursued. This could be achieved by providing healthcare mediation-related information through the hospital homepage, in-hospital intranet, inward/outward newsletters, study sessions for patients/staff, hospital trips, and so forth. Perhaps most important, however, is that this matter must be treated as an issue of hospital management's recognition and/or one of entire domestic medical system.

4. Conclusion

Healthcare mediation is still at an early stage of dissemination, and some causes of the delay have been specified, including lack of public relations and insufficient understanding by medical experts. For this real issue, it is essential that more effort for publicity be exerted and the hospital management's understanding about healthcare mediation be improved. Meanwhile, there seems to be a more challenging issue in healthcare mediation, that is, a matter of neutrality/impartiality of medical healthcare communication facilitators. During the process of healthcare mediation, they obviously exert their efforts to avoid favoring one party but to control the balance of holding their respect/empathy for the parties with maintaining their mental discipline. Once this balance is lost, though, what will happen to their neutrality/impartiality? In principle, healthcare mediation is implemented only when both parties agree to participate in it. In case the meeting is rejected by one party or both, however, will healthcare mediation then fail? Although these points need to be argued in a more in-depth ethical or philosophical manner, this paper, to a limited extent, presents those as subjects to be addressed in the future.

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