

A Structure of Doctor's Civil Liabilities: In Search of a Contract-based Uniformed Legal Framework Best Serving Both Doctors and Patients

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Table of Contents

1. Introduction
2. Contract is a better conceptual tool than delict/tort for the law to employ where it is involved in the relationship between doctors and patients
 - A. Underlying Thoughts
 - B. Why is contract preferable to delict/tort?
 - C. Metaphor of Archipelago of Contracts
 - D. Historical Development of Academic Theories on the Concurrence of Actions
 - (i) Theory of Concurrence of Actions (adopted by court)
 - (ii) Theory of Conflict of Civil Code Provisions
 - (iii) Theory of Double "Sounds" of A Single Action
 - (iv) Great Unified Theory of the Causes of Obligations
 - (v) Where We Are Now
 - E. Hirano's Point of View (A Theory of Hierarchical Concurrence of Actions)
3. Period of Interest
 - A. Judicial Precedents and Prevailing Academic Opinion
 - B. Hirano's Point of View (A Theory Distinguishing between an Intentional Tort and a Non-intentional Tort)
4. Allocation of the Burden of Proof with regard to Non-Performance
 - A. Factual Non-Performance
 - B. Excuses
 - (i) Prevailing Opinion
 - (ii) Hirano's Point of View (Excuse as a Defence)
 - (iii) Difference from Tort
5. Allocation of the Burden of Proof with regard to Causation
 - A. *De facto* Presumption of Causation

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- B. Relationship between Impossibility I and Impossibility II
 - C. Proportional Causation Theory based on Bayes' Theorem
 - D. Easy Mistakes in Judges' Deliberation on Causation
6. Standard of Proof
- A. High Probability
 - B. Comparative Probability
 - C. Balance of Probabilities
 - D. Discussions
 - (i) Practical Problems after 2000
 - (ii) Roots of the Requirement of High Probability
 - (iii) Court Practice
 - (iv) Reflections on the Lumbar Shock Case
7. Damage: Loss of a Significant Possibility, Chance or Reasonable Expectation (Patient's Interests to be Protected by Law)
- A. Loss of Significant Possibility
 - B. Loss of Chance (Patient's Reasonable Expectation)
8. Conclusions

1. Introduction

The purpose of this paper is to build a general, foundational theory of medical law. For reasons explained herein, the central conceptual tool in this theory will be a type of contract that generates obligations binding both doctors and patients. This is in response to a call for a study that seeks to propose a legal theory of medical malpractice, which may possibly combine the theory of the duty of care and the theory of the construction of terms of contract.¹⁾ Such a study has been urged to be made following the rejection, by the Supreme Court of Japan, of a proposition that the obligations of doctors include, unless otherwise stipulated in express terms of contract, "a duty to exert utmost endeavour to provide patients with medical service as thorough, serious and faithful as possible (which is an example of contractual 'obligation of means' as opposed to that of result) irrespective of the standard of medical care and skill".²⁾ The Supreme Court rejected an attempt at overcoming problems which are not quite unlike those surrounding the *Bolam* test by "a responsible body of professional opinion" in English law.³⁾ The theoretical basis of the Japa-

1) SHIOMI Yoshio, *Keiyaku Sekinin no Taikei (System of Contractual Liabilities)* (Tokyo: Yuhikaku) 2000, pp. 209-210. cf. For similarity between the court's imposition of the duty of care and the finding of an implied term, see Lord Hoffmann in *South Australia Asset Management Corporation v York Montagu* [1997] AC 191 at 212.

2) The Supreme Court, Judgment of 8 June 1996, [1996] 1450 Hanrei Jiho 70, 812 Hanrei Times 177.

3) *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587.

nese court ruling has been criticised to be far removed from the theory of contract, allegedly due to the futility, so far, of discussions concerning the basic theoretical framework of medical law.⁴⁾

Having said that, this study does not end up proposing a theory within the field of the doctor's contractual liabilities. It is intended to be a theory with applicability to service contracts in general, which generate obligations of means. Many aspects of this theory may, after some minor modifications, be adapted to contracts guaranteeing specific results (obligation of result) as well as to delict/tort. Following on from this, in a kind of domino effect, the theory may develop into a general theory of the laws of obligations.

2. Contract is a better conceptual tool than delict/tort for the law to employ where it is involved in the relationship between doctors and patients

A. Underlying Thoughts

The key concepts in this paper are: contract as collaboratory concept vs. delict/tort as accusatory concept.

The law of contract helps parties in achieving a common purpose towards which they have agreed with one another. By making contract, parties have created between them a legal relationship in which they are committed themselves to the realisation of the agreed purpose. Such a legal relationship is called *die Willensgemeinschaft*, or "community of the wills". Put in English terms, doctors and patients are "partners" working together towards achieving their agreed upon purpose of curing or alleviating the patient's disease or injury. Therefore, in the event of a failure to achieve the purpose, a redress should firstly be sought within the framework of contract law. It is inappropriate to dissolve their partnership where a medical accident takes place, and to treat the doctor as a wrong-doer and the patient as a victim in an attempt to resolve the case within the framework of delict/tort law. In fact, doctors are highly embarrassed, offended or even frightened to be sued and branded as wrong-doers, delinquents and tortfeasors.

It is the present author's point of view that a shift in emphasis is warranted from the protection of the patient's *right* to that of medical care *contract*. In order to ensure the fulfillment of the objectives of medical care contracts, it is necessary to improve medical care environment in which medical care contracts are performed (e.g. provision of better system and place of work, better equipment and staff for medical professionals; and fair access to medical institutions and resources).

This approach, which employs the conceptual tool of contract, seems to be optimal in serving both the patients and the medical personnel involved. Today, it is no longer enough for us to cry out for the protection of patients on the assumption that the latter are

4) SHIOMI, op. cit.

always the weaker and aggrieved parties in a situation where something goes medically wrong.

B. Why is contract preferable to delict/tort?

In contrast to tort law, which seeks a solution from the point of view of the aftermath of the tort, contract law encourages doctors and patients to agree in advance on those rules that will cause both parties to feel secure and satisfied.

Tort law scholars do not conceive their subject to be backward-looking; from their point of view, tort law gives only an *ex post facto* decision case by case, where the accumulation of such decisions will eventually develop into a coherent set of standing rules.

However, this argument may be acceptable only among jurists (in particular those who are specialised in the studies of tort). It is unreasonable to expect that doctors will check all the volumes of judicial precedents in order to comply with them. Furthermore, as judicial precedents provide more than one rule, it is difficult even for jurists to sort through the complexities so as to identify which rule ought to be applied in which set of circumstances.

By contrast, if there is a set of rules, which clearly state, “you should comply with the terms of your contract before you act; if you breach one, you will be held legally responsible; as long as you comply with them, you will basically have no liability”, then for doctors, such a set of rules are far more comfortable and are easier to heed to.

By agreeing on a set of rules in advance, parties can build their relationship independently, which may develop into a relationship of trust and confidence between them. This may lead to creating a relationship of trust and confidence not only between individual doctors and patients but also between the doctor and the patient generally, and help disperse their mutual distrust. Where disputes arising between the parties give rise to actions in tort or criminal prosecutions, these can only leave both parties intensifying their distrust of one another.

If their relationship is based on a contract, even if it may be unrealistic to have all possible conjectures in their contemplation in advance, doctors and patients can make additions or modifications to their terms as they go along with the agreed therapeutic process, and they can find the best choice at each stage in the process, while sharing information between themselves.

It is not intended to recommend that parties produce a thick bundle of contract documents. What matters here is the parties’ mutual mindset, not legal technique.

Doctors are greatly displeased with the current situation where they are required to be tried under rules created *ex post facto* by perfect strangers (namely judges, who are lay persons in medicine). If contract is employed, they would not find any reason to complain where they are to be tried by the terms to which they have committed themselves.

C. Metaphor of Archipelago of Contracts

There are four sources/causes of obligations in civil law, namely, contracts, delict/tort, *unjustified* enrichment and *gestion d'affaires*. A hierarchical division of labour among them may be illustrated by a metaphor of the archipelago of contracts (see appendix 1).

Suppose that people are “floating on the sea” of no manifestation of intention, where the rules of *gestion d'affaires* (*gestio negotiorum*) apply to a good Samaritan who has intervened to look after another's affairs or business without his request to do so,⁵⁾ while the rules of delict/tort apply to a person who has wronged another. In the provision of medical care in the absence of contract, the rules of *gestion d'affaires* apply, where an unsolicited medical intervention succeeds, while the rules of tort apply where such an intervention fails, and has caused death or injury to the other person.

Where the manifestation of intentions of two or more people floating on this sea have come to an agreement, the agreement generates an “island” of contract where the rules of contract apply. There are a variety of such islands of contract, which comprise an archipelago. Where the subject matter of contract is the provision of medical care, there is an island in the form of the medical care contract.

Parties who escape the application of the rules of contracts, tort and *gestion d'affaires*, sink to the seabed, from where they may be salvaged by the rules of *unjustified enrichment* (to be distinguished from the equitable rules of “unjust enrichment” or “restitution” in Anglo-American law, which are designed to make the defendant disgorge any unjustly obtained gain). *Unjustified enrichment* is the English translation of the German *ungerechtfertigte Bereicherung*, and refers to “enrichment without cause” (after *enrichissement sans cause* in French), which ought to be returned. It is not ordinarily expected that the rules of *unjustified enrichment* are applicable to the provision of medical care.

Where no just and fair disposal of a case is possible by the application of these rules, there may be blessings from the heaven, in other words, clouds of angels may provide parties with salvation by employing the General Part (*Allgemeiner Teil*) concepts of *good faith*, *public order* and against *abuse of right* (these are not quite unlike equity, e.g. constructive trusts, although particular contexts in which such concepts are employed in civil law differ from the rules of equity). Thus, the rules of contract may still apply in special circumstances where, strictly speaking, there is no solid island of contract,⁶⁾ for example, where a party is responsible for creating a mirage of a contract island, and for misleading another to believe honestly that there is such an island, changing his position in reliance on it, *die Rechtscheintheorie*, that is, the “theory of legally protected appearance of contract”

5) English law neither helps an “officious” intervention nor recognises such a source of obligations. See *Boardman v Phipps* [1967] 2 AC 46. But the best interest rule in equity is ultimately traceable to the rules of *gestion d'affaires*.

6) See the concurrent opinion of Justice CHIBA Katsumi of the Supreme Court, Judgment of 22 April 2011, 64-3 Minshu 1405, for the frontier between contract and tort.

provides the misled party with such an island of contract (“constructive contract”); and where a party has *almost* made a contract with another, but not yet fully done so, the court may still find *culpa in contrahendo* (“fault in the process of making contract”). Occasionally, the legislature assumes the power of angels to make statutory interventions so as to modify the rules of contract in the Civil Code, for example, by the enactment of the Consumer Contract Act.

Where statutes provide special tortious liabilities, such as in the case of the Product Liability Act, Fire Liability Act and Automobile Liability Assurance Act, these comprise jetties in a harbour of an island of contract, where the rules of contract and of tort concurrently apply.

From above, there is the “Sun” of human rights in Constitution, which illuminates the archipelago. All civil law rules are to be interpreted in the light of human rights, so as to give effect to these rights as far as it is reasonable to do so (i.e. the indirect application of human rights in the sphere of private law).

Such a metaphor of the archipelago of contracts is intended to help illustrate the hierarchical division of labour among the causes of obligations in their application.

Where a dispute gives rise to an action, in other words, to legal proceedings, angels are set in motion over the archipelago, but the hierarchy among the causes of obligations does not disappear. Even where legal proceedings have started, the distinctions and hierarchy among the causes of obligations under substantive law do not suddenly disappear once and for all. This is because substantive law is primary, while procedural law is secondary. The existence or not of rights and duties of obligations under substantive law is tested and determined through proceedings in accordance with the rules of substantive law. Actions may activate the angel of good faith, whose operation may create an island of “contract in action”, i.e. a contract *ex posto facto* imposed by the court (“constructive contract”). Therefore, the old doctrine of “subject-matter of action” (*Streitsgegenstand*), whereby the rules of substantive law apply to proceedings, seems to be appropriate for the coherent understanding of the relationship between substantive obligations and procedural actions. It follows that because the hierarchy among the causes of obligations under substantive law should be applied in legal proceedings, actions should be ranked and distinguished accordingly between the principal action and accessories/alternatives.

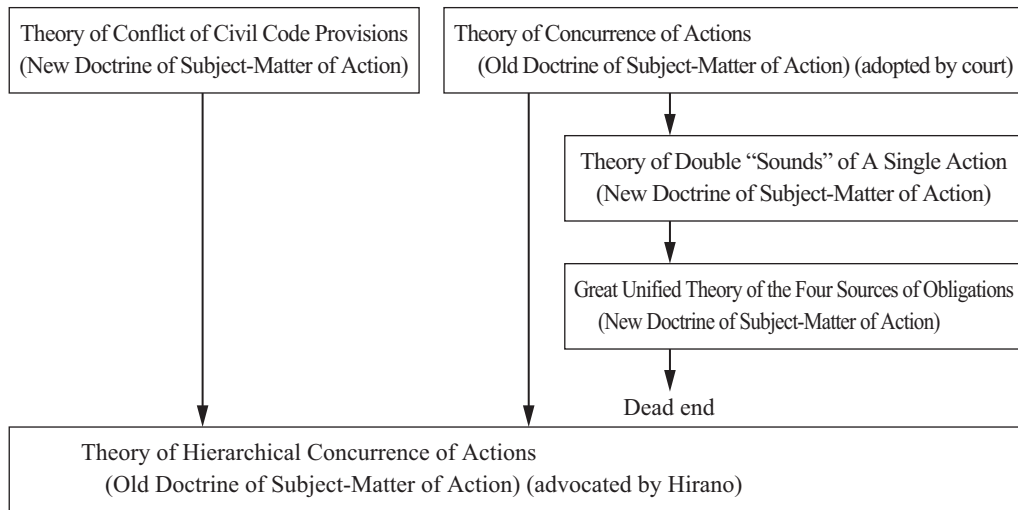
D. Historical Development of Academic Theories on the Concurrence of Actions⁷⁾

(i) Theory of Concurrence of Actions (adopted by court)

See appendix 2

As long as a single matter, or a factual situation, falls within the descriptions of two or

⁷⁾ The association between the respective theories and the doctrines of subject-matter of action is not definitively established. cf. OHMURA Atsushi, *Kihon Minpo II (Basic Civil Law II)* (Tokyo: Yuhikaku) 2003, p. 327.



more sources/causes of obligations under the Civil Code, each cause of obligations finds a corresponding action,⁸⁾ for example, one action asserting contractual obligations, and another tortious obligations.⁹⁾ Courts are said to have consistently been taking a stance of adopting this theory of concurrence of actions under the old doctrine of subject-matter of actions.¹⁰⁾

(ii) Theory of Conflict of Civil Code Provisions

This theory sees a conflict of causes of obligations under Part III, Civil Code, behind the conflict of actions. In this theory, contractual obligations take precedence over tortious obligations because of the Germanic interpretation of the structure of the Civil Code. Since advocated by Kawashima in 1934, this theory had been dominant until the 1970s among civil code theorists and civil procedure theorists.¹¹⁾

(iii) Theory of Double “Sounds” of A Single Action

Along with the subsequent development, in the field of civil procedure law, of the new doctrine of the subject-matter of action by Mikazuki,¹²⁾ a new theory has emerged,

8) cf. “... when, since 1873, the name of a form of action is used to identify a cause of action, it is used as a convenient and succinct description of a particular category of factual situation which entitles one person to obtain from the court a remedy against another person.” per Diplock LJ in *Letang v Cooper* [1965] 1 QB 232, at 243. Following the abolishment of the forms of action, the common law causes of action have become closer to sources of obligations but not fully.

9) cf. Lord Goff of Chiveley in *Henderson v Merrett Syndicates Ltd* [1995] 2 AC 145 agrees at p. 191 with Oliver J in *Midland Bank Trust v Hett, Stubbs & Kemp* [1970] Ch. 384, who said at p. 522, “... where concurrent liability in tort and contract exists the plaintiff has the right to assert the cause of action that appears to be the most advantageous to him in respect of any particular legal consequence”.

10) cf. SHINDO Koji, *Shin Minji Soshō Ho (New Civil Procedure Law)* 5th ed. (Tokyo: Kobundo) 2011, p. 311.

11) KAWASHIMA Takeyoshi, *Minpo Kaishaku Gaku no Shomondai (Problems of Interpretation of Civil Code)* (Tokyo: Kobundo) 1949, pp. 1-155.

12) MIKAZUKI Akira, *Minji Soshō Ho (Civil Procedure Act)* (Tokyo: Yuhikaku) 1959, p. 101.

where a single factual situation may appear to be the subject-matter of two or more actions, but where there is only one single action in substance (Okuda¹³). Put in English terms, they say that there is only a single action “sounded” in both contract and tort.¹⁴

(iv) Great Unified Theory of the Causes of Obligations

Thereafter, a “great unified theory” of the four causes of obligations has been advanced by Shinomiya.¹⁵ Due to practical difficulties unifying the causes of obligations, studies have reached a dead end and cannot go any further on this theory.

(v) Where We Are Now

“The issue of concurrence of actions is still in chaos” (Kato¹⁶).

“None of the theories advanced thus far has gained sufficiently wide support in the scientific community. The situation is chaotic.” (Hirai¹⁷).

E. Hirano’s Point of View (A Theory of Hierarchical Concurrence of Actions)

The basis on which the theory of conflict of Civil Code provisions stands, i.e. that contract law prevails over tort law, is correct (see the metaphor of the archipelago of contracts).

However, giving priority to contract may lead to substantial problems, such as imbalance of power between the parties, which needs to be rectified. This point can account for why the theory of conflict of the Civil Code provisions lost support in the period of rapid economic growth when corporate activities boomed in Japan (1960-1980): where, if an action sounded in contract is the only available means for seeking relief, contracts would, for example, be made in standard terms prejudicial to consumers, who are in a position of relative weakness. Thus, an action sounded in tort should be concurrently allowed as an alternative action with which to give relief to aggrieved parties.

Subsequently, there has been a significant development in the legal community aiming to address issues of inequality between contractual parties by employing the General Part concepts of public order, good faith and against abuse of right. To date, substantial problems associated with the prioritisation of contract have been resolved outside the sphere of the Civil Code, as a result of a series of enactment of special statutes, designed to protect the weak and aggrieved parties, for example, the Land and Building Leases Act, the Inter-

13) OKUDA Masamichi, “Seikyūken to Soshobutsu” (Action/Claim and Subject-Matter of Action) (1) and (2), (1968) 213 Hanrei Times, pp. 4-14; and (1968) 214 Hanrei Times, pp. 2-17.

14) cf. Diplock LJ said in *Letang v Cooper* [1965] 1 QB 232 at 244 “... that factual situation may fall within the description of the tort of trespass to the person (and that of the tort of negligence). It does not mean that there are two causes of action. It merely means that there are two apt descriptions of the same cause of action.”

15) SHINOMIYA Kazuo, *Seikyūken Kyōgo Ron (Concurrence of Actions)* (Tokyo: Ichiryūsha) 1978.

16) KATO Masanobu, “Seikyūken Kyōgo Ron” (Concurrence of Actions) in *Minpo Gakusetsu 100-nenshi (History of A Hundred Years of Academic Opinions on Civil Law)* (Tokyo: Sanseido) 1999, p. 353.

17) HIRAI Yoshio, *Saiken Kakuron I, Keiyaku Soron (Particulars of Obligations I, General Rules of Contracts)* (Tokyo: Kobundo) 2008, p. 15.

est Rate Restriction Act, the Consumer Contract Act, the Labour Contract Act, the Automobile Liability Assurance Act, and the Product Liability Act.¹⁸⁾ Today, the background circumstances have greatly changed since the 1970s, when the theory of conflict of Civil Code provisions was rejected.

In the context of the Civil Code, it is consistent to give priority to contract in accordance with the theory of conflict of Civil Code provisions, i.e. that of the causes of obligations.

It should be noted, however, that the theory of conflict of the causes of obligations cannot provide a logical reason for the view that a medical malpractice cannot found an action on tort, even though it satisfies the constituting elements of the tort under the Civil Code. Such illogical denial of an action contravenes Article 76 (3) of the Constitution, which authorises the court to try and decide a case only in accordance with law. It also infringes the plaintiff's right to access to court, which is guaranteed under Article 32 of the Constitution. Taking all these points into consideration, it ought to be said that a single matter of medical malpractice founds two actions, one on contract and the other on tort, respectively, under substantive law.

With reference to the metaphor of the archipelago of contracts, which illustrates the hierarchical structure in the application of the causes of obligations of the Civil Code, the most logical explanation seems to be that a single medical malpractice founds both actions on contract (for non-performance of obligation) and on tort, of which the former is prior to the latter.

In terms of the joinder of actions, where the plaintiff "sounds" his actions both in contract and in tort on the same matter concurrently, he has, so far, been free to choose the priority of pursuit between the two (selective joinder of actions). However, an action sounded in contract should always be the principal action, while that in tort should be an alternative action (prioritised joinder of actions).

The most straightforward interpretation in accordance with the structures of the Civil Code and the Civil Procedure Code would arrive at this conclusion.

3. Period of Interest

In Japan, where actions on the same matter may be concurrently sounded in contract and in tort, a major reason why the plaintiff's counsel tries to employ tort as far as it is possible to do so, unless the action is time-barred, is that in tort, interest on damages runs from the day of the accident in question, whereas in contract, interest on debt/damages

18) Imbalance between the parties under medical care contracts should, in principle, be re-balanced by legislative interventions, by enacting special statute to be called, "Medical Contract Act", or something similar; or by inserting a new chapter of "medical care contract" in the Civil Code. Until this is done, however, there is no choice but to pursue a solution through the construction of the relevant provisions of the Civil Code and the Consumer Contract Act.

runs from the day when the action/claim for damages for non-performance is brought to court.

A. Judicial Precedents and Prevailing Academic Opinion

Secondary obligations to pay damages both in tort and in contract (for non-performance of primary obligations) are categorised as statutory obligations.

A statutory obligation comes into existence by the operation of law, but the question of whether or not and when to exercise it is left to the obligee. Therefore, where there is no specified date of performance, the obligor is not liable for delay in performance until the obligee demands/claims performance (article 412 (3) Civil Code). Then, according to a plain construction of this clause, the liability for late performance of an obligation of whichever source/cause, whether primary or secondary, should arise at the time when a demand/claim/action for payment is made (in Japanese language, there is little distinction between a legal action, claim, demand and invoice for payment).

Under the authority of a couple of pre-war rulings,¹⁹⁾ however, the courts consistently adhered to a view that both of the secondary obligations in contract and tort would become payable at the time of the occurrence of damage. A prevailing academic opinion supports this view, mainly due to fairness and history (e.g. Wagatsuma²⁰⁾).

By contrast, the current case law dictates that where an action is sounded in contract, damages for late performance runs only from when the action/claim is brought (The Supreme Court (until 1947), United Divisions, Judgment of 27 May, 1921,²¹⁾ which is followed by the current Supreme Court, Judgment of 18 December, 1980).²²⁾

B. Hirano's Point of View (A Theory Distinguishing between an Intentional Tort and a Non-intentional Tort)

It is not justified to treat a party who is liable for tort more unfairly than obligors of the other types of the Civil Code obligations, simply because s/he is a tortfeasor.

Not all tort victims claim damages, and what is more, a tortfeasor cannot even know whether or not a tort victim will exercise his/her right to claim damages until s/he is notified of the victim's intention to claim. Therefore, it is not deleterious to the tort victim to calculate interest on damages from the time of such a notice.

It is true that in a medical malpractice case, the fact that the patient suffers harm does not immediately become obvious, so it is unavoidable that the patient makes a claim for

19) The Supreme Court (until 1947), Judgment of 20 October 1910 (16 Minroku 719) and Judgment of 13 February 1911 (17 Minroku 49).

20) WAGATSUMA Sakae, *Shintei Saiken Soron (General Rules of Obligations, New Edition)* (Tokyo: Iwanami) 1964, p. 105.

21) 27 Minroku 963.

22) 34-7 Minshu 888.

damages after a certain period of time has elapsed since the occurrence of harm. Nevertheless, this is no justification for making the tortfeasor (the defendant) liable to pay interest on damages for a period between the occurrence of the harm and the commencement of action in court. It would be reasonable that where a victim, suspecting of a medical error, first demands an explanation from the doctor, the victim is deemed to have made a claim for damages at that point in time implicitly and conditionally (on condition that a medical error has taken place), with interest on damages running from this point onward.

Doctors will not accept the period of interest if they are held liable for delay from before the point in time at which they know that they have committed any medical error, or before they hear any complaint from patients or, as the case may be, from their bereaved family members.

Fur semper in mora est (“a thief is always in delay”) is a maxim which applies to an intentional tort.

Consequently, it should be construed that interest on damages for an intentional tort runs from the date of the commission of the tort. This construction is also fair because it imposes on an intentional tortfeasor a heavier liability than it does on a negligent tortfeasor. On the other hand, in the case of a negligent tort, the usual rule for a statutory obligation should apply, that is that interest on damages runs from the day after the day when an action/claim for damages in tort is brought, as in the case of a person (the plaintiff) who has enriched another without legal reason.

For legislative purposes, relevant provisions may be drafted along the following lines: “interest on debt or damages for a defective performance of an obligation shall run from the day of the failure in performance”; “interest on damages for an intentional tort shall run from the day when the tort is committed”; and “interest on damages for a negligent tort shall run from the day after the day when an action in tort is brought”.²³⁾

4. Allocation of the Burden of Proof with regard to Non-Performance

Since an obligation to provide medical care is an obligation of means, a defective performance of this type of obligation and the obligor's imputability (*Zurechnungsgrunde*) are inseparable, and cannot be distinguished from each other. Accordingly, the obligee must allege and prove the obligor's imputability even in contract as would be the case in tort. Thus, there is no substantial difference between contract and tort in this respect. This has been a common view in the academic community so far.²⁴⁾ In the pages below, the

23) The period of interest varies from jurisdiction to jurisdiction. In many jurisdictions, it is prescribed by law from a policy-oriented perspective. In Japan, it is determined through the construction of the Civil Code.

24) SUZUKI Rokuya, *Saiken Ho Kogi (Lectures on the Law of Obligations)* 2nd ed., (Tokyo: Sobunsha) 1992, p. 606.

validity of this view will be examined (see appendix 3, chart 1).

A. Factual Non-Performance

The concept of non-performance should be divided into two different concepts of *factual* non-performance and the absence of excuse from imputation.²⁵⁾ In other words, non-performance in the eyes of law is obtained by subtraction of excuse from factual non-performance.

In a medical malpractice case, factual non-performance refers to a deviation from the standard of medical care or from the terms of medical care contract. The plaintiff bears the burden to allege, and to prove the deviation from the standard of care or from the terms of contract.²⁶⁾

- For details of the concept of deviation from the standard of care, see appendix 11: diagram of marginal cost curve and the doctor's breach of the duty of care.
- For details of the specific process of decision-making on factual non-performance, see appendices 8 and 9: flowcharts of the process of decision-making on the doctor's breach of the duty of care in the light of the standard of care).

B. Excuses

(i) Prevailing Opinion

The view was once held that, in an action founded on contract, the obligor bears the burden of proof as regards any lack of imputability ("impossibility") (Kobe District Court, Tastuno Branch, Judgment of 25 January 1967). Subsequently, Nakano has advocated that in the case of an obligation of means, if the obligor's non-performance (in this category, imperfect performance) is objectively established, his/her subjective imputability is also established, such that s/he cannot argue any lack of imputability as defence.²⁷⁾ This opinion has since gained wide support and has become an established and prevailing theory.²⁸⁾

(ii) Hirano's Point of View (Excuse as a Defence)

Even though an obligation to provide medical service is an obligation of means, if the doctor is unable to provide medical service in a manner which satisfies the standard of care and skill due to circumstances beyond his control, the doctor should be allowed to aver an

25) NAKATA Hiroyasu, *Saiken Soron (General Rules of Obligations)* New ed., (Tokyo: Iwanami) 2011, p. 133.

26) The Supreme Court, Judgment of 9 June 1995 (49-6 Minshu 1499), Case of Retinopathy of Prematurity at Japanese Red Cross Society Himeji Hospital.

27) NAKANO Teiichiro, *Shinryo Saimu-no Fukanzenriko to Shomei Sekinin (Imperfect Performance of Medical Care Obligations and Burden of Proof)* in *Gendai Songaibaisho Ho Koza (Lectures on Modern Law of Damages, Vol. 4)* (Tokyo: Nihon Hyoronsha) 1974, p. 71.

28) MORITA Hiroki, "Kekka Saimu/Shudan Siamu no Kubetsu no Igi nituite" (On the Significance of Distinction between Obligation of Result and Obligation of Means) in *Suzuki Rokuya Sensei Koki Kinen (Festschrift for Suzuki Rokuya's Seventieth Birthday)* (Tokyo: Yuhikaku) 1993, p. 109.

excuse from imputation as a defence.

The prevailing opinion is that as far as an obligation of result is concerned, factual non-performance (non-attainment of the guaranteed result) and the obligor's imputability (absence of any excuse) are separate questions of fact (the present author has no objection to this).

Also, according to the prevailing opinion, in the case of an obligation of means, any finding of non-performance of the purpose of an obligation ("imperfect performance") should be made through the following process:

- [1] define the scope of an obligation;
- [2] identify the obligor's actual conduct; and
- [3] determine how far the conduct has fulfilled the defined obligation.²⁹⁾

When this process is applied to a medical care contract, the process runs in the following order:

- [1] define the standard of medical care;
- [2] identify the obligor's actual medical conduct; and
- [3] determine how far the conduct has satisfied the standard of care.

What matters here is to what extent case-specific circumstances are taken into account at the first step of defining the scope of an obligation or the standard of care. The established judicial precedent admits that the standard of medical care is not uniform nationwide, while describing this concept in the following terms with some degree of abstraction as being that "standard of medical care with which a doctor in a certain department of a certain size of medical institution in a certain region is expected to comply".³⁰⁾

Take the example of a cardiovascular physician working on duty at an accident and emergency department of a local public hospital at night, with only three-year experience in medical practice. He has had no sleep in the past twenty-four hours, and is required to attend to a couple of patients brought to the hospital simultaneously by ambulances, one of them having sustained rupture of internal organs in a tragic road traffic accident, and the other being an infant who has lost consciousness after a sudden seizure. While an experienced doctor is also on duty that night, he is too busy at attending to a difficult delivery. The hospital's medical equipment is out of date, and the hospital has been suffering from communication blackout caused by an approaching typhoon. Such peculiar circumstances surrounding the young doctor, although not uncommon, are not taken into account in the definition of the standard of medical care and skill.

Among such case-specific circumstances, might that which is beyond the given doctor's or medical institution's control be treated as impossibility, and thus as an excuse from

²⁹⁾ OHMURA Atsushi, *Kihon Minpo III (Basic Civil Law III)* (Tokyo: Yuhikaku) 2005, p. 106.

³⁰⁾ The Supreme Court, Judgment of 9 June 1995, 49-6 Minshu 1499, Case of Retinopathy of Prematurity at Himeji Red Cross Hospital. cf. The *Bolam* test "by a responsible body of professional opinion". *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587.

imputation from non-performance of an obligation of means, just as in the case of an obligation of result?

Of course, if such particularised standard of care as that of a doctor attending a number of emergency patients at night etc. is adopted in the first step of the defining the standard of care, the-third-step determination as to how far that doctor's actual conduct has satisfied the standard, would have almost automatically been achieved at the first step, and no issue of excuse would arise. However, it is beyond the patient's ability to allege and prove such specific circumstances surrounding his/her doctor.

Therefore, the plaintiff (the patient) should be deemed to have sufficiently discharged his burden of proof as regards the defendant's imperfect performance by the averment and proof of the standard of care in abstract terms, and of the defendant's conduct falling short of such a standard.

Particular circumstances surrounding the medical conduct in question should be left to the defendant (doctor or medical institution) to prove as defences. Specifically, the defendant should be allowed to defend him/herself by arguing that his medical conduct might have fallen short of the standard of care as described in abstract terms by the plaintiff, but there were intervening impediments affecting the defendant, such as the arrivals of an unexpected number of patients, the communication blackout caused by a natural disaster, the shortage of staff, including doctors, which cannot be made up for through the hospital's independent efforts, and the inability to modernise the hospital equipment due to the financial difficulties of the local government. These are examples of excuses ("impossibility I") as indicated in chart 1.

If this argument is accepted, the defendant would be recognised to have exerted his utmost endeavour under the circumstances, which means that he is recognised to have fully performed the purpose of the obligation of means (an obligation to exert one's utmost endeavour). In other words, factual non-performance exists, but legal non-performance does not exist. An obligation of result shares the same structure of decision-making in this respect.

A distinction between an obligation of means and that of result is useful for the determination of what constitutes performance or factual non-performance. In medical care cases, deviation from the standard of medical care or the terms of medical care contract constitutes factual non-performance of an obligation of means while non-attainment of the guaranteed result constitutes factual non-performance of an obligation of result.

However, this distinction between the two types of obligation does not mean that they are completely different from each other, in terms of the structure of allegation and proof. In both types, the defendant may allege and prove an excuse ("impossibility I").

It seems to the present author that the prevailing theory does not pay much attention to such specific circumstances, but falls short of critical thinking, being shackled with its own dogmatic idea that "because a medical care case involves an obligation of means, the

defendant's imputability and excuse do not matter".

(iii) Difference from Tort

In an action founded on tort, the duty of care takes into account any given specific circumstance, so that the determination of negligence takes into account any case-specific circumstance.

Because of this, in order to prove the defendant's negligence (breach of the duty of care), the plaintiff has to allege and prove all the facts corresponding to the factual non-performance and the absence of any excuse on the part of the defendant.

However, it is extremely difficult for the plaintiff to allege and prove the specific content of the defendant's duty of care, while taking into account all of the particular circumstances surrounding the defendant. To overcome this difficulty, where an action is founded on tort, a technique with which to reduce or shift the plaintiff's burden of proof would be warranted. However, it remains unclear as to whether or not there is any theoretical basis, or any extension thereof, of an attempt to reduce or shift the plaintiff's burden of proof only in certain classes of cases, such as medical malpractice cases, where there is a significant imbalance of power between the parties with regard to evidence.

In contract, by contrast, the burden of proof can be allocated between the parties appropriately in accordance with the parties' respective accessibility to evidence.

5. Allocation of the Burden of Proof with regard to Causation

A. *De facto* Presumption of Causation

In an action sounded in contract, the plaintiff bears the burden of proof in establishing causation, but in reality, the successful proof of non-performance and of some damage gives rise to the *de facto* presumption of causation.

e.g. if the non-performance of an obligation to return a leased property and the specific amount of rent are proved, it is presumed by experience without any further proof that damages in the sum equivalent to the rent arise from the non-performance.

Such presumption is valid in the case of an obligation of means as well. However, if the defendant successfully proves otherwise, that is, to prove the absence of reasonable possibility from the beginning to avoid the damage claimed ("impossibility II"), the presumption is rebutted, and the chain of causation is broken.³¹⁾ For details of the type-II impossibility, see appendix 3, chart 1.

31) In *Downton Abbey*, Series 3, during Sybil's labour, two doctors have an argument over a diagnosis of eclampsia. Dr. Clarkson insists on caesarian section, while Sir Philip Tapsell does not see any problem. Sir Philip prevails and Sybil dies after giving birth to a girl. But after further research, Dr. Clarkson has discovered, as it appears, that caesarian section would not have saved the mother. This is an example of impossibility *ab initio* which is discovered after the event.

e.g. due to the failure of an attorney, who serves as a counsel for the defendant, to file an appeal by the time limit (non-performance), the judgment in the first instance against the defendant becomes final and binding. The defendant is condemned to pay a judgment debt and thereby incurs loss. The causation between the non-performance and the loss is presumed, without any further proof, but if the attorney successfully proves that the appeal court would have supported the judgment in the first instance, namely, the absence *ab initio* of reasonable possibility to avoid the loss claimed, the presumption is rebutted.

B. Relationship between Impossibility I and Impossibility II

The type-I impossibility relates to the judges' determination of the cause of non-performance from a prospective perspective, or more specifically, a determination as to whether or not a reasonable person, in the shoes of the defendant at the time of his conduct in question, could have foreseen and avoided the damage claimed. Materials to be taken into account in order to make a decision from this perspective should be limited to those which are accessible to the defendant at the time of the conduct in question, e.g. medical literature available by the time of the conduct in question. The matter at stake is a possibility so as to avoid the consequence from a prospective perspective, i.e. at the time of the conduct in question. Was there any reasonable means available with which to avoid the consequence, for a reasonable person of like background as the defendant's, to choose?

The type-II impossibility is impossibility *ab initio* and relates to the judges' determination of causation from a retrospective perspective, or more specifically, a determination as to whether or not a reasonable person, i.e. a judge at the time of the trial, could avoid the damage claimed. Materials to be taken into account in order to make a decision from this perspective include all materials accessible to a judge at the time of his judgment, such as the latest medical literature produced by the parties. The matter at stake is a possibility to avoid the consequence from a retrospective perspective, that is, with all the means available at the time of the trial.

Impossibility of both types I and II are subject to the process of deliberation shown in appendix 9 which contain a decision-making flowchart on the doctor's breach of the duty of care, with respect to the foreseeability and avoidability of the damage. The judges go through this process after the doctor's factual non-performance of his obligation is established by the deliberation process of appendix 8 on the standard of medical care.

The defendant is excused from imputation from factual non-performance by reason of a type-I impossibility, if (i) s/he could not be reasonably expected to have foreseen the risk (in an abstract sense, fear or apprehension would suffice); (ii) s/he could have foreseen the risk and has discharged the duty to foresee it in fact, but could not be reasonably expected to have avoided the consequence prospectively; or (iii) s/he has discharged the duty so as to avoid the consequence.

If no excuse is granted at this stage, the case moves on to the next stage of making a determination as to causation.

Since causation is presumed *de facto* after the proof of factual non-performance and of some damage, such presumption is rebuttable and the chain of causation may be broken only where the defendant has successfully proven that s/he cannot be expected to have avoided the foreseen risk. This is also generally called “an excuse by reason of impossibility”, but it is to be called impossibility type II, because it is different from impossibility type I, above.³²⁾

So far, courts have been applying both the standard of medical care test and the foreseeability and avoidability test, and courts have been criticised for the arbitrary and unprincipled manner in which they select and apply one or both of the tests. It is hoped that this paper makes it clear that the tests are to be applied at different stages in a principled manner.

C. Proportional Causation Theory based on Bayes' Theorem

In medical malpractice cases, illness or injury is normally given, and there is necessarily a concurrence of a number of causes. The but-for test cannot be applied in order to establish causation where there is a concurrence of a number of causes.

A method currently seen to be the most effective in calculating the proportional contributions of a number of causes to a result, is Bayes' theorem. The theorem has been applied in a wide range of disciplines including information engineering, financial engineering, business science, psychology and politics. In the field of statistics, the theorem is even more influential than the frequency theory of probability.

Where there is a number of concurrent causes, it is not an exaggeration to say that a proportional causation theory based on Bayes' theorem is *sine qua non*. Otherwise, the court is bound to effect either under-compensation or over-compensation all of the time.

King's theory, which has been widely supported among the common law jurisdictions, also points out that the all-or-nothing rule of causation is unreasonable and proposes an idea of compensation proportionate to probability.³³⁾

In connection to this, Principles of the European Contract Law (PECL) 9:504 pro-

32) HASHIMOTO Yoshiyuki, *Iryokago Sosho niokeru Wariaiteki Kaiketsu (Proportional Resolution in Medical Malpractice Litigation)* in *Sekinin Ho no Tagenteki Kozo (Multidimensional Structure of the Laws of Liabilities)* (Tokyo: Yuhikaku) 2006, considers that the unlawfulness of fault is diminished in medical malpractice cases involving (i) side effects, (ii) yet-to-be established remedy, and (iii) yet-to-be established knowledge, and causation is weakened in cases involving (iv) adverse prognosis. Perhaps, the weakening of the unlawfulness might correspond to the type-I impossibility, and that of causation might correspond to the type-II impossibility.

33) KING, Joseph, Jr. “Causation, Valuation and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences” (1981) 90 Yale LJ 1353. cf. HIRANO Tetsuro, “Loss-of-Chance Doctrine in the UK, USA, Canada and Australia and ‘Significant Possibility’ in Japan (1)” (2011) 44-3 Ryukoku Hogaku 70.

vides, “The non-performing party is not liable for loss suffered by the aggrieved party to the extent that the aggrieved party contributed to the non-performance or its effects.” This provision might be construed to justify a similar proportional causation theory.

Bayes’ theorem helps calculate the probability that substandard medical care was provided in a case in which a patient died. If this is calculated, it is no longer necessary to hold the doctor fully liable for the entire consequence first of all, and then to make reductions in the award of damages by calculating comparative negligence by analogy. It is possible to hold the defendant liable only to the extent that s/he has contributed to the consequence, by excluding the contributions made by the given illness or injury, or by the conduct of the patient or of any third party.

Bayes’ formula of conditional probability appears thus:

$$Pr(A_i/B) = \frac{Pr(A_i)Pr(B/A_i)}{\sum_{i=1}^n Pr(A_i)Pr(B/A_i)}$$

A distinctive feature of Bayes’ theorem is that it helps to calculate the probability that a certain event is a cause of the result by calculating the probability of a cause backwardly from the result, based on the conditional probability that the result emerges from a cause, which can be discerned by experiment.

Assume, for example, that the probability of the patient’s death (B) is 70% on condition that the medical care provided for the patient falls short of the standard of care [$Pr(B/A1)=0.7$], and 40% on condition that the medical care provided to the patient is up to the standard [$Pr(B/A2)=0.4$].

Subtraction of the latter from the former may seem to suggest that a 30% chance of the avoidance of the death has been lost due to substandard medical care.³⁴⁾ However, subtraction is not a right method here. Then, to put the relevant probabilities into Bayes’ theorem, which returns the probability that substandard medical care has contributed to the death [$Pr(A1/B)$] is 0.64, on the basis of the prior probability of 0.5 each for the provision of substandard medical care, and for that of up-to-standard care (Bayes’ theorem assumes that there are equal prior probabilities among unknown factors according to the principle of insufficient reason). Therefore, the probability that the death is caused by substandard medical care is 64 percent.

Take a more complicated example:

1. The probability that the patient would have undergone a given examination if the doctor had explained the need for it, is 80 percent.
2. The probability that the patient would have been found to be suffering from a disease if s/he had undergone the examination, is 70 percent.
3. The probability that the disease would have been cured if it had been properly treated, is 50 percent.

34) e.g. *Matsuyama v Birnbaum* 452 Mass 1; 890 NE 2d 819 (Mass. 2008).

The result of the multiplication of all these probabilities is 28%, which indicates the probability that the patient would have recovered if s/he had been provided with up-to-standard medical care. Now, suppose that the probability of the patient's death after sub-standard medical care is 90% (which means that there is a 10% chance that the patient would not have died even if no measure had been taken). The contribution of substandard medical care to the patient's death is 0.56, in accordance with Bayes' theorem. Therefore, 56% of the entire damage should be compensated by the defendant. As such, Bayes' theorem enables an objective calculation of the proportion of contribution, even where there are a number of concurrent conditions.

Where the defence of the contribution of other causes (*nova causa interveniens*) is advanced, which is almost inevitable in most medical malpractice cases, it is necessary to apply Bayes' theorem to calculate the proportion of contribution by each of the alleged causes. In most cases, such a partial defence is accepted.

In the process of decision-making on type-II impossibility, the judges are required to resort to Bayes' theorem to calculate proportional causation, because the type-II impossibility involves the process of calculating the contribution of the alleged non-performance to the alleged consequence, by taking into account all the relevant conditions ascertainable at the time of the trial.

D. Easy Mistakes in Judges' Deliberation on Causation

It is an easy mistake, which is all too frequently made, even in common law jurisdictions, to deny causation where there is only a 28% chance of recovery after the provision of up-to-standard medical care, because the requisite standard of proof, which is more than 50%, is not discharged. By the same token, it is a mistake to allow 100% compensation where there is only a 56% chance of recovery. The common error is to equate the chance of recovery with the proportion of contribution of the defendant's breach of duty to the damage in question. The error is caused by confusion between (1) *novus actus interveniens* ("a new intervening act") which breaks a chain of causation, and (2) contribution of other factors, *nova causa interveniens* ("a new intervening cause"), to the damage.

The issue of the standard of proof can be translated as judges' evaluation of evidence (*Beweiswürdigung*), i.e., their evaluation of how far the plaintiff's allegation is true. He may be asserting that there was a 20% chance of recovery or a 60% chance. Where judges' evaluation of the probative value of the plaintiff's evidence is more than 50%, his assertion is accepted whether it is that there was a 20% chance of recovery or a 60% chance, and the respective proportion of the sum of compensation as claimed may be awarded. Where judges' evaluation of the probability of the plaintiff's evidence is 50% or lower, which means that the presumption of causation is rebutted by the defendant's evidence, and that the chain of causation is broken, no damages may be awarded, whether the breach's contribution to the damage has been accepted as 50% or as 80 percent.

Thus, judges' decision-making on causation involves two issues: (1) *novus actus interveniens* which breaks a chain of causation, and (2) *nova causa interveniens*, i.e. contribution of other factors to the damage. The former is an all-or-nothing question, while the latter is a question of proportion. It seems to the present author to be futile to continue debating whether causation is all-or-nothing or proportion, because the underlying hypothesis of both of the arguments proves itself to be wrong.

The first issue is qualitative, and is to be resolved by the application of the but-for test, while the second issue is quantitative, and is to be resolved by the application of Bayes' theorem. Where there is no discernible concurrent factor to the damage, the case can be disposed of by resolving the first issue. Where there are concurrent factors to the damage, as in such a category of cases as medical malpractice cases, the second issue must be resolved.

6. Standard of Proof

A. High Probability

Prevailing academic opinion and case law require a high degree of probability beyond reasonable doubt (Supreme Court, Judgment of 24 October 1975, Lumbar Shock Case³⁵). It is said that probability of more than 80% is the requisite standard in judges' evaluation of evidence.³⁶ In fact, there is no legislative basis for this position.

B. Comparative Probability

It is not necessary to prove a high degree of probability. It is sufficient to show that allegation is comparatively more probable than not. The acceptable degree ranges from 60 to 70 percent, although this depends on the degree of clarification.³⁷

C. Balance of Probabilities

The standard of proof in civil cases should be "on balance of probabilities" as in the common law jurisdictions. The requisite threshold is often described in terms of "more than half" or "more than 51 percent".³⁸ The English courts consider it wrong and mislead-

³⁵) 29-9 Minshu 1417

³⁶) KURATA Takuji, *Minji Kotsu Soshō no Kadai (Problems of Civil Road Traffic Accident Litigations to be Addressed)* (Tokyo: Nihon Hyoronsha) 1970, p. 191.

³⁷) ITOH Makoto, "Shomei, Shomeido oyobi Shomei Sekinin" (Proof, Standard of Proof and Burden of Proof) (2001) 254 *Hogaku Kyoshitsu* 33; "Shomeido wo meguru Shomondai" (Problems concerning the Standard of Proof) (2002) 1098 *Hanrei Times* 4.

³⁸) ENDO Naoya, *Law School Kyoiku Ron (On Law School Education)* (Tokyo: Shinzansha) 2000; TAMURA Yoko, "Shomeido no Hoteki Seishitsu" (Legal Character of the Standard of Proof) (2008) 321-322 *Ritsumeikan Hogaku* 303 and "Minji Soshō ni okeru Shomeido Saiko" (On the Standard of Proof in Civil Procedure, Further Thought) (2009) 327-328 *Ritsumeikan Hogaku* 517.

ing to describe the standard of proof in such numerical terms. There is an inevitable inference from the expression 'on balance', which is not apparent in the Japanese translation, that the court takes into account all the evidence.

D. Discussions

(i) Practical Problems after 2000

On 22 September 2000, the Supreme Court has recognised the loss of a significant possibility as an object of compensation (see 7A below)³⁹⁾. Since then, a higher degree of proof tends to be required in order to establish causation, where there are an increasing number of cases in which the court's attention is diverted to the issue of a significant possibility.⁴⁰⁾ The description of the standard of proof in terms of "high probability" suggests more than 80 percent. Cases where the probability of causation is less than 80%, tend to pursue the loss of a significant possibility.

(ii) Roots of the Requirement of High Probability

The standard of proof in criminal cases⁴¹⁾ has been adopted in civil cases by accident. The standard of "beyond reasonable doubt" may be calculated to be more than 90% in criminal cases, rather than only 80%, but it is wrong to adopt the same standard of proof in civil cases. Proof is sufficient if allegation seems to be "more probable than not". The common law criminal standard of proof has been introduced after the Second World War, while the civil procedure remains under the influence of German law.

(iii) Court Practice

The present author's years of experience as a judge has led to the consideration that in practice, judges tend to evaluate evidence of parties on balance of probabilities. If a feather of evidence tips the balance in favour of one party, it tends to precipitate such a sudden turn of the balance in the mind of a judge, as is sometimes described in terms of "avalanche of evidential evaluation". In his/her judgment, such an avalanche tends to be expressed in terms of "high probability". When judges or future judges study abroad, nowadays, an overwhelming majority of them visit English-speaking common law countries rather than German-speaking countries, which academics might prefer. It seems to the present author that, as a result, many judges support the standard of proof on balance of probabilities.

(iv) Reflections on the Lumbar Shock Case

The Supreme Court ruling in the Lumbar Shock Case, which has adopted a high probability beyond reasonable doubt as the civil standard of proof, actually states that the proof does not need to be that of natural science, and that the reasonable estimation of an

39) The Supreme Court, Judgment of 22 September 2000 (64-7 Minshu 2574).

40) ISHIKAWA Hirotohi and OHBA Megumi, "Soto Teido no Kanosei no Hyoryu" (Drifting Idea of A Significant Possibility) (2010) 61-3 Ho to Seiji 464.

41) The Supreme Court, Judgment of 5 August 1948 (2-9 Keishu 1123).

ordinary person is quite sufficient. However, these remarks tend to be ignored. Some judges on Medical Bench have required the plaintiff to prove medical or etiological or developmental or generation mechanisms of the health damage in question and have dismissed the statistics of a 78% chance of survival, for the reason that the rate falls short of the standard of high probability.⁴²⁾ This ruling has misconstrued the tenets of the Lumbar Shock ruling.⁴³⁾ Judges are conflating the criminal standard of beyond reasonable doubt with the civil standard of high probability. A civil case is sufficient to be proven on balance of probabilities in the reasonable estimation of an ordinary person.⁴⁴⁾

7. Damage: Loss of a Significant Possibility, Chance or Reasonable Expectation (Patient's Interests to be Protected by Law)

See appendices 4 to 8, charts 2 to 6

A. Loss of Significant Possibility

In actions founded on contract, two respective instances of ruling by the Supreme Court dated 22 September 2000,⁴⁵⁾ and 11 November 2003,⁴⁶⁾ have recognised, as an object of compensation (cf. head of damages), the loss of an adequate⁴⁷⁾ or significant possibility that death or serious after-effect would not have occurred but for the negligence of the doctor. Such a possibility can be clearly classified as a performance *interest* of the patient arising under every medical contract.

The concept of such a significant possibility can be incorporated into a contract by construing that the doctor is necessarily (and therefore by an implied term) obliged to preserve such a significant possibility as a performance interest of his patient (it is desirable that this should be expressly stipulated by a statute or as an express contractual term).

This concept seems to be quite original to the Supreme Court of Japan, which has recognised the duty to compensate the loss of such a significant possibility only in cases involving death or serious after-effects. This concept can be positively evaluated as a kind of *floodgate*, which controls the number of actions passing through the court's doors, such that the court may concentrate on meritorious actions alleging infringements of a certain class of very important "legal goods" (*ho-eki*; *Rechtsgüter*), or "legally protected inter-

42) Osaka District Court, Judgment of 29 September 2010, [2010] 2116 Hanrei Jiho 97.

43) cf. ITOH Makoto (2010) 1086 Hanrei Times 13 criticises the case along a similar line.

44) YAMAMOTO Kazuhiko (2010) 1086 Hanrei Times 30 has noted, "It seems to me that the standard of proof is a question of distribution of the risk of losing the case. Parties in civil cases are equals and their respective positions are interchangeable, and therefore, in my view, the basic standard of proof should be comparative probability ..."

45) 64-7 Minshu 2574.

46) 57-10 Minshu 1466.

47) The Japanese original here uses the adjective *soto*, which appears in another context, such as the concept of *adäquate Kausalität* (*soto ingakankei*), which is translated as "adequate causality" in English.

ests”, because the general recognition of compensation for loss of chance may cause the court to become flooded with a great number of unmeritorious and frivolous claims.

B. Loss of Chance (Patient's Reasonable Expectation)

The Supreme Court's judgment of 25 February, 2011⁴⁸⁾ held that there is a room to award compensation even merely for an “infringement of *expectation*”, where the medical conduct in question was extremely poor. The infringement of expectation in this ruling should, in substance, be regarded as a loss of chance⁴⁹⁾.

In fact, this 2011 ruling of the Supreme Court of Japan was founded on tort. The “medical conduct in question was extremely poor”, in other words, falling far short of the standard of care. This may be construed in contract to mean falling far short of contractual expectation, which constitutes a failure in the performance of an important obligation, in other words, loss of important performance interest of the patient, which may not be tangible enough to be calculated in economic terms, but which the law of contract must protect. The loss of, or interference with, significant possibility/chance, the right to self-determination, the dignity or quality of life, etc., are protecting some intangible interests, quite independently of health. These interests are to be collectively called “interests of reasonable expectation of the patient”.

There are interests which may be protected by law even where their infringements do not necessarily entail any tangible damage, for example, the legally protected interests under the old common law trespass to the person, namely, a range of voluntary interference with the freedom of movement, physical security and integrity of another person, which is actionable *per se*, in other words, without proof of any actual damage. So, if a doctor, knowing that a patient is a Jehovah's-witness, who has refused to give consent to any blood transfusion for religious reasons, nevertheless goes on to give the patient a blood transfusion, the doctor is guilty of trespass, and condemned to pay damages, even in such a case where the blood transfusion saves the patient's life. The damages are likely to be nominal in such cases.

In contract, the patient's performance interest, that is the obligation as owed by the doctor to the patient, which the law of contract must protect, can, and ought to be, much wider than the security and integrity of the patient's body, for example, reasonable *expectation*⁵⁰⁾ of respect for the patient's autonomy, dignity or quality of life, and significant possibility or chance of recovery, so long as such reasonably exists.

48) [2011] 1344 Hanrei Times 110.

49) HIRANO (2011) 145-2 Minshoho Zasshi 249, HIRANO (2011) 44-3 Ryukoku Hogaku 313.

50) In English law, damages can be awarded for the loss of expectation as a performance interest of a contract. *Ruxley v Forsyth* [1996] AC 344; CARTWRIGHT, John, *Contract Law: An Introduction to English Law of Contract for Civil Lawyer*, 2d ed. (Oxford: Hart Publications) 2007, pp. 263-264.

8. Conclusions

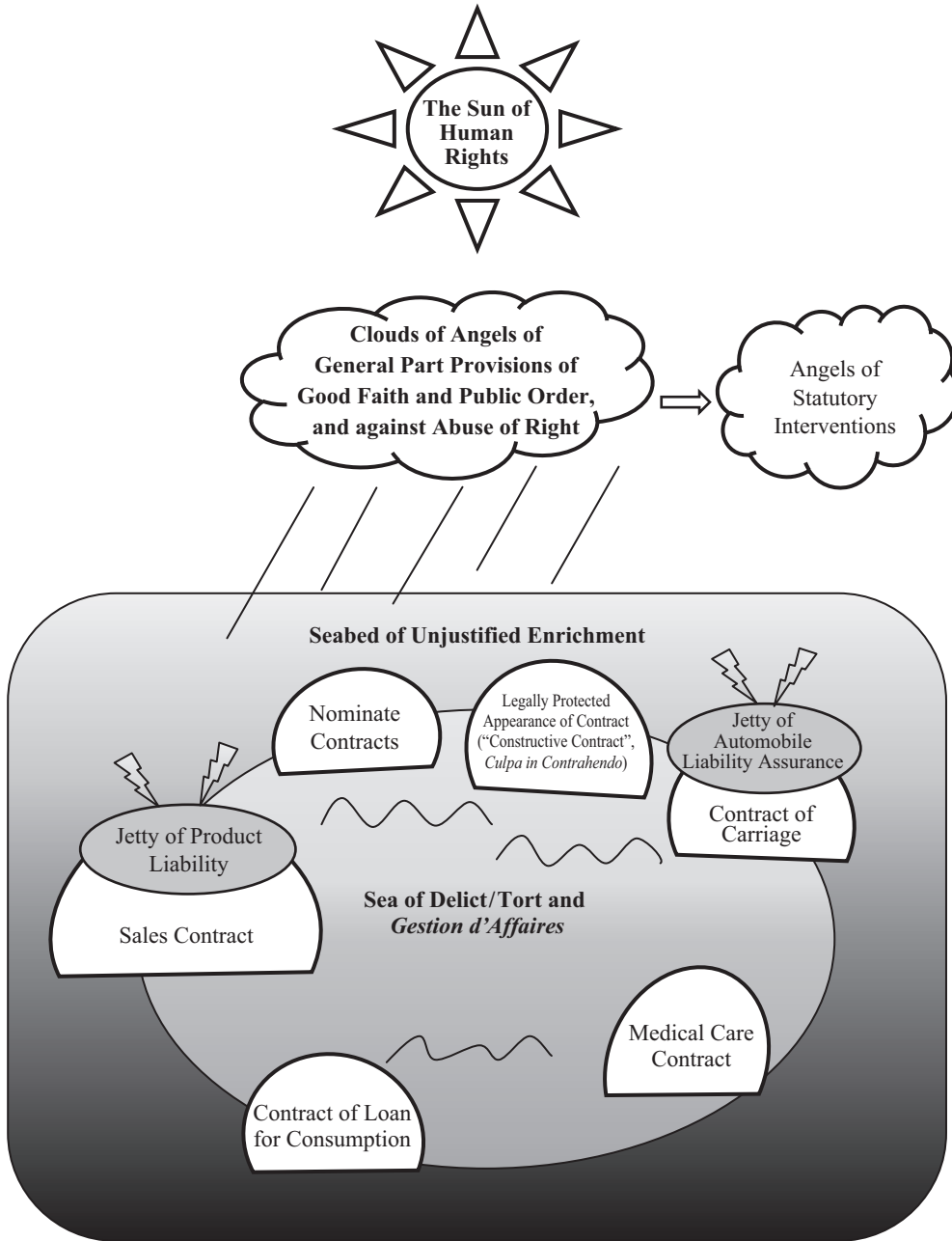
Ohmura argues that the purpose of the enhancement of the applicability of the law of contracts, which the proposed amendment of the Civil Code is designed to promote, is the development of a “society based on contract”.⁵¹⁾ A society based on contract is a society which employs a contract as a tool with which to regulate the relationship between parties, in other words, a society which employs the contract as a tool with which to improve its structures. In such a contract-based society, contract is not merely a tool of transferring property, but also an essential tool with which to draw people into relationship. In the context of the type of contract for the provision of medical service, contract is a tool with which to connect patients and medical service providers, and to regulate their relationships. Among medical service providers, there are some who see the introduction of the concept of contract - as well as medical litigation - into the medical community, as law’s interferences with their autonomy and integrity. However, medical care contract contributes to the clarification of obligations (rights and duties) of the medical service providers and patients as well as towards the betterment of medicine.

Doctors tend to find the law embarrassing, offensive and frightening, largely because there is uncertainty about what is going on in the legal process, which appears to come to a conclusion, so far, in a black box. Those flowcharts of the court’s process of decision-making on liabilities, which are attached to this report as appendices, are intended to help disperse such uncertainty of law for doctors, and to help doctors understand in advance in what circumstances the court imposes legal liabilities on them. It is hoped that these represent models of decision-making process which help make crystal clear the rules by means of which the court determines civil liabilities of doctors; bridges the gaps between medicine and law, between doctors and patients; and enhances their mutual understanding and co-operation.

51) OHMURA Atsushi, *Minpo Kaisei wo kangaeru (On the Revision of the Civil Code)* (Tokyo: Iwanami) 2011, pp. 160-179. cf. MAINE, Henry J. C., *Ancient Law* (London: John Murray) 1861, Chapter V.

Appendix 1.

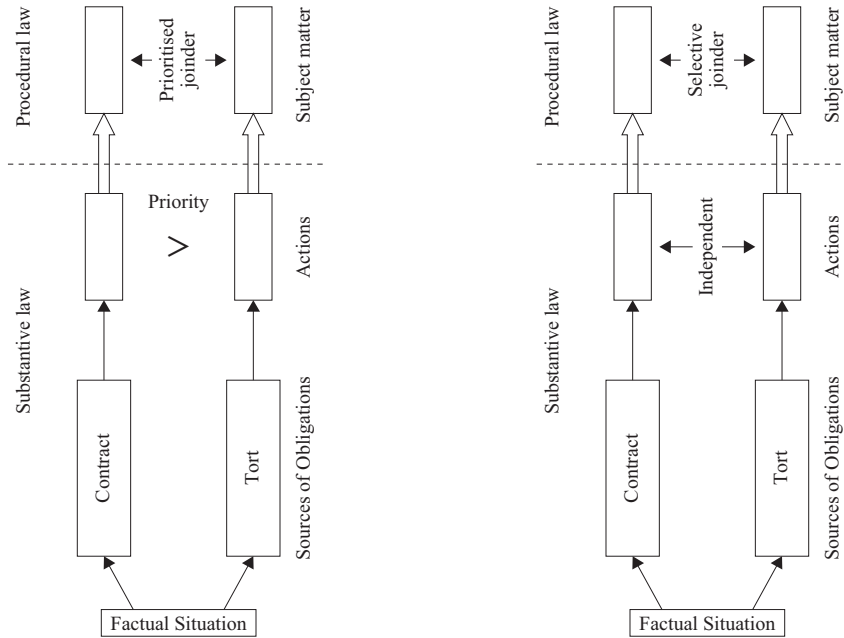
Archipelago of Contracts



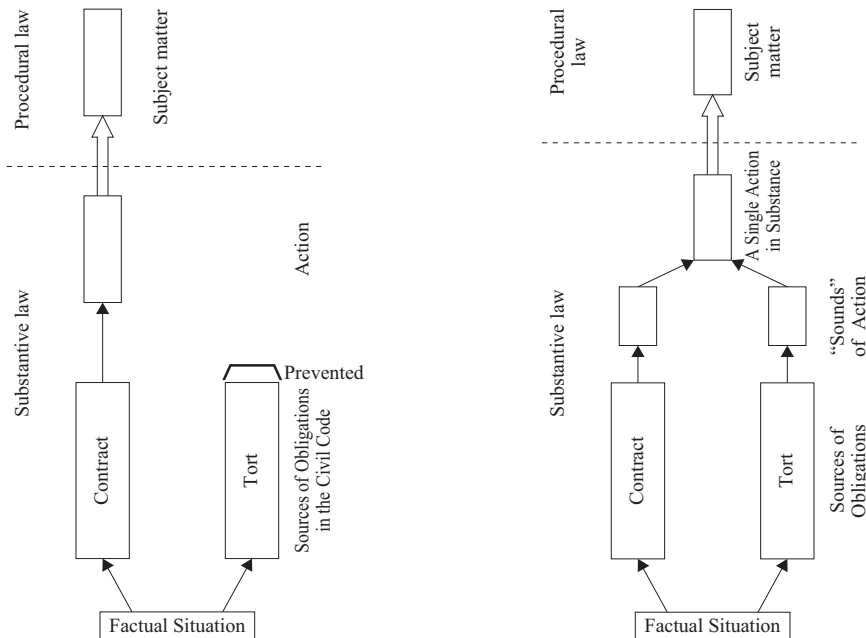
Appendix 2.

Adapted from the charts of Tatsuaki MAEDA “*Kōjutsu Saiken sōron*” 3rd ed. (1993) 226–227

Theory of Hierarchical Concurrence of Actions (Hirano’s view) (1) Theory of Concurrence of Actions (prevailing theory)

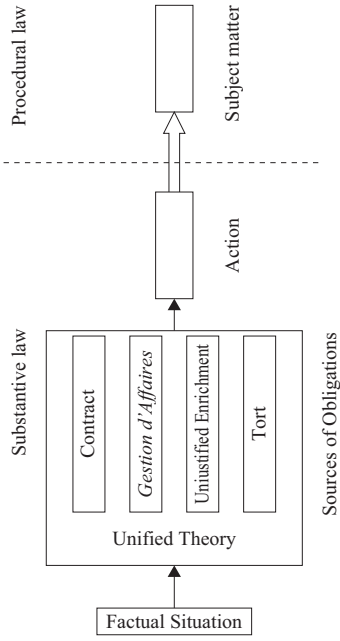


(2) Theory of Conflict of Civil Code Provisions (3) Theory of Double “Sounds” of A Single Action



Appendix 2.

(4) Great Unified Theory of the Sources of Obligations



Appendix 3.

Chart 1

Fatal and Serious Cases, Level 1

Occurrence of fatality/serious after-effects where causation between non-PF and the damage is apparent

Plaintiff's Case	Standard of proof	Content		Defendant's Case	Standard of proof	Content
I. factual non-PF (a) Standard of medical care/term (b) Actual Medical Conduct	Over 50%	Breach of duty to KAD to explain to transfer patient to provide remedy	← Defense ← Denial	excuse (b) 's satisfaction of (a) = PF of the purpose of the contract	Over 50% (with burden of proof) At least 50% (without burden of proof)	Impossibility I = (i) the doctor could not have foreseen the risk (absence of prospective possibility to foresee), (ii) the doctor could have foreseen the risk and actually performed the obligation to foresee it, but could not have avoided the consequence prospectively (absence of prospective possibility to avoid); or (iii) the doctor performed the obligation to avoid the consequence Ex. Emergency cases, unavoidable complications
↓						
II. Causation	Over 50% PS de facto from I and III	Existence of retrospective possibility to avoid	← Denial ← Defense	Break in the chain of causation Contribution of other causes (e.g. acts of the patient or third parties, progress of the disease or injury)	At least 50% (without burden of proof) Over 50% (with burden of proof)	Impossibility II = Absence of retrospective possibility to avoid Proportional causation theory using Bayes' theorem
↓						
III. Damage	Over 50%	Consequential damage	← Denial	Non-occurrence of the entire or part of the alleged damage	At least 50% (without burden of proof)	

PF = performance

KAD = keep abreast with developments in medical science and technology

PS = presumption

Appendix 4.

Chart 2

Fatal and Serious cases, Level 2

Occurrence of fatality/serious after-effects where there is a significant possibility of avoidance but for non-PF

Figure 1

Plaintiff's Case	Standard of proof	Content	Defendant's Case	Standard of proof	Content
I. Non-PF					
(ii) (i) ↓		Same as Chart 1			
II. Causation ↓					
III. Damage					

Figure 2

Plaintiff's Case	Degree of proof	Content	Defendant's Case	Degree of proof	Content
II. Causation ↓	Over 50%	Existence of possibility to avoid the loss of a significant possibility (effect)			
III. Damage	Over 50%	Existence of a significant possibility that the patient's death or serious after-effects would not have occurred at the time of the accident			

PF = performance

Appendix 5.

Chart 3

Fatal and Serious Cases, Level 3

Occurrence of fatality/serious after-effects other than Levels I and II, after extreme non-PF

Figure 1

Plaintiff's Case	Standard of proof	Content		Defendant's Case	Standard of proof	Content
I. Non-PF		Same as Chart 1				
(ii) (i) ↓						
II. Causation						
III. Damage						

Figure 2

Plaintiff's Case	Degree of proof	Content		Defendant's Case	Degree of proof	Content
II. Causation		Same as Chart 2				
III. Damage						

Figure 3

Plaintiff's Case	Standard of proof	Content		Defendant's Case	Standard of proof	Content
I. Extreme non-PF (a) Standard of medical care/term (b) Actual Medical Conduct (c) Manifest deviation	Over 50%	Extreme breach of duty	← Defense	excuse	Over 50% (with burden of proof)	Impossibility I
			← Denial	PF of the purpose of the obligation	At least 50% (without burden of proof)	
III. Damage	Over 50%	Infringement of the patient's reasonable expectation interest (e.g. loss of chance to receive proper and timely medical care, infringement of the right to self-determination)				

PF = performance

Appendix 6.

Chart 4

Non-Fatal/Serious Cases, Level 1

Occurrence of some (physical or mental) health damage other than fatality or serious after-effect or mental distress where there is apparent causation between non-PF and the damage

Chart 4 is identical with Chart 1, except that the damage in question is not the patient's death or serious after-effects (which means e.g. that funeral expenses and bereavement do not necessarily arise).

Appendix 7.

Chart 5

Non-Fatal/Serious Cases, Level 2

Occurrence of some health damage other than fatality or serious after-effect, where causation cannot be established

Figure 1

Plaintiff's Case	Standard of proof	Content		Defendant's Case	Standard of proof	Content	
I. Nonperformance							
(ii) (i) ↓							
II. Causation		Same as Chart 1 = Chart 4					
↓							
III. Damage							

Figure 3

Plaintiff's Case	Standard of proof	Content		Defendant's Case	Standard of proof	Content
I. Extreme non-PF (a) Standard of medical care/term (b) Actual Medical Conduct (c) Manifest deviation	Over 50%	Extreme breach of duty	← Defense	excuse	Over 50% (with burden of proof)	Impossibility I
↓			← Denial	No manifest deviation	At least 50% (without burden of proof)	
III. Damage	Over 50%	Infringement of the patient's reasonable expectation interest				

PF = performance

Appendix 8.

Chart 6
No Health Damage Cases

In such cases, infringement of the patient’s interest, such as “chance to receive proper and timely medical care,” “right to self-determination,” and “dignity or quality of life,” becomes an issue, instead of health damage.

Chart 6 is basically identical with Chart 3.

Plaintiff’s Case	Standard of proof	Content		Defendant’s Case	Standard of proof	Content
I. Extreme non-PF (a) Standard of medical care/term (b) Actual Medical Conduct (c) Manifest deviation	Over 50%	Extreme breach of duty	← Defense	Excuse	Over 50% (with burden of proof)	I
			← Denial	Performance	At least 50% (without burden of proof)	
			← Denial	No manifest deviation		
↓						
III. Damage	Over 50%	Infringement of the patient’s reasonable expectation interest				

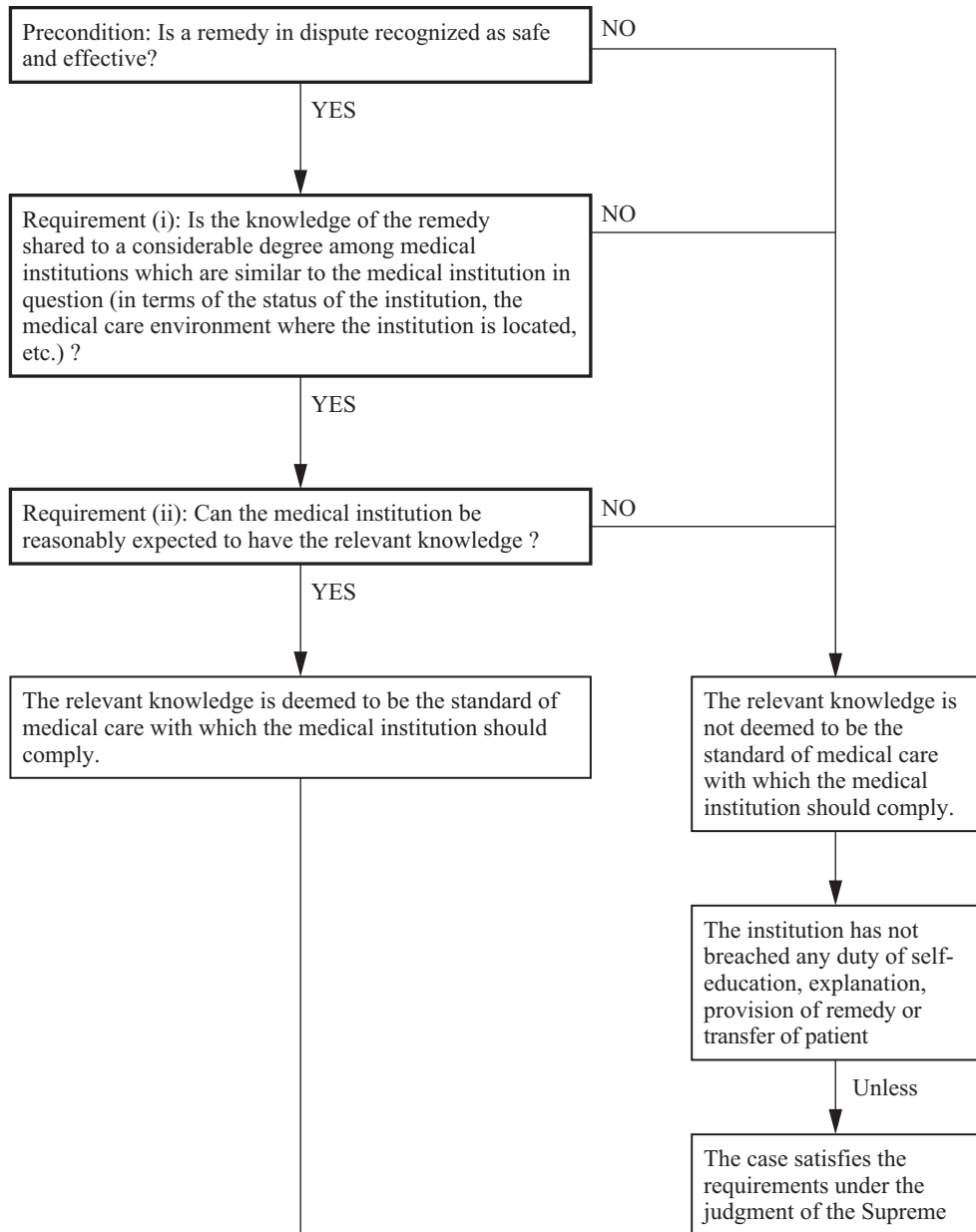
Appendix 9.

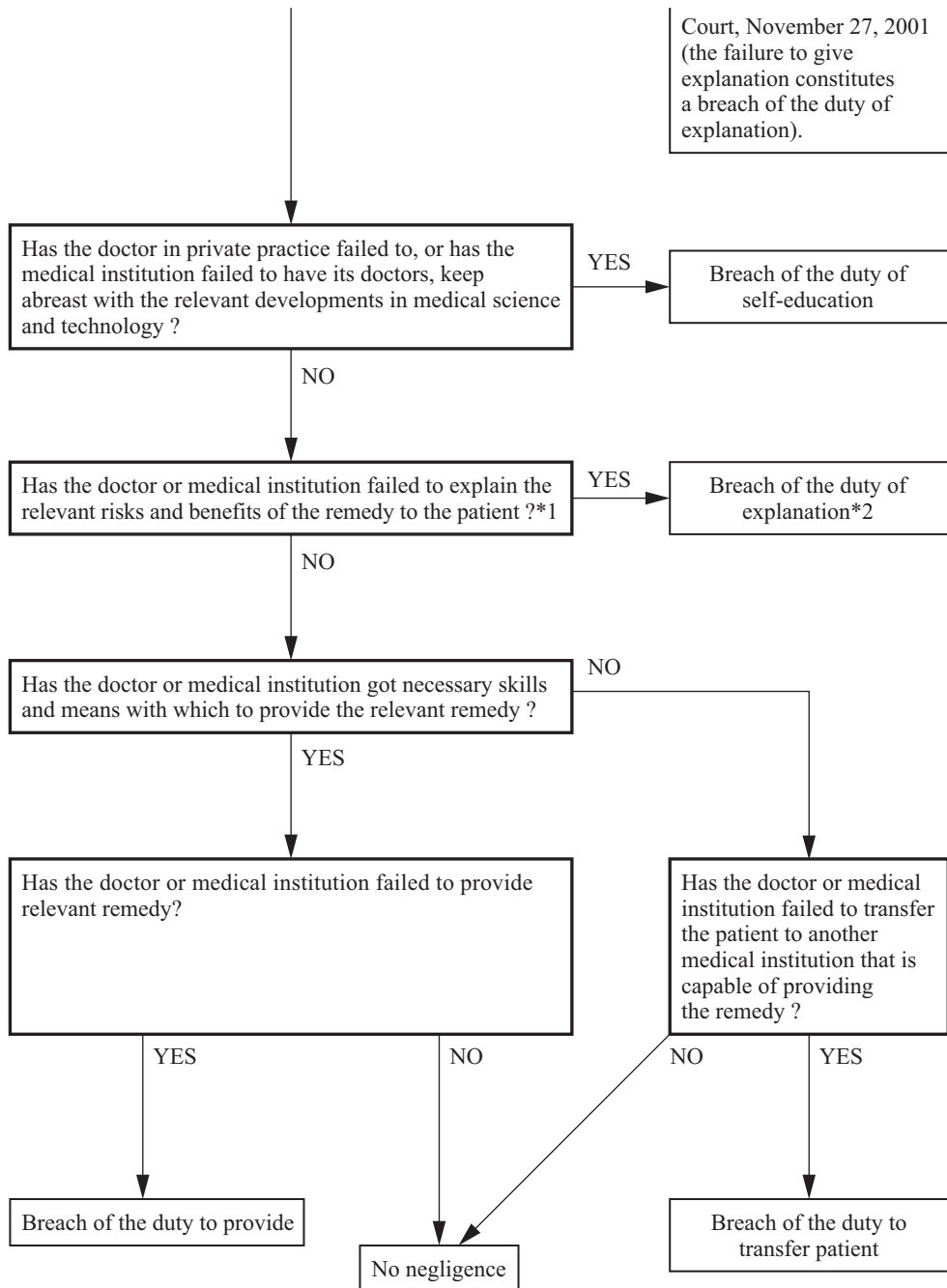
Flowcharts of the process of decision-making on the doctor's breach of the duty of care

1. The Standard of Medical Care Approach

These charts show the process of making determination as to factual non-performance (within the bold square in Chart 1), so as to determine whether or not the medical conduct of the defendant doctor or medical institution has satisfied the standard of medical care.

Matters within bold squares below must be alleged and proven by the plaintiff.





* 1 : It may become an issue whether or not the terms and wording of explanation and the manner and circumstances in which it was given, have satisfied the standard of medical care.

* 2 : However, the doctor or medical institution is rarely held responsible for a breach of the duty of explanation even where they have failed to explain or have given an inadequate explanation, as long as they have actually provided up-to-the-standard medical care.

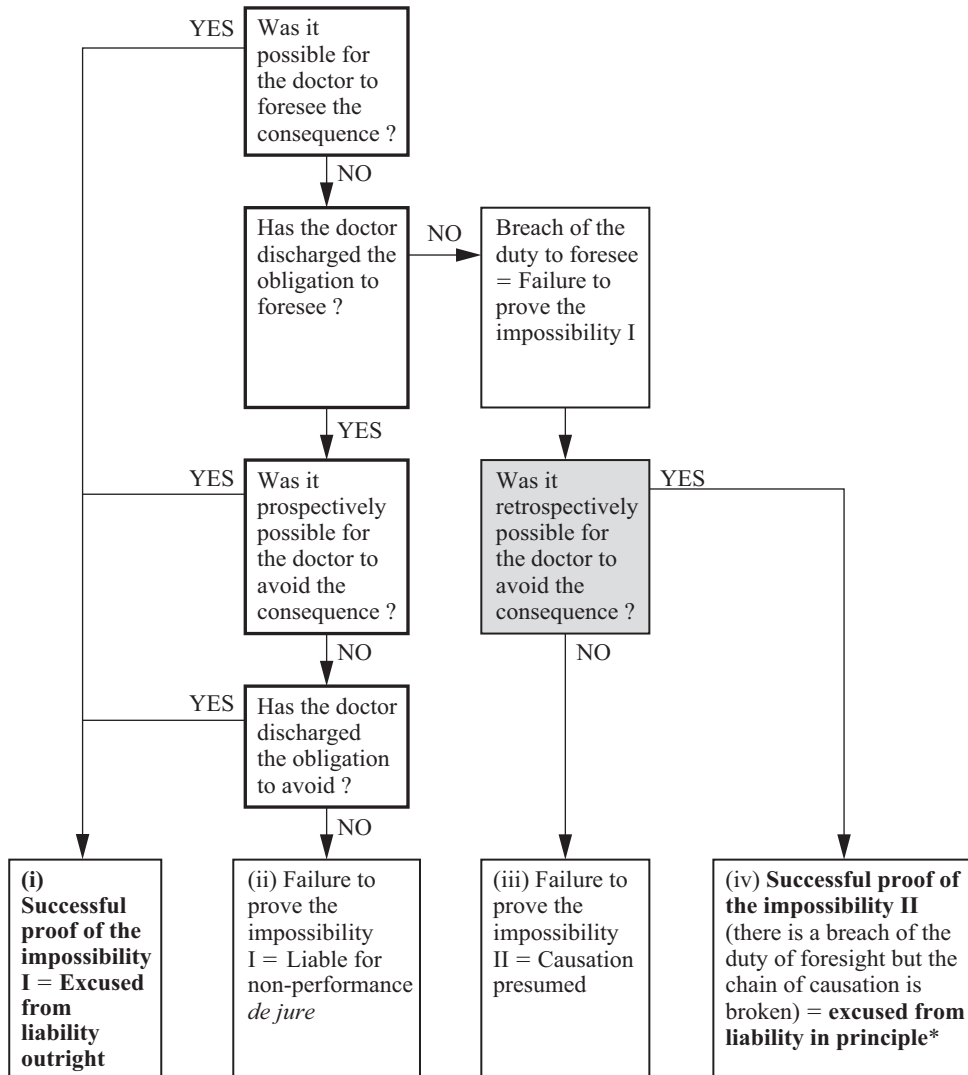
Appendix 10.

Flowcharts of the process of decision-making on the doctor’s breach of the duty of care

2. Foreseeability and Avoidability of the Consequence Approach

The charts below show the process of making determination as to Impossibility. Matters within bold squares below must be alleged and proven by the defendant as a defense against the allegation of non-performance.

The matter in the shaded square must be proven by the defendant in order to reverse the presumption of causation.



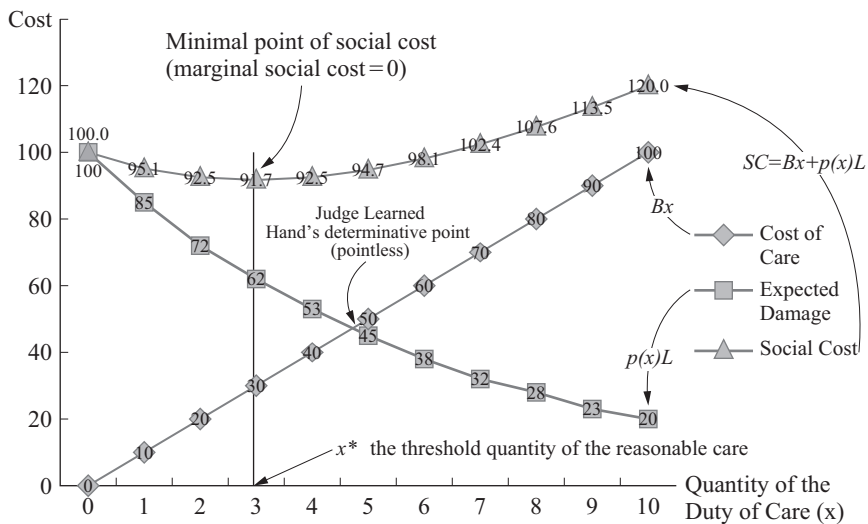
* In this case, the doctor has failed to discharge the obligation to foresee but the chain of causation between the failure and the consequence is broken, so that the doctor is, in principle, excused from liability for the consequence. However, if the deviation from the standard of medical care or from the terms of medical care contract is in the extreme, the doctor may be held liable for the infringement of the patient’s reasonable expectation interest (Chart 6).

Appendix 11.

Marginal Cost Curve for the Determination of the Doctor's Breach of the Duty of Care

KAGAYAMA Shigeru "Koi mataha Kashitsu, Ingakankei niokeru Teiryobunseki no Hitsuyo"
 (The Necessity of Quantitative Analysis in the Determination of Dolus, Culpa and Causation)
 (2011) 15 Meijigakuin Law Review 26

The value of x at a point where the social cost curve (the sum of marginal cost of care and marginal expected damage) is minimum, that is, where the inclination of the social cost curve is zero (horizontal), is determined as the threshold quantity of the duty of care i.e. the standard of medical care. Where such a threshold quantity of the duty of care is increased or decreased to a certain point under the terms of a medical care contract, the quantity at that point shall be the threshold quantity of the duty of care under the contract. If the actual medical conduct in question falls within the area on the left of the vertical line going through the minimal point of the social cost curve, i.e. the line of the threshold quantity of reasonable care at x^* , that conduct constitutes "factual non-performance."



Hand Formula: a doctor is in negligence where the cost of care is smaller than the expected damage.
 Quantitative analysis of law: a doctor is in negligence where the marginal cost is smaller the marginal expected damage.
 According to the quantitative analysis of law, the Hand formula is clearly wrong.

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