Troublesome Patients as Experienced by Doctors in Japan

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Introduction

> “The past few decades have witnessed a loss in physicians' autonomy, their dwindling prestige, and a deep professional malaise in many advanced nations (...). In Japan, the grievances of physicians seem immensely more serious than those in Western nations. Japan's healthcare system is on the verge of collapse because Japanese physicians are utterly demoralized." (Yasunaga 2008a, 1)

Thus opens an article written in 2008 by Hideo Yasunaga, who at the time was employed as a teacher of medical administration and policy studies at the Graduate School of Medicine, University of Tokyo. Pressing warnings of a national health care system losing stability due to the social stress experienced by its professional workforce were at that point in time nothing especially new in the field of Japanese language literature authored by doctors. Perhaps the only characteristic that makes his article stand out is that it appeared in an English language publication, whereas most authors writing on this topic never sought a readership beyond Japan's national borders.

Although he never drops the exact term, Yasunaga is describing a situation that within said literature circles has become more commonly known as '*iryo hokai*' (医療崩壊), which literally translates to 'the collapse of medicine', with 'medicine' referring to an abstract system of medical care rather than specific medication or treatments. Far from being in the general lexicon, the term is mostly limited to the discourse which it defines, and while it is occasionally used to address pending failures in the medical system due to unsatisfactory resource allocation or bad economic planning on a political level, it mostly accompanies frustrated criticism aimed at the social aspect of clinical healthcare, or more specifically: the doctor-patient relationship as experienced in the twenty-first century.

Bioethics has been a significant topic of discussion in Japan for multiple decades now. Both popular and academic interest in it has flourished, as shown bythe appearance around 1985 of popular debates and mass-media interest around issues such as organ transplantation, euthenasia, and Informed Consent, to name a few prominent examples (Takahashi 2005, 8)[1]. It seems safe to assume that a large amount of people in Japan have become more actively critical of the care they are given, and the way they are given it. Probably as a result of this, there is a notable amount of anthropological research being done within Japan about the experiences and expectations of patients and their immediate

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[1] Takahashi (2005) will serve as a general introduction to this topic.

families in physically and emotionally trying clinical situations.

What frequently lacks, however, is similar research that focuses on the experiences lived and arguments given by the other half of the social construction that is the doctor-patient relationship: the doctor. Yet the notable amount of literature whose authors wear that title on their sleeve while speaking of a 'collapse' of the healthcare system due to their 'utter demoralization' suggests that there is a sense of social crisis that is thoroughly localized in Japan's national medical system, and deserves analysis and consideration in its own right.

Questions thus left open concern how these doctors in Japan have attempted to articulate the interpersonal difficulties they have or are experiencing in encounters with their patients, what discursive and historical background of modern medicine these utterances take place in, and finally, how they can be interpreted using existing critical social theories regarding biomedicine and social power structures. In terms of international studies, the overarching question is what kind of societal role these doctors in Japan are trying to construct for themselves opposite their patients, and in what way one can interpret their constructions to be informed by existing ideals regarding political and social relations which biomedicine originated from, and continues to owe its *raison d'etre* to.

The particular semiotic ways that these doctors understand their experiences and choose to express them in language is both informed by and constitute a discourse. A discourse acts as a body of symbolic meaning that is continually added to and shared by those who speak within it . It allows abstract concepts such as power to take on concrete substance that can be understood and experienced as reality by a collective of people in a particular historical time and place (Locke 2004, 11).

By analyzing several medical/clinical discourses in which power and professionalism are perceived to be challenged by patients, I aim to show some of the ways in which the societal roles of biomedicine and its professional practitioners are realized and shared by some doctors in current day Japan. As a theoretical background, I will first discuss social theory on the role of medical knowledge and expertise in the new systems of power that sprung up in the modern era of nationalism. Then, I will provide a discussion of the aforementioned *iryo hokai* discourse, as well as its immediate historical background. Finally, I will analyze articles published in Japanese magazines meant for a readership of medical professionals, which feature 'troublesome patients' (*komatta kanja*) as their main topic.

Chapter 1

Literature - The Political Origins of Biomedicine

Michel Foucault's *The Birth of the Clinic* traces the creation and institutionalization of the modern medical 'gaze', locating its birth in the political and national reformations that took place in the French Revolution. The shift sovereignty from the monarch to the citizens of a new republic called for a fundamental change in the way populations were to be administrated, and therefore power to be organized. This occasioned the birth of biopolitical systems, which aimed at creating a strong nation by actively creating and shaping its population. The modern conception of biomedicine as a professionalized system that is there to keep the population healthy first saw popular acceptance during this time, as one of the main elements of biopolitics. The special position that medical professionals would take in social configurations of power within this new system was based on two ideals held by the revolutionaries. The first was that the maintenance and improvement of people's bodily health was the sole purview of a nationalized medical profession, whose power over said bodies was meant to be similar to that held by the Christian clergy over people's souls. The second was the teleology that a medicalization of society would ultimately eliminate all diseases and deviations, and return it to its original state of health (Foucault 1973, 36).

Based on these foundations, biomedicine came to play an important role in the new systems of power at the national level. Healthiness, be it physical, mental, or social, became an object of systematic production. To this end, a centralized discourse of medical knowledge was constructed, which was to be constantly worked on by those qualified to do so. This bank of medical knowledge and the power invested into its operators by the structure of the modern nation state to both add to it by rational observation, as well as to actively apply its knowledge to benefit the population's state of health is what constitutes a medical gaze upon society (*ibidem*, 33-37).

The medical gaze as described by Foucault can be interpreted as being based on a Derridean binary opposition of 'normal versus abnormal'. In Derrida's cultural analytical method of deconstruction, binary oppositions are social constructs that dominate thought, which serve to create seemingly tangible meaning by dividing the perceived world into pairs of mutually opposite concepts. Importantly, these pairs are thoroughly hierarchical, as one pole invariably is seen as dominating the other (Derrida 1982, 195). The Foucauldian medical gaze isolates human 'normality' through rational experimentation, generalizing that knowledge into theory, and then applying that theory to the population with the aim of normalizing the pathological elements out of it (Foucault 1973, 40-41). Thus, the biomedical discourse focuses primarily on disease and its elimination.

Ivan Illich has in many ways elaborated on the discourse of the medical gaze and its status as a symbolic system of normalization, though in a much more personal and critical tone. His argument that "The medical establishment has become a major threat to health", as his book *Limits to Medicine* starts, can be seen as a blunt summary of the central concept of discussion in said book: that of *iatrogenesis,* which refers to injuries or illnesses caused by medical treatments, examinations, or any other procedure intended to heal the afflicted.

Although he did not invent this concept, Illich elaborates on it by applying it besides physical damage to the cultural and social effects that professionalized biomedicine has on society and the people that live in it. He does this by splitting it into the three forms of clinical, social, and cultural *iatrogenesis,* of which the last two are most relevant here.

The concept of social *iatrogenesis* perhaps most closely resembles Foucault's insights into the social workings of the modern clinic. He defines it as "a term designating all impairments to health that are due precisely to those socio-economic transformations which have been made attractive, possible, or necessary by the institutional shape health care has taken." (*ibidem*, 40). To Illich it seems to refer to the logical extreme of the growth of the medical gaze's power to control the population's thoughts and behaviours regarding health, leading to a diagnostic monopoly on people's problems that changes their environment in such a way as to disable individuals from identifying and solving health-related problems in their own way. Life itself becomes medicalized, under the society-wide assumption that equal access to health-care services is the best solution to solving health problems.

The discussion of cultural *iatrogenesis* centers on the cultural effects of what Foucault identified as one of the founding myths of biomedicine in the French Revolution, that of medicine's potential and ultimate goal of eliminating disease. Specifically, Illich compares pre-industrial societies and medicalized post-industrialized societies in how their inhabitants conceived of pain and death, and the cultural methods by which they interpreted their experiences with them. The main conclusion he reaches on this front is that industrialized medicine, by virtue of the symbolic ambition to eliminate suffering itself, has created cultures in which people are unable to understand pain as an inevitable part of life. Pain and 'unnatural' death come to be seen as an undesired absence of medical care (*ibidem*, 194).

Many criticisms can be made of Illich's views. He was evidently very critical of professionalized and industrialized systems of medicine, though I am surely not the first to say that he does not give enough due attention to the autonomy and intellect of said 'slaves', and their reasons for being content with that status. Likewise, moments of conflict within the system of political and social power that is biomedicine, between those who practice it and those who patronize it, are only examined to the extent that it proves Illich's gripes about how thorough *iatrogenesis* is on a cultural level. Finally, the book is at the time of this writing almost half a century old, and very much a product of its time and the author's specific circumstances.

Nevertheless, biomedicine as a system imbued with symbolic power and a mission to produce health and provide a counter to pain and disease still exists in society today, including Japan, as shall become clear in the following pages. As a lens for understanding social difficulties experienced by doctors in the clinical doctor-patient relationship in Japan, Illich's analyses hold weight, precisely because I am concerned with moments where doctors feel that the beliefs and actions taken by their patients are undermining the medical system, apparently to the point of collapse. It will allow for a better understanding of what aspect is under threat, and why.

Scholarship that applies critical social theories such as the above to the way the national system of medical care in Japan functions politically and socially, and how people experience and use it, are few when it comes to English language publications. Margaret Lock has released multiple publications about the degree of medicalization that has taken place in modern Japan of such phases of life as old age (Lock 1984) and menopause (Lock 1993), as well as the incorporation of 'traditional' Chinese herbal medicine (*kanpou*) into the national health insurance (Lock 1990).

Although I shall not dwell on her work too much, the conclusions she makes in her article on the medicalization of the elderly has relevance to my focus, showing some of the social theory about rationalism and *iatrogenesis* I have discussed earlier. Her focus is very much on the theoretical financial incentives for medicalization, although she takes care to examine this from the point of view of the medical consumers rather than the professional medical discourse itself. It was the elderly patients' interest in taking 'traditional' *kanpou* that is seen as the impetus for its subsequent incorporation into the dominant discourse of biomedicine, and the national health insurance system. It is in Lock's analysis of this incorporation that *iatrogenesis* as Illich defined it is pointed out, at least in the clinical sense. She argues that while *kanpou* was likely mostly effective due to its treatment of symptoms, combined with the localized social meanings attached to it by its practitioners and consumers alike, its incorporation into models of rational science shifted its objective to the curing of disease. The practitioners of the biomedical model assumed that *kanpou*'s proven efficacy was due to some kind of biologically demonstrable disease-curing property, disregarding definitions of healing that value other aspects. Lock argues that *kanpou* was incorporated based entirely on this assumption, leading to over-prescription of herbal medicine to elderly that caused them to have stomach problems more often than not (Lock 1990, 131-132).

This highlights some of the potential conflicts that can and have happened in Japan between biomedicine-focused interpretations of a 'condition', and the interpretations formed by those who actually live that 'condition'. It also demonstrates that nationalized medicine in Japan can be characterized as 'modern biomedicine', in that its practitioners tend to not only judge the legitimacy of their methods by the degree to which they can be scientifically proven to have a disease-eliminating effect, but also tend to assume that this is what other systems of healing prioritize. Indeed, despite Lock concluding in her book on menopause that it is not medicalized in the dominant medical discourse in Japan, and that physicians who do see women for it tend to emphasize the social origins of physical problems (Lock 1993, 294), she also discusses the generally high level of health-consciousness and pharmaceutical use present in Japan, and mentions that there are medical experts in Japan that push for a discourse on menopause that eliminates the societal slant in order to focus on the biological causes (*ibidem*, 280).

Medical anthropology has a fairly large presence as a field of academic writing in Japan as well, which, as can be expected, contains a much larger number of authors concerned with contextualizing social conceptions of medicine held by people within Japan than does the English-language literature. One common aspect of said Japanese literature is that it takes the patient's point of view as the primary object of analysis, only referring to medical discourse when it conflicts with that of the patient. The field is too large to do an extensive discussion of here, but one work that illustrates the field as a whole is Ukigaya's chapter on what it means to "heal" for different parties involved in medical matters, in a collected volume titled *An Ethnographic Approach to Contemporary Medicine*.

The chapter, spanning forty pages, starts by touching on the way research on regenerative medicine is reported on by the mass media and incorporated into governmental policies. However, this quickly leads into an examination of how such political discourses are affected by patients' views on healing, arguing that very often, patients' own hopes and high regard of 'state-of-the-art' medical research results in funding getting put towards research that a majority of medical researchers themselves would argue is unnecessary, unimportant, or an inefficient use of resources in light of simpler alternatives. The rest of the chapter consists of interviews with patients of various illnesses in order to understand what they value in a healing method, and why they make the choices that they make regarding support of research policy (Ukigaya 2004). The rest of the book is of a similar focus, and very much informed by a Foucauldian approach, as his views on normative power over mind and body as he expressed them in "Madness and Civilization" are discussed in the introduction (Kondou & Ukigaya 2004, 16-19).

All I have discussed so far illustrates that both English-language and Japanese language anthropological writings of the past couple of decades make it clear that in Japan, as anywhere else in the world, social context factors heavily into the way people decide on how to conceive of healing, and how to approach it practically. More importantly for my angle, they also suggest that nationalized biomedicine is ultimately a product largely of social influences that exist in Japan today, which is ultimately what guides private and public decisions on what issues to treat medically, and how to do so.

However, what is frequently missing from the field of medical anthropology is attention for the experiences of the other half of the doctor-patient (or more generally the expert-layperson) relationship: the medical expert. Their position frequently seems taken for granted as those exerting power from within an authoritative professional discourse. As Lock's article on medicalization of *kanpou* suggested, their worldview is indeed very much influenced by the ideals of European nationalism and rationalism as described by Foucault. Yet it is very rarely examined more closely in detail how the power implied by this discourse is experienced by its wielders in any specific social place or time. In the next chapters, I hope to fill that gap to some extent, by analyzing the clinical and professional medical discourses in Japan that concern doctors' conflicts with some of their patients.

Chapter 2

Background - The *Iryo Hokai* Discourse

iryo hokai, as mentioned in the introduction, is a rhetorical collapse of the medical system that was predicted by some vocal doctors in Japan starting around 2006. It bears saying that remarkably little has been written on the subject from a sociological or anthropological point of view. As such, there is not much existing ground to discuss, nor is there much to provide an accurate picture of its proponents' ideals and goals besides what analysis I can provide myself.

Indeed, Kurioka Mikiei, one of the few writers that has taken up the topic, identifies *iryo hokai* discourse as necessarily existing almost entirely in the social space of internet discussions. This is due to the nature of the discussions relying on certain characteristics of this 'new medium' to thrive. That is, Kurioka believes that proponents of *iryo hokai* discourse use the anonymity involved with online blogs in order to engage in anti-social behaviour against patients and their families, such as posting verbal personal attacks on plaintiffs of medical lawsuits in blog posts, or leaving inflammatory comments on patient support blogs, without having to face the social retribution that would inevitably occur if they made similar statements or actions in a place where their name and/or face would be visible, such as on television (Kurioka 2007, 119-120 & 126).

Kurioka argues that such activities are a form of confirming group solidarity in a time of perceived social crisis. The identification of *iryo hokai* as an anonymous and internet-based movement makes it very difficult to isolate conventional characteristics of *iryo hokai* discourse, such as even a rough estimate of the amount of its proponents, or their social, geographical, or economical status, besides that they work in the medical sector. As the article states, one can only deduce dominant ideals regarding medicine based on what is said within the discourse, which is what Kurioka seems to aim at. Ultimately, he concludes that aforementioned social 'counter-attacks' by doctors represent their fears of having their professionalism attacked in a society where patients are becoming more discerning, critical, and powerful as consumers (*ibidem* 128-129).

Now, my main aim in this text is not necessarily to describe *iryo hokai* itself, but rather the difficulties doctors in Japan are experiencing with patients more generally. Although it will be my aim to show that there is significant overlap, both of these represent a somewhat different discourse, expressed in a different medium. As such, I will not limit myself to *iryo hokai* as Kurioka describes it, but rather use it as a background to understand the results of the analysis in chapter three. Thus, it seems prudent to first give a short summary of *iryo hokai* discourse, and its immediate historical background.

The book that acts as a primary reference for proponents of *iryo hokai* discourse is one with the term in its name, released in 2006 by Komatsu Hideki, titled "*iryo hokai - 'Tachisari-gata sabotaju' to ha nani ka*" (Kurioka 2007, 120). In the book, Komatsu, a doctor who practices in Japan, identifies the problematic situation of doctors with certain 'high risk' specializations leaving employment at hospitals, leading to critical understaffing that he claims is putting the medical system at serious risk of collapse. This is what is referred to in the subtitle of his book as *tachisari-gata sabotaju*, or 'sabotage by leaving'. He also discusses the causes and proposes solutions (Komatsu 2006, 157).

Now, in order to get across what is meant by 'high risk', and to therefore understand what is encouraging these doctors to leave employment (at least according to Komatsu), it is important to discuss his conception of the causes first. At the start of the first chapter, Komatsu puts it in the most abstracted terms: "There is a large gap between what patients think 'medicine' is, and what doctors think 'medicine' is"[2] (*ibidem*, 5). A summary of his elaboration is as follows. Patients tend to expect medicine to be all-powerful, and capable of curing anything (*ibidem*, 5). However, such expectations are inherently in conflict with the nature of medicine, which is ultimately uncertain in its effects, and cannot provide guarantees for a good outcome without undesirable side effects (*ibidem*, 11-13). As a result, patients, having had their demands repeatedly denied as a group, have in recent times become wildly sceptical (*gishinanki*) of anything the medical system provides them, leading to an aggressive response anytime things don't go the way they expect them to (*ibidem*, 19).

Komatsu sees the best example of this attitude in the increase of medical malpractice suits. Indeed, around the turn of the millenium and some years in its wake, there were a number of lawsuits that had a high profile in the media, in which a hospital's responsibility for patients' deaths was brought into question. While the majority of these cases end up in civil court, it is notable that many of the more famous cases were handled in criminal court instead, with direct involvement of the police (Leflar 2012 82-83).

At the time, the most common complaint about police involvement in medical affairs from the side of medical professionals was that police did not possess the medical expertise necessary to make qualified and valid decisions regarding whether a medical error constitutes malpractice or not. It was also often claimed that police intervention disrupts the very aim of medicine to improve itself, because

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[2] Any translations in this paper, such as this one, will be my own unless otherwise specified.

during police investigation the doctor's access to the scene of the accident becomes limited if not impossible, preventing in-house investigation for the purposes of preventing future mistakes. In cases where the patient's death was due to a clear and less disputable error, such as injection of a drug other than the one intended, it was claimed that bringing such matters to criminal court is unjust because it places individual blame on well-meaning practitioners, whose mistakes were due to shortcomings or limitations of the system they were working in (Gotou 2009, 883).

Similar arguments have been made in regard to civil cases, in that people in law-related careers are seen as making unqualified decisions about medical matters by those in medicine-related careers (Kurioka 2007, 118). The biggest difference in the way civil and criminal cases are perceived by the doctors who commented on them mostly seemed to be concerned with the investigative power the police has as compared to a private plaintiff and their lawyer, who have next to none, yet also have a duty to provide evidence that establishes guilt. Komatsu's chapter on the role of the police in society establishes them as a powerful force that is tasked with keeping peace by preventing violent acts. Specifically, he emphasizes that they are a force that is itself based on the use of violent measures, and as such possesses a large amount of destructive power (Komatsu 2006, 41).

Komatsu interprets this power as the element that causes people who have experienced malpractice to turn to the police when convential civil litigation is deemed an unfeasible means of getting back at the offending medical establishment or practitioner for not living up to their standards (*ibidem*, 41-42). More recently, Robert Leflar has made a similar interpretation, though from another perspective, by arguing that Japan has historically had very few checks on the authority and quality of individual medical professionals and their work, with criminal adjudication and its associated power filling in a gap on the part of such public accountability (Leflar 2012, 82-83).

Both of these authors seem to make an assumption that Kurioka observed in *iryo hokai* discourse, namely that there is an alliance between socially powerful institutions such as the media and police, and malpractice victims, against medical practitioners. Komatsu himself mentions that the police are mainly a problem because, besides aforementioned power and lack of medical knowledge, their tendency to readily sympathize with victims causes them to spring to action on their behalf too readily (Komatsu 2006, 41-42). Kurioka discusses the tendency of *iryo hokai* bloggers to criticize the way medical malpractice cases have been reported on in the media, and the accusations they hurl at popular mass media for always blindly siding with the patient or their surviving family (Kurioka 2007, 118).

Such accusations of blind alliance, criticisms against laymen commenting on the legality of medical error, and resistance against direct police involvement all give an image of the way such doctors in Japan conceive of their role in society, and the what is should mean in terms of power. First of all, the opinion that police and legal experts have no place in deciding whether a particular medical act constitutes malpractice or not could be seen as a claim to intellectual monopoly over the interpretation of medical acts. Such claims would assume that the only correct way to approach the evaluation of an act of clinical medicine is by examining the scientific actions performed, and comparing them to the standards set by a body of medical and biological knowledge about the human body, which is only understandable and editable to those who belong to the community of medical experts.

Secondly, the very questioning of this science-centric conception of medicine by those outside of the medical profession being seen as an affront to medical science and the medical profession further shows the assumptions of professionalism and the biological nature of healing in the way the motivations behind such critical looks are figured. In reference to his earlier-discussed argument that patients have unrealistic expectations of medicine to act as a panacea, Komatsu says in no ambiguous terms that a 'bloated' (*kodaika shiteiru*) patient rights consciousness is fundamentally at odds with the medical system, because medical practitioners work out of benevolence rather than a concern with legal or economic matters (Komatsu 2006, 157). This, along with the opinions discussed earlier, shows the impression that professional medicine is under attack by a result-focused society that doesn't know what it's talking about. However, claims in Komatsu's book regarding patients' reasons for being critical of medical practice are not backed by relevant citations of sociological or anthropological materials. As such, whether these claims are correct or not, they are ultimately a product exclusively of the medical discourse he is defending. Indeed, one could argue that by emphasizing that patients value physically provable results the most, he is actually uncritically projecting onto society the very biomedical discourse within which he himself works, along with its assumptions as discussed earlier.

Finally, the matter of a perceived alliance between sueing patients and the police and media can be seen as a reaction to not only the challenge to the authority of medical knowledge such an alliance represents, but also to the particular type of public visibility this form of challenge imposes on them. The sheer authoritative power of police intervention, combined with the constant surveillance of modern mass media, puts doctors who are under suspicion of malpractice in Japan into a position that John Thompson, in his discussion of politics in modernity, has dubbed the 'reverse Panopticon'. This concept is based on Foucault's concept of the Panopticon, which is a prison that is built in such a way that a large amount of prisoners are knowingly under constant, yet invisible surveillance. It was Foucault's contention that this represents the normalizing institutions of modern nation-states as discussed earlier, in the sense that prisoners in the Panopticon, knowing they could be seen at any moment, internalize the kind of behaviour expected of them to the extent that they adhere to it even when they are not being watched. Where Foucault's panopticon involves the many being watched and judged by the few, Thompson's reverse Panopticon involves the few being watched by the many (Thompson 1995, 133-134).

Thompson applied this concept mainly to politicians, who for the past half-century at least have been under close and live scrutiny of the people they represent, due to their obligation to appear and speak on such media as television and radio, where their words and actions are perceived virtually instantly by a relatively enormous amount of people. This makes their mistakes and scandals much more easily noticable to the public, forcing them to extremely cautious in the way they present themselves and their political stance (*ibidem*, 140-148).

The heavy criticism of mass media, lawyers, and police that get involved in medical matters by doctors that speak within the *iryo hokai* discourse shows that they perceive themselves to be in a similar position as the politicians described by Thompson. That is, their mistakes are made not only more visible and open to public scrutiny, but that scrutiny also takes place under a certain form of social detainment in the form of their being 'under suspicion' of malpractice, in various different senses of the phrase. Indeed, here too Komatsu's conception is that due to the aforementioned litigious nature of society doctors are now forced to stay silent while their benevolence is being treated as a crime, not being allowed to reprimand anybody even when faced with the most 'unreasonable' (*rifujin*) of matters (Komatsu 2006, 157). A sense of being in this sort of reverse Panopticon can be taken as the main impetus for those writing in the *iryo hokai* discourse, given the heavy emphasis on lawsuits and expectations about doctor's performance made by patients that are deemed unreasonable. In light of this, it would also make sense that the discourse would thrive on largely anonymous internet blogs, as Kurioka discussed.

Those writing in the *iryo hokai* discourse need not have been targeted personally by the police or the media. The bloggers, as far as Kurioka has analyzed, have referred exclusively to well-known cases they had no personal involvement in (Kurioka 2007, 126-127). As Kurioka suggests, and much like many other social movements, the discourse largely functions as a means of expressing solidarity on behalf of those affected in a time of perceived social crisis, with 'social crisis' in this case being a clash between patients and doctors on the opinion about what medical science can and should be capable of, and the feared result of this situation being that doctors will collapse under the ensueing stress to the point that the medical system collapses.

This situation resembles a paradigm crisis as described by Thomas Kuhn. His oft-cited theory on the structure of science states that it is not a linear progression of discoveries that add to a scientific field over time, but that the history of science can be divided up into 'paradigms' seperated by paradigm crises. A paradigm functions as a Foucauldian discourse in the sense that it is a collection of theories that have been the most succesful at meeting the needs of a group of people for explaining how their observed reality functions at a scientific level, and which in so doing regulate the patterns by which science is conducted, thereby indirectly influencing how and what kind of discoveries are made (Kuhn 1996, 23-24). While a paradigm is stable, 'normal' science following its models is conducted, which is the type most people intuitively think of when the term 'science' is mentioned. However, while a paradigm tends to be robust and resistant to change due to its models, it is precisely this that causes a scientific crisis to occur when strong enough evidence has accumulated to prove the fundamental assumptions of a paradigm wrong. It is at points like these that revolutionary scientific theories are sought to serve as fundaments to fit the new evidence, and when these are found and become accepted, a paradigm shift is said to have occurred (*ibidem*, 64-68 & 90-91 & 111).

Although Kuhn explained his concept of the paradigm crisis in regard to dominant discourses of scientific knowledge, rather than what one might call social expectations, the current crisis experienced within the *iryo hokai* discourse nonetheless qualifies as such a crisis. While perhaps not as fundamental a change as the Copernician theory would be to astronomy, certain assumptions about the way a system works that were functional before are now being challenged by new evidence, prompting a search for a new understanding of the principles. In this case, the assumptions being broken regard the idealized doctor-patient relationship held by doctors in Japan. The evidence breaking those assumptions is the more critical stance of patients, which is experienced by these doctors as 'unreasonable' and 'litigious'. Finally, the new model being sought after is a new form of the doctor-patient relationship, the ultimate shape of which is as-yet unknown.

The actual magnitude and influence of this paradigm crisis, and therefore its power to actually bring about a significant shift, is hard to tell, and beyond the scope of my argument. The question left open that can be answered, however, is what direction the search might be taking. As discussed earlier this chapter, several changes have already been proposed, adopted into the *iryo hokai* discourse, and enacted locally, by Komatsu and those doctors who share a similar philosophy. However, this represents but a few examples, expressed in the form of concrete ideas, at a level that is largely abstracted from the actual practice of interacting with patients they deem troublesome, exactly due to it being written from a perspective that is primarily motivated by the reverse Panopticon effect brought about by high-profile lawsuits and police intervention. What is not sufficiently explained by an analysis of *iryo hokai* as a discourse, such as that provided by Kurioka, is how doctors in Japan are influenced by its themes in their day-to-day professional lives, as they attempt to interact personally with patients.

Thus, we arrive at the main aim of this paper. I have provided an image of and analyzed one of the medical discourses in Japan that seems to be the most prominent at identifying and tackling a social paradigm crisis regarding the doctor-patient relationship. In order to get a sense of the degree to which this discourse has (or has not) influenced doctor's experiences of their clinical work, the next chapter will introduce and analyze several primary sources in which doctors in Japan discuss accounts of their concrete experiences with patients that are describes in said sources as '*komatta*', or 'troublesome'.

Chapter 3

Main Analysis - The "Troublesome Patient" Discourse

The Method

As mentioned in the introduction, I will be employing the method known as discourse analysis to make my argument. For fear of repeating myself, this method sees human communication as constructing social reality through the use of contextually significant symbols and signs, expressed through language. Language thus constructs and continually reconstructs discourses, consolidations of signifiers that are situated in a particular historical time and place, which in turn govern the possible interpretations of utterances made by those who share that discourse. Utterances can thus be said to signify more than just their linguistic content; they are made in a discursive context, and have social meaning (Locke 2004, 1-5 & 16).

Since discourses are socially constructed, they are heavily implicated in the configuration and realization of power relations (*ibidem*, 25). As discussed, biomedicine in the modern era onward has played a large role in the building of nations. The discourses associated with it in Japan, as elsewhere, define how symbolic relations of power such as the doctor-patient relationship are defined, experienced, and realized by doctors. Therefore, utterances made by doctors regarding patients will carry a certain perception of social power, which the speaker in question is asking or expecting the reader to subscribe to as well.

Discourse analysis provides a method to interpret the utterances made by these doctors, thereby learning more about the way power relations are experienced by them. Importantly, since utterances do not occur in a discursive vacuum, they have to be interpreted with knowledge of their context (*ibidem*, 5). Thus, frequent references references will be made to both the *iryo hokai* discourse discussed in chapter three, as well as the social theories discussed in chapter two.

The Sources

The materials that will be under analysis consist of articles sourced from commercial magazines that focus on subject matter of a medical nature, which are published throughout Japan and have doctors and pharmacists as their core readership. The articles were found in and retrieved from the *Ichushi* (医中誌) online database for articles and other materials that deal with medical subject matter, and are published in Japan. One of the more common euphemistic ways to refer to a patient that socially behaves in ways speakers of medical expertise in Japan tend to have trouble with is "*komatta kanja*"[3]. The articles were found using this term's rendition into Japanese characters (困った患者). They were all published in between 2007 and 2017, thereby representing a range of time that lies in between the publishing of Komatsu's book and the present year, although the majority of articles that I will focus on for this analysis were published in 2010.

None of the articles under discussion here can be said to fall directly under the *iryo hokai* discourse as discussed earlier in this paper. That is, they do not use the *iryo hokai* term, do not cite Komatsu's book at any point, and are not primarily concerned with large-scale issues such as lawsuits and 'sabotage by leaving'. Although such issues might occasionally be mentioned in passing, their focus is more on sharing impressions about confrontations with patients that were experienced in clinical situations, and giving advice on how doctors might handle such confrontations 'better'.

For the purpose of keeping a narrow scope, all articles are sourced from two related but different monthly-published magazines called *Nikkei Medical* and *Nikkei Drug Information*. These are published by the the magazine publishing company Nikkei Business Publications, which is a major subsidiary of the internationally-known financial newspaper company Nikkei. The magazines are quite similar to each other, differing mainly in that the former is targeted at pharmacists, and the latter at doctors employed in hospitals and clinics. The formed has been in publication since 1972, and the latter since 1998. According to the readership profile on the company's own website, 64% of Nikkei Medical's readership is "quite satisfied" with the content, and only just over 1% replied that they had any level of overall dissatisfaction. Although these statistics should not be taken as conclusive evidence in any way, combined with the magazine's status as a long-runner they suggest that the opinions expressed in its articles resonate with the majority of the readership on some level (Nikkei BP 2017a; Nikkei BP 2017b).

These two magazines in particular have over the years hosted a number of special features that cover the concept of 'troublesome patients'. These are always about four or five articles in length, and accompanied by a survey about 'trouble' experienced with patients that has been specially conducted for that feature, among a fairly large sample size (typically several thousand) of doctors or pharmacists.

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[3] A phrase which I will hereafter refer to by my translation: "troublesome patient"

Each of the articles discusses a different variety of 'troublesome patient' in detail, with the main body housing three detailed personal accounts and opinions given by anonymous correspondents, which is supplemented by such matters as suggestions on how to approach the variety of 'troublesome patient' in question, discussion of the survey results, and a collage of numerous very short letters also sent in by doctors or pharmacists, stating opinions and personal experiences in a couple of sentences. Finally, sprinkled in each of the specials are illustrations which depict a scene that involves at least one medical staff member and one patient interacting with each other, which is presumably meant to represent a typical encounter with a 'troublesome patient'.

The overall structure, tone, and conclusion of these specials has stayed consistent over the years. The only significant changes between these specials have been in the exact categorisation of 'troublesome patients' they choose to maintain, the layout and presentation, and the art style of the accompanying illustrations. This in itself might indicate that the conceptualization of the main issues and opinions expressed in the discourse has not significantly changed in the past decade; it certainly makes a strong case for the conjecture that the issue has not disappeared off the radar of the readership during that period.

The analysis itself will focus primarily on determining what aspects of patients' behaviour are being problematized within the articles, and by extension what sort of behaviour is expected from them. This will mainly be done by examining the way language and imagery is used to communicate experiences and opinions within the discourse of the medical community the magazine is published in, as well as to express beliefs about the desired forms of the doctor and patient roles. The object of analysis includes not only the actual anonymous accounts given by doctors, but also occasional contextual elementsy such as aforementioned illustrations and article layout. which can be interpreted as an implied elaboration on the part of the magazine editor concerning what is said in the main text, without necessarily referring to it directly.

Before the analysis proper begins, it seems prudent to mention a few matters. First of all, this analysis is not meant to criticize or judge the views or behaviours of the individual doctors whose accounts or advice will be examined, or, indeed the behaviour of the patients that they discuss. Although a discourse analysis aims to be critical, I take that to mean that it tries to understand the consequences of statements in language for configurations of power, not to blame the individual language user (Locke 2004, 1-2). Secondly, due to this being a short qualitative analysis, the opinions that will be examined have been selected due to the belief that they are the most effective at showing a general theme surrounding 'troublesome patients' that is present in one of the clinical discourses in Japan, in a relatively easy-to-digest amount of words. The aim is therefore not to suggest that these materials represent the entirety of this discourse, the variety of opinions and points of discussion expressed within it, or that it is indeed the only dominant discourse that is concerned with the doctor-patient relationship in Japan.

The Analysis

A good place to start a discourse analysis of a visual medium such as a magazine is at the same place as the reader. One way an article might attract the attention of a potential reader is by making its title have relevance to an issue the reader cares about, in a way that makes it clear to the reader that their points of view similar to theirs are being represented. The *Nikkei* series always discusses 'troublesome patients' by category, devoting one article to each 'type'. While the name they give to these types and the exact delineation between them has seen variations, the following categories have been taken as the primary topic of an article at least once, and some of them multiple times:

- Patients that claim to know better, based on information gained from other sources than the doctor.
- Patients that demand a treatment/test that they have selected on their own accord.
- Patients that refuse treatment/tests.
- Patients that stay hospitalized too long.
- Patients that demand hospitalization/check-ups for insignificant conditions.
- Patients that are problematic with financial matters.
- Parents that are too protective of their children.
- Patients that are quick to complain about the clinic's/hospital's business practices/threaten legal action.
- Patients that demand special treatment.
- Patients that have no ill will, but are difficult to deal with anyway.

There is a fair bit of overlap between categories. For example, "patients that demand special treatment" might one year be discussed as a seperate category, but in another year be discussed as part of "parents that are too protective of their children" or "patients that are quick to complain about business practices". This list in its entirety is meant mainly as an indication of the issues that these articles choose to appeal to as a way to attract readers, and which can thus be considered fairly common ways in which doctors are articulating their difficulties with patients. I will limit myself to discussing the values and preconceptions held within the discourse that such categorizations might stem from, referring to the list as necessary, and citing select examples in order to argue how the articulation of opinions on such issues shows some of the ideals held by doctors that are speaking within that clinical discourse.

As can be inferred from some of the categories, one of the major issues commonly associated with 'troublesome patients' is that they make demands about the way their treatment should go. The phrase that is ubiquitous in the primary materials under analysis is '*rifujin na youkyuu*', which translates as 'unreasonable demand'. The semantics of this phrase suggest firstly that the demands themselves are considered by those uttering the phrase to be impossible, improbable, or simply undesirable to fulfill, and secondly that those posing the demands are unwilling to make compromises on them.

Now, the idea of patients being stubborn in getting their way is of course a very general complaint that could apply to almost all of the items on the category list. It also does not tell us much about what kind of demands doctors are considering 'unreasonable', or perhaps more importantly: why. In order to give this concept some more substance, it will be fruitful to select a couple of the categories above and introduce some examples of 'unreasonable demands' within them in more depth.

The first account I shall look at was published in 2010 in *Nikkei*, and is part of an article titled "[Patients that] wield medical knowledge" (*iryo chishiki o furikazasu*), with the subtitle "[Doctors are] having trouble with self-diagnosis based on false/biased information" (*katayotta joho ni yoru jikoshindan ni konwaku*) (Nikkei Medical 2010a). This account can be said to under the category of patients who refuse tests, as well as the category of patient who claims to know better. It concerns a doctor making a home visit to a roughly seventy-year-old male patient who called in with complaints of waist pain and numb legs. The first thing that strikes the doctor is the amount of medical books lining the patient's shelves. In fact, he is struck by the man's passion for learning. However, he quickly remembers that he was told before heading to the patient's house that the old man was notoriously hard to handle due to his penchant for "only following his own beliefs". In fact, the patient had only ever been to the hospital once, at which point a certain disease was suspected, but no further tests for diagnosis ever performed.

The doctor's experience quickly gets worse from this point on. First, the patient starts talking at length about the research he has done by himself, and what it told him about his disease's progress. Then, he refuses to accept the doctor's suggestions for him to come in for tests. When the patient also complains about digestive problems, the doctor tries to explain how to deal with them, yet is promptly cut off by the patient telling him he already knows and does not need the help. The only thing the patient seems to listen to is what is written in one of his books, which the doctor identifies as folk 'medicine' of which the effectiveness has not been proven at all. In the end, the doctor is stuck listening for just short of an hour to the patient's complaints that the medicine he received at the hospital was of no use, and that visiting the hospital was therefore pointless.

The part in the narrative quoted below seems to serve as a climax, for reasons that will be discussed in a moment.

> Dr. C attempted to convince the patient to take an image test and receive a differential diagnosis, but the patient had no intent to listen, replying only with "In my studies I have found out that with the current state of medicine, my condition cannot be cured. If I myself say I have given up, can't you just leave me be?"

To this, the doctor tries once more to convince the patient that they should evaluate the state of the disease by doing more tests, because it might allow them to come up with a treatment option. However, the patient holds on to the "preconceived notion" that what he has "cannot be healed". The doctor reluctantly decides to give up, since he judges that it will only lead to trouble if the treatment turns out to have no effect.

The speaker uses rather loaded language to describe his assessment of the situation and those acting within it, which makes his opinions fairly clear. The subtitle of the article already suggests before the narrative proper starts that the opinion of the patient is going to be wrong due to it being based on 'false/biased information'. In this case, that information is actively sought out by the patient himself, who has a collection of books on various medical topics. This fact creates a moment for the doctor, in which he evaluates the patient positively for his fervour. However, he then immediately remembers a fact about this patient, which was told to him by his colleagues, and which turns the filled bookcase into plot device of a poetically ironic foreshadowing. That fact being that the patient only "follows his own beliefs".

At this point in the narrative, everything the patient says and does starts revolving around this characteristic that was ascribed to him. Furthermore, the terms used to describe his behaviour and the criticisms he is making, as well as the terms used to describe the doctor's behaviour in contrast, make it clear that this trait is an overwhelmingly negative one, and one that is seen as the driving cause of a confrontation between doctor and patient. "Even though" the doctor "tries to explain" (*setsumei shiyo to shite mo*) how to deal with digestive problems, the patient "cuts him off" (*saegitte shimau*). When the doctor "politely" (*teicho ni*) refuses the invitation to read a book on folk medicine, which, as the narrative takes time to explain, has not been proven to be effective, he "has to suffer being forced to listen to the patient's complaint" about the hospital treatment (*guchi o kikasareru me ni atta*).

The quote given above is unusual amongst the articles under discussion in that it not only gives a seemingly direct quotation of the patient's words, but also because said quotation is that of the patient stating his own motives and wishes in a very of direct way. He communicates in quite clear terms that he has given up on hospital treatment, and tries to get the doctor to accept this as well. From his complaints about the medical treatment he received and his unwillingness to go to the hospital himself, it seems plausible that the patient does not feel comfortable or trusting of being cared for by medical staff. Two possibilities concerning his active study of medicine is that it is either simply a way for him to attempt take his healing into his own hands, or that it is an attempt of him to speak to the doctor on the level of a discourse that the doctor will understand. It could very well be both.

The moment that the patient says this quotation is interesting from the perspective of the narrative, because it marks the point where the doctor starts losing the motivation to build a retort, ultimately qualifying the patient as "not having any intent to listen" because he is "taken by preconceptions that he cannot be healed". Similar articles featuring patients that are described as stubborn tend to have them requesting a specific treatment, or conversely refusing examinations because they claim to already know what's wrong with them. Such cases could be explained as a concern with effective use resources such as time and money, or a professional sense of duty to make sure a patient who is expecting to be healed does not get the wrong treatment. Yet this is not a case where the patient would be a burden on the resources of the doctor if given what he wants, nor is there any ambiguity as to his wish to be left alone. This suggests that there is another reason entirely that the doctor perceives the patient's wishes and behaviour as 'troublesome'. The patient, by both using medical knowledge in a way that the doctor does not approve of from a scientific standpoint, as well as articulating his desire to not be under hospital care, is infringing on the doctor's sense of professionalism, and its accompanying power to define what it means to heal.

The fact that the doctor fails to provide a suitable retort and decides to give up suggests that he is unable to comprehend or accept the system of values that lead to the refusal of care in a clinical environment, using biomedical methods. In a similar way to the doctors that prescribed Chinese herbal medicine as discussed by Lock, the doctor speaking in this article values healing methods in terms of the degree to which they have undergone scientific testing that proves their effectiveness in curing disease for a prototypical human body. In doing so, he is unreceptive to the possibility that the patient has a different interpretation of healing, which might involve social meaning attached to folk medicine, or as his plea suggests simply the experience that hospital treatment does not do him any good. The doctor's choice of words shows that he actively derides as mistaken preconceptions the patient's attempts to convince him of the benefits of his own choices, and his complaints about the hospital treatment being ineffective. He considers this a waste of his time.

At the end of his narrative, the doctor describes himself as being able to do nothing but sigh as he leaves the patient's house. This part cements the doctor's confusion, as he attempts to understand why the patient called him over in the first place. He reasons that the patient either wanted validation for his self-diagnosis, or just somebody to talk to. At this point, there is a heavy emphasis on a feeling of professional failure as well, since the doctor laments that he could not introduce a healing method to the patient. The narrative finishes by mentioning that the patient has since continued to refuse hospitalization.

One final aspect of this article that is interesting is the doctor's reasoning for deciding to give up on trying to convince the patient. Namely, he felt that forcibly having a patient who is taken by the preconception that he cannot be healed to take a hospital treatment could lead to trouble if said treatment ends up not working. It is never outright stated what kind of 'trouble' the speaker anticipates, making it impossible to say anything about the assumptions at play with any certainty. However, an analysis of the context in which the account appears in the magazine article might hint at how this statement was interpreted by the editor put the account where in that context.

Directly underneath the end of the doctor's narrative in the article, one can find a box of around half a page tall, titled: "Ways to deal with patients that wield medical knowledge". The text inside discusses results to a survey question that asked doctors how they are dealing with patients that "adhere to knowledge gained from television and the internet like a golden rule". The box discusses many of the same issues that the doctor's narrative made mention of. In particular, the issue of 'trouble' is mentioned using the same word (*toraburu*, a loanword from English) as in the doctor's narrative. Here, it is elaborated on to a much greater extent, explaining that "in order to avoid trouble having to do with whether you said something or not, you should record into their medical chart in detail all the patient's demands and words, as well as the contents of the explanation given against them by the doctor". It then goes on to suggest putting a special mark on the charts of 'patients that require caution', and sharing this information with comedicals, as well as rigorously having the patient and their families sign permission forms and documents explaining the state of their disease. This is all in order to make it easier to handle should complaints be submitted later on.

The suggestions given in this box suggest that its writer is concerned with similar issues as the *iryo hokai* discourse. Specifically, it advocates giving a clear explanation about the disease state of the patient. Furthermore, this explanation should be based on 'proper' medical knowledge, as a counter to the 'biased' information that the patient picked up from other sources. The rest of the box of advice can be summed up by its subtitle, which reads "gauge the patient's genuine intentions (*shin'i*), and confidently show them the proper medical information". Presumably taking the above narrative as an example of what not to do, it advises letting patients who bring their own information say their part, praising them for their work, and to perhaps consider their work if it makes sense. As the subtitle suggests, this is not in order to understand the position or mindset from which the patient is speaking, but because treating the patient this way will make it easier to succesfully communicate the 'correct' information to them afterwards.

The prevailing theme that patients are being deceived by information they find on television or the internet falls in line with the *iryo hokai* beliefs that patients are becoming more hostile because doctors cannot live up to their unrealistic expectations, and that the popular media are devoting themselves to provoking such hostility. The suggestions show large similarities to Komatsu's argument that patients should be told in fully unambiguous terms what they can expect from treatment, down to implementing his suggestion that permission forms be rigorously used. Although this box still does not exactly define 'trouble' aside from mentioning 'complaints', considering this context it is not unlikely that the discursively looming danger of being brought to court is part of what makes the prospect of 'trouble' seem risky enough for the article to suggest the measures it does, and for the doctor in the narrative discussed above to reluctantly decide to refrain from further trying to help his patient.

One of the issues to come up in the previous article is that of the patient not being willing to listen to the doctor's advice. The way the old man complained at length about the medicine he had been given from the hospital and the way he tried to convince the doctor of the efficacy of his self-chosen treatment were described as stubborn, uncompromising, and caused by preconceptions, whereas conversely, the doctor's own attempts at doing essentially the same thing were described in more polite and somewhat dutiful terms. By extension, the advice the article gave afterwards emphasized the importance of giving a patient 'wielding' their own ideas the 'correct' medical information, but simultaneously listening to what they have to say in order to make them more receptive to these ideas. At the same time, it also advised keeping records on patients that are predicted to continue being 'troublesome'.

It seems that what characterises a 'troublesome patient', at least in this article, is not merely the fact that they make demands that are impossible to fulfill, as is the contention of Komatsu, but that they protest decisions made by a medical professional at all. The hypothesis can be made that one of the key characteristics of a 'troublesome patient' in the eyes of those using that term is a lack of trust in a doctor's discretion to say what is best for them. Indeed, the column of short opinions sent in by doctors, which is contained within the same article, has a short narrative which frames a patient's asking why his cancer pain relief treatment was not being carried out according to World Health Organisation guidelines as a troublesome complaint, without specifying how the patient reacted to the doctor's reasoning. It is mainly the act of calling the doctor's discretion into question, often using medical information gained through other channels, that is the issue highlighted in such narratives.

There are some cases which show in a more explicit manner the belief that what characterizes a non-'troublesome patient' is an attitude of trust towards the doctor's discretion, or which show the expectation that such an attitude is the default one for any patient, with 'troublesome' patients being an abnormality that can be normalized, so to speak. The next article I will discuss was published in *Nikkei Drug Information* in 2007, and as such was targeted at pharmacists (Nikkei Drug Information 2007). However, unlike most of the articles in the *Nikkei* specials, the ones published in this particular issue are not a collection of narratives supplemented by advice; rather, they focus on giving the advice itself. The article in question falls under the category of patients that are problematic about financial matters, and is titled: "Patients that nag about payment" (*shiharai-meguri kuchi urusai kanja*).

This article discusses patients that demand (*yokyu*) services they deem unnecessary be left out in order to reduce the overall price. It works on the general premise that such behaviour is becoming more commonplace due to patients "becoming more knowledgable of their own rights". The person who wrote the article is a licensed pharmacist who is responsible for providing education to pharmacy staff at a large company called Sogo Medical. The main problem she points out is that many pharmacists are unable to handle complaints about payment in a calm manner, resulting in them feeling sorry for the patient, and doing the wrong thing by giving in to their demands. The reason this is considered a bad outcome by the author is that it amounts to treating patients unequally, as the act of dropping cost is based on a moral decision regarding which patients are worth pity, and which are not.

The solution she proposes is that pharmacists should learn to confidently present their service as one that corresponds in value to the amount of money it costs. This requires that the pharmacist is good at listening to the patient's complaints, and tries to understand the thoughts that lie behind them, as the complaints are not always about the money itself, and can in fact be the result of an accumulation of the patient's dissatisfaction with the way they have been treated so far.

The article does not go into further depth regarding its advice, and the summary I have just given is almost a direct translation of its entirety. Here, the assumption seems at play that patients do not primarily make complaints for reasons that relate to their opinion about the actual treatment provided or their personal situation; for example, because they are actually worried about their budget, or unsatisfied with the service itself. Instead, they complain due to the way this service is presented to them by the pharmacist. The proposed solution thus amounts to reinforcing the pharmacist's discretion and authority by adding to their list of responsibilities the duty to appeal their service to sceptical patients in such a way that they become able to appreciate its value.

This solution takes as its premise that the medical service a pharmacist provides actually has such self-evident value in its entirety, and that everybody agrees on the existence of that value regardless of their personal beliefs or circumstances. A patient's reluctance to pay can not be due to a subjective difference in the perception of value of said service, or regarding medical treatment and the medical profession as a whole, but has to be due to a failure on the pharmacist's part to present this service in a way that allows the patient to see its intrinsic value, undistracted by 'false' perceptions that stem from clumsy explanations and anger at bad service. In short, it is expected that any patient fundamentally has or will have trust in the medical establishment as a whole, and is or will be willing to pay full price for its products if they can simply be skillfully shown that this is exactly what they will receive.

Another article that was similarly about pharmacists' difficult run-ins with complaining patients makes largely the same points as the previous article (Nikkei Drug Information 2017). However, it makes the theme of trust more explicit by comparing the different amounts of it that doctors and pharmacists enjoy in society. The belief presented is that pharmacists are facing a lot of non-payment, excessive profanity, and 'unreasonable demands' from their patients because pharmacists garner a lot less of it than doctors do. The reason given for this is that, whereas doctors are popularly perceived to carry a lot responsibility in regard to deciding on a treatment, pharmacists tend to be treated as a middle-man that is just supposed to hand over the medicine prescribed by the doctor. Here too, the solution proposed is for the pharmacist to appeal their role to the patient, by showing their subjectivity and responsibility, and communicating the fact that they are doing their best to make sure that the medicine the patient is receiving will be safe and proper for their needs.

This article makes it clear that the writer believes, similarly to writers in earlier articles, that patients file complaints because they are dissatisfied with the directly visible professional attitude of the pharmacist. The belief in patients' intrinsic trust in the medical system and profession as a whole is stated rather directly by making a comparison between doctors and pharmacists, as doctors are described as enjoying such trust automatically due to their societal reputation, whereas pharmacists have to overcome the hurdle of lacking said reputation. This is somewhat different than the previous article, which stated similarly to Komatsu that it was patients' rights consciousness that was causing the issue. Nevertheless, here too the proposed way to combat the rise in complaints takes the form of becoming more competent in displaying the value of one's service. "If you cannot appeal your own role to the patient, you allow the window for the making of complaints to open. Even more so if you start stumbling and are unable to provide sufficient explanation".

The writers in the previous two articles seemed fairly confident that patients as a rule do fundamentally value good medical care over maintaining their budget. One might argue that such beliefs are either simply optimistic, or characteristic only of pharmacists who are projecting their own societal role onto an idealistic image of doctors, as the writer from 2017 seemed to do. I would instead argue that these doctors' belief in a concept of fundamental trust by patients towards the medical professionals is indicative of a more general conception of patients in the clinical discourse I am discussing as being categorizable into a Derridean dichotomy of 'good' and 'troublesome', based on whether they show a sense of value for a given medical professional's discretion over their treatment. If this conception were taken to be present, the opinions of the pharmacists discussed above would merely represent a stance on this issue that argues that all 'troublesome' patients are ultimately 'corrigible' into 'good' ones.

One narrative that shows another perception of this type of 'troublesome patient' appeared in *Nikkei Medical* as part of the article that focuses on patients "shouldering economical circumstances" (*keizaiteki jijou wo kakaeru*). It appeared in the 2010 'troublesome patients' series (Nikkei Medical 2010b), and was sent in by a female dermatologist who felt like patients were "becoming more and more neurotic about money" (*kanja ga okane ni dondon shinkeishitsu ni nattekiteiru yo ni kanjiru*). Her story concerns a man in his late 40s who came into her office with 2000 yen in cash, asking to be healed for that amount exactly. This demand flusters her a significant amount, due to the amount of time and effort that cross-checking costs with the pharmacy and calculating the total price would take. She goes on to describe the patient laying on "demands" one after the other, such as to "prescribe cheap generic drugs only", all while the waiting room is filling up with patients. The main narrative closes with the patient "unbelievably" making "one final demand", which is to write a letter of introduction to a doctor in a different city. This messes up the doctor's calculations, as the costs of accessing the health care database would make her go over the 2000 yen limit. She ends up waiving this final cost for the sake of getting it over with.

Now, this particular account is interesting for a couple of reasons. One is the fact that, whereas most doctors in other narratives such as the ones I have discussed earlier tend to describe themselves as making an ultimately futile attempt to convince a stubborn patient that their demands are unreasonable, the doctor in this account never talks back to the patient at any point, and despite thinking it might've ended if she had just said "I don't know how to make that work", decides to "give in to the demands". The reason she gives for this is that she had a run-in with a similar patient who started yelling profanity at the nurses and office staff when he did not get what he wanted, and she felt responsible to prevent that by "enduring" and "accepting all of the demands".

The situation of a female doctor expecting a male patient to become abusive if spoken against, and therefore deciding to "endure the demands", suggests that gender undertones play a significant role in troublesome doctor-patient interactions. In this case, a label of 'troublesome' and a suspicion of abusive behaviour is being explicitly put on a male patient who is described as having been "neglecting his disease", "neurotic about money", and "layering on demands" (the final one of which is emphasized by serving as a sub-header). Additionally, the patient speaks in an excessively demanding tone, using the imperative conjugation of verbs without any honorifics. The doctor's past experiences, which are likely not limited to the office, but indicative of broader social gender dynamics, encourage her to take a cautious stance based on the above three descriptions. From the doctor's point of view, the above three descriptors are all connected by a theme of disregard for the medical system, in that they either show that the patient values other considerations over receiving medical care, or that he makes doctors use their time on matters other than performing medical tests or diagnoses. Thus, abuse of the medical system is expressed with undertones of male violence.

The issue of time spent on non-medical matters is the final point I shall address for this article. By 'non-medical matters' I refer simply to any activities that an arbitrary doctor would consider to be outside of their professional purview, and therefore a waste of their working time. In this article, quite a lot of emphasis is put on the amount of time the patient's requests were taking, and how this resulted in the waiting room filling up. This emphasis on the patient taking a long time to deal with was also found in the narrative about the old man who insisted on not coming in for hospital examinations. The implication that they could be treating other patients instead seems like a fairly clear indication that doctors consider listening to patients' complaints or making efforts to accommodate requests that are not directly related to the treatment or examination itself to not be worth their time and effort as a medical professional. Indeed, many articles in the 'troublesome patients' series place a large emphasis on waiting rooms becoming more crowded while a patient is busy being 'troublesome'. This includes the earlier discussed advice in the 2010 article on patients that "wield medical knowledge", which does suggest letting patients have their say, but acknowledges that doing so "places large demands on time and mental resources" during "busy hours", and that it is therefore important to place a strict time limit on the patient.

The last article up for analysis is not from the *komatta kanja* series of specials, although it was still published in *Nikkei Medical* in 2010. It is titled "How to turn a patient into your biggest fan" (*Kanja o jibun no daifan ni suru hoho*) (Nikkei Medical 2010c). Unlike the other articles, this one was written not by a medical professional, but by a professor of 'performance studies', and aims to give advice on how doctors can communicate with patients in such a way that they will leave the office with a positive opinion of the experience. The reason I think this article falls under the angle I am taking despite not directly focusing on doctor's experiences with 'troublesome patients', is that it speaks of patients in a similar way to the discourse I have described so far, suggesting that the writer is aware of the issues being raised, and addressing those who raise them.

Following on my identification of a Derridean conception of patients in terms of 'good' and 'troublesome', what sets this article apart in particular is that it categorizes patients in similar terms, using them as descriptors of how desirable a given person is to a doctor as a patient. As the title suggests, a 'good' patient in this case is one that has potential to end up becoming a 'big fan' of the doctor. The article gives two main reasons for this being favorable. The first is that "when doctor and patient have a good relationship, they don't have to worry too much about being considerate of eachother, and can be more direct in the way they talk to each other", which then allows the doctor to understand the patient's circumstances, and give treatment that fits them. The second reason given is that a positive evaluation of their experience will motivate patients to spread word-of-mouth to their friends and family members looking for medical help for a similar problem, thereby increasing the amount of patients coming to the clinic.

The actual characteristics by which one can recognize a 'good' patient are that they explain their complaints logically, that they listen closely to what their doctor is telling them about their condition, and that their answers to questions show that they understood what the doctor is asking them. The article also provides some characteristics of 'troublesome patients', which are largely the opposite of the above. They do not listen to questions, continue talking for long periods of time without getting to the point, and they file complaints for 'very trivial things' (*goku sasai na koto*).

The article continues by giving advice on how to treat these different kinds of patient. It suggests establishing a rapport with patients that are 'good' according to the characteristics given above, by asking them primarily open questions rather than closed ones, and repeating the answers they give back to them in one's own words. This will let them understand that their doctor is listening to them and understands them, the benefits of which are explained thusly. First of all, it will cause them to properly state their own thoughts in response to an open question. Second of all, it is likely to turn them into a fan of the doctor, as stated earlier. Finally, it also increases their trust in the doctor, making them likely to listen more clearly to instructions.

On the other hand, 'troublesome patients' are best dealt with by only asking closed questions. The article considers these effective in this case precisely because they prevent superfluous things from being said, which ensures that the conversation does not liven up, ultimately making the patient want to leave the office as soon as possible. Essentially, the point is to avoid trouble by giving 'troublesome' patients the impression that their complaints will not be listened to anyway.

One particularly interesting aspect of this article is that the writer mentions that "I can't really call them this in a loud voice" (*amari okina koe de ha iemasen ga*) when first bringing up the concept of 'troublesome patients'. I have established previously that doctors that complain about 'troublesome patients' tend to emphasize the amount of their time such patients waste, as well as those patients' tendency to 'stubbornly' not listen and follow the doctor's orders. The article's advice specifies behaviours similar to these as characteristic of 'troublesome patients'. However, given the comment quoted above, and the vagueness of terms by which troublesome behaviour is defined, it is likely that the author knew the audience she was addressing, and what form of advice would appeal to them, but also perceived the statements she was making as politically controversial. tements on the topic of patient autonomy that could become politically controversial if read by the wrong people.

The characterization of 'troublesome' patients in this article as those that do not listen and talk endlessly without getting to the point is one that was applied in other articles to patients who tried to independently appropriate medical knowledge and/or tried to get the doctor to spend their resources according to a set of personal values regarding healing that did not align with the disease-oriented views of the doctor. The advice put forward in this article to make them want to leave on their own accord is perhaps uncommon. We have already witnessed several pieces of advice in which doctors were encouraged to either understand their patients' complaints to some degree, and to try to convince them that their worries are unfounded. Perhaps the angle this particular writer takes is due to her focus on 'performance', as the main benefit of the advice is explained as an increase in positive reputation, and therefore more patronage. However, it is the fact that such relatively bold and direct advice is given that makes the issue it addresses stand out. Thus, the suggestion to effectively make any patient that shows signs of being 'troublesome' feel unwelcome to the point of wanting to leave shall stand as an indicator of how severely the discussed patient behaviours are problematized in the discourse in which it is proposed.

Chapter 4

Discussion and Conclusion

The analyzed materials show that doctors writing in the 'troublesome patient' discourse tend to problematize patients that cast doubt on their professional opinions and instructions, patients that make 'unreasonable demands' regarding such matters as money and use of the doctor's time, and finally, patients that attempt to appropriate medical (or non-medical) knowledge in order to make a decision about their own treatment plan without letting the doctor use their professional discretion on the matter. Said narratives, presumably due to being targeted at a readership of colleagues, do not hide their disapproval of such behavior, describing 'troublesome' patients with loaded words such as 'stubborn', 'unwilling to listen', and 'unreasonable'.

Advice that is given within this discourse for how to handle such patients' complaints tends to emphasize presenting patients 'correct' medical information to supplant the 'biased' information they are bringing to the table. Whether it is a patient that is sceptical of hospital treatment, or unwilling to spend money, the main advice is usually to practice presentation first and foremost, so as to better convince the complaining patient that what they are claiming is incorrect, and that the medical professional in question can indeed be trusted to provide a medical treatment that is worth the money it costs.

The 'troublesome patient' discourse can be said to have some parallels with the main thrust of *iryo hokai* discourse as articulated by Komatsu. Within that discourse, patients are thought to file lawsuits or otherwise seek revenge on doctors who were not able to help them because they hold them up to an unreasonably perfect standard of competency. Both discourses see the problem as a matter of patients having an inaccurate or unreasonable impression of what biomedicine is, and what medical professionals should be able to provide. They are also similar in that the suggestions for solutions given essentially turn the problem into a responsibility of the professional first and foremost. The doctor or pharmacist is to become an educator, a businessperson, or a psuedo-psychiatrist. Whichever path one decides to follow, they all lead to bolstering the professional's privilige to define what healing is, and how it should be carried out.

I make no guarantees, nor do I even believe that these discourses hold the exact same views. In fact, comparing them makes for an interesting situation from Illich's and Foucault's points of view. That is, doctors that speak in the *iryo hokai* discourse are in effect trying to combat one of the main factors behind cultural iatrogenesis, namely the idea that medicine is ultimately capable of ending disease, while those in the magazine articles are actively supporting the social iatrogenesis of putting every matter relating to health under the purview of such a system that they now identify as fundamentally flawed. Of course, it should also be kept in mind that these beliefs do not seem to be mutually exclusive either, since for example the dermatologist in the article about the patient wanting to be healed for 2000 yen experienced extreme disbelief when the patient requested a drug 'that would instantly cure everything' (Nikkei Medical 2010b). In a sense, this is a remarkable, and if Komatsu's entirely subjective musings are to be believed rare step away from one of biomedicine's historical reasons for being economically and ideologically supported as an important part of modern power structures at the national level: the ideal of the medical professional returning society to an undiseased state (Komatsu 2006, 16-17). If we are to assume that the stated solution would thus contradict a doctor's professionalism, then how would it be resolved?

The stated reason for the necessity of such changes in the *iryo hokai* discourse is clear: Komatsu argued that patients need to know the limits of medicine so that they will be able to accept when a treatment goes awry, instead of blaming the doctor for it. In the time that Komatsu was writing his book, lawsuits were perceived as a pressing concern, causing doctors to neglect their work out of fear for being targeted. Also taking into account the emotionally loaded language used in all of the works I have discussed, there seems to be a deep sense that the doctor's benevolent role and place is being threatened by changes in society and patients, who are described as becoming more critical due to increasing amounts of rights consciousness.

The implications of such changes to those speaking in the analyzed discourses is that this makes patients vastly more concerned with the quality of healthcare they are receiving, and their doctor's ability to provide it in a pleasant and effective way. Although there is no reason to doubt that this is true as well, the conception of the issues that are making patients 'unreasonable'. The type of advice given in some of the articles shows the assumption of its writers that patients will ultimately listen and comply with what a doctor has to say, as long as he is skilled enough at saying it. Komatsu also does not question the efficacy of his method of facing patients with the hard reality of medicine's limits in the shape of a disclaimer form, and Kurioka claimed that *iryo hokai* speakers tend to claim that family members of medical accident victims are just looking for somebody to blame for their feelings of loss (Kurioka 2007, 125-126).

These assumptions provide one explanation for why promoting an honesty policy is not seen as problematic for the profession as a whole. As Illich suggested, the biomedical world view creates a monopoly on interpretation, to the point that those who think in its terms do not self-reflect on their perception of its value. They expect patients to accept medical care, because they do not believe that patients might disvalue biomedicine, its standards, or any of its associated world views and practices. If patients take issue with anything, whether it is considered a valid complaint or not, it is taken to be with the quality of service provided by the medical caregiver, and their level of professionalism.

The magazine articles provide enough evidence that doctors' and pharmacists' sense of professionalism is indeed being challenged. Patients are sometimes not listening to the doctor's orders, asking them to spend their time on non-medical matters, questioning their subjectivity and importance, or appropriating medical knowledge for their own goals. This is just what was apparent from the articles discussed here, where patients were not the main focus; the field of medical anthropology in Japan offers many more examples, as discussed in chapter one. What the analysis does show is that when such a challenge arises, the those in the discourse either locate the problem in the professional's skills, or meet it with a mixture of confusion, fear, and exasperation.

These particular discourses thus respond to the social paradigm crisis by configuring it primarily as a problem of authority over medical knowledge and control over healing methods. As we have seen and discussed, the solutions being offered aim to recover control over the professional integrity of the doctor and pharmacist roles. In a sense this could be seen as reactionary, though much of the advice there is also acknowledgement that changes in social expectations are unavoidable, and that doctors will have to adapt to them to some degree. The articles that I have analyzed naturally do not represent all that is said on the matter of social difficulties in clinical situations in Japan, nor does it even represent the entirety that is said within the discourse of articles in *Nikkei Medical*. Due to my narrow scope, covering all of the nuances accurately would have been impossible.

I have understood the doctor-patient relationship in Japan as a discursive and symbolic configuration of authority with significant roots in scientific and political westernization efforts of the modern era. As professionalized medicine in Japan today very much continues to follow the model of modern biomedicine, the changes on both sides of the relationship have to be seen in the context of international shifts in regard to social and political concepts that concern biomedicine today. As we have seen here, concepts that play a significant role are professionalism, freedom of access to information, perceptions of personal rights and liberties. On the other hand, more research is also needed to better understand how the perception of these changes is influenced by sociological aspects that find their specific substances and expressions at a more local level, such as gender dynamics and configurations of social hierarchy that might by perceived by those within them as tradition. However, those are subjects for another paper.

Conclusion

In this paper I have demonstrated that there exist a number of clinical medical discourses within contemporary Japan that for the past decade have been concerned with discussing the social difficulties that doctors and pharmacists have been experiencing with some of their patients. Those speaking in these discourses frequently explain the problem as one of patients increasingly making unreasonable expectations of the doctor's time-use and ability to cure any ailment, or simply being highly sceptical of the doctor's abilities to provide adequite care, due to patients' rights consciousness having become stronger in the past decades. This reasoning shows the influence of a biomedical world view, in that doctors are subsuming patients' motivations into such a world view's absolute valuation of itself. That is, patients are not perceived as critical of the concept of biomedicine, its assumptions and methods, or its dominance as a healing method in modern society, but of the ability of its professional agents to skillfully perform these elements.

These trends have roots in state-building ideologies of modern era nationalism, and are also at least partially brought about by and expressed in terms of more recent social movements that are not unique or isolated to Japan in main thrust, such as those regarding patient/individual rights, consumerism, and gender. This paper thus provides one local perspective on how these movements interact or conflict with established structures of power in society. However, the focus of this paper has in the absence of suitable literature regarding the doctor and patient roles in Japan been largely on the current state of affairs as observable in primary sources. More research is needed to determine how societal discourses that define these roles have taken shape in Japan historically, and thus what the issues that are being raised in them signify in a sense that is socially broader, but also more local to the national community that is referred to as 'present day Japan'.

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