

Research Article

Higher Awareness of the Need for the Education in Medical Mediation Practitioners in Hospitals in Japan

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Abstract

Overcoming the negative feelings of patients and their families toward healthcare professionals is critical to resolving medical accident disputes in Japan. To address this issue, a medical mediation model for conflict resolution has been developed and training has been provided. However, it is not studied how those who have completed the training perceive the model in the medical field. Therefore, we conducted a survey on this point. Fifty consenting participants from across Japan were asked to answer 13 questions. Each item was rated on a scale of 1 (no need at all) to 10 (need is essential). At the same time, respondents were asked to indicate whether or not they practice medical mediation. The group that answered that they were practicing was divided into "P" group (n=28) and the group that answered that they were not practicing into "No P" group (n=21), and the Wilcoxon test was used to compare the evaluation scores. In question 2 (Satisfaction with medical mediation education), the P group was 4.68 (mean) ± 2.29 (standard deviation) compared to 3.24 ± 1.81 for the No P group, a significant difference. In the other items, both groups scored 6 or more points. The items with higher scores in the P group and significant differences were six items. They were informed consent support, cognitive conflict resolution, and need for mediation education. These results show that there are differences in perceptions of medical mediation between practitioners and non-practitioners of medical mediation. The need for medical mediation education was also inferred. The study suggests the need to ensure the quality of medical mediation by providing continuing medical mediation education.

Keywords: Medical mediation, Necessity, Awareness, Education, Practitioner

Introduction

Mediation is used in a wide range of fields, including justice and education, as a means of conflict management [1]. However, it is not widely used in medicine. The reason for this is that life, death, and physical disabilities inevitably occur during medical treatment, and the accompanying loss of trust and anger strongly dominate the minds of patients and their families, making it difficult for healthcare providers to deal with such situations. For this reason, various mediation education and training programs have been conducted in healthcare [2,3]. We have developed a "medical mediation" model for the purpose of addressing this issue in the literature [4]. This model is defined as follows. It is a relationship adjustment model that supports the prevention and adjustment of cognitive discrepancies (Cognitive Imperfection) by promoting information sharing through facilitating dialogue between the patient and the healthcare providers. In other words, medical mediation is a model for consensus building based on respect for autonomy and collaborative decision-making [5].

Based on this model, we have developed a two-day training program, an educational program consisting of theory, skills learning, and role-playing [5], and have conducted it with Japanese medical professionals for more than a decade [6,7]. As a result, the program

has reduced the number of court cases involving medical disputes, improved communication between medical personnel and patients as well as between professionals, provided support for informed consent, and improved the quality of medical safety [8,9]. On the other hand, after the completion of this training program, the study of medical mediation is still left to the independent matter of each participant. Therefore, continuous training of trainees is necessary to maintain the practical and theoretical quality of medical mediation, but the status of awareness of medical mediation among trainees who have completed the training is unknown. The purpose of this study was to clarify how training completers understand medical mediation while working in the medical field.

Methods

In conducting the study, it was anticipated that there would be differences in perception of the specific content and necessity of education depending on whether or not the respondents were practicing as medical mediators after completing the training.

Working Hypothesis

Practitioners and non-practitioners do not differ in their perception of and need for medical mediation education.

Exploratory Survey Period

August 31, 2021 to September 30, 2021

Target

Hospitals with training completers throughout Japan were asked to participate. Among them, 20 facilities were selected from among those that had obtained consent for this survey from physicians at the assistant director level or above and assistant nursing directors or above at facilities that had obtained cooperation for this survey. The questionnaire was then sent and collected directly to 50 medical mediators working in the medical field at those facilities. The subjects to whom the questionnaire sheets were sent were those who fulfilled the following conditions: training completers who had attended a two-day basic medical mediation training course at least one year in the past.

Questionnaire

A 13-item self-administered questionnaire was distributed.

Respondents were asked to indicate whether or not they had practiced medical mediation to date.

Next the respondents were asked to rate their responses to each item on a 10-point scale from 1 (not at all approve) to 10 (fully approve).

Q1: Awareness of medical mediation

Q2: Satisfaction with medical mediation education

Q3: Change in feelings due to medical mediation education

Q4: Contribution of medical mediation to resolving cognitive conflicts

Q5: Contribution of medical mediation to informed consent

Q6: Contribution of medical mediation to reducing psychological burden on patients and families

Q7: Contribution of medical mediation to psychological burden of health care providers

Q8: Change in the relationship between medical professionals due to medical mediation education

Q9: Contribution of medical mediation to daily medical and nursing care (Q10 and Q11 are open-ended questions to get specific understanding)

Q10: Situations in which medical mediation is applied

(1) Post-accident response, patient consultation, medical consultation

(2) Informed consent

(3) Terminal care and decision-making

(4) Routine medical treatment

(5) All of the above

Q11: Expectations for medical mediation education (free answer)

Q12: Necessity of medical mediation in medical education

Q13: Necessity of medical mediation for medical professional

Data Analysis

Respondents were divided into two groups according to their responses of whether or not they practiced. That is, the group that practiced medical mediation was designed as a Practitioner (P) group, and the group that did not practice as designated as the non-practitioner (No P) group. Descriptive statistics were obtained for Q excluding Q10 and Q11. Next, a Wilcoxon test (rank sum) was performed, and $P < 0.05$ was considered a significant difference between the groups. JMP Ver. 14 by SAS was used for the analysis. Questions 10 and 11 were excluded from the analysis because they were intended for quantitative analysis.

Ethics

Individual consent was obtained from research collaborators and respondents. In consideration of personal information, confidential treatment was performed and researcher ethics were observed.

Results

The valid response rate was 98%. Respondents ranged in age from 30 to 65 years. The breakdown of respondents' occupations was 25 physicians, 13 nurses, and 11 medical staff (3 medical social workers and 8 clerical staff).

Table 1 shows the descriptive statistics and test results for Q1 through Q13, excluding Q10 and Q11. The scores for Q2 were lower than the scores for the other questions in both the P and No P groups, i.e., lower than 5 points indicating neither satisfaction nor dissatisfaction, indicating a low level of educational satisfaction. Although Q12 and Q13 showed significant differences, the mean differences were smaller (1.1 and 0.68) compared to the mean differences between P group and No P group of 1.44 to 2.43 in Q1 to Q5, which also showed the same significant differences.

On the other hand, there was no significant difference between the P and No P groups in Q6 to Q9. The P group scored more than 7 points, while the No P group also scored more than 6 points, which was higher than the midpoint of 5 points.

Discussion

In the United States, when a medical accident occurs, the legal process begins immediately [10]. In Japan, such a response is considered undesirable due to social and cultural backgrounds. Considering this background, we developed a Japanese "medical mediation" model [11,12]. This model is a conflict management model that focuses on the psychological reactions of Japanese people when a medical accident occurs and their responses to negative feelings toward medical personnel. This study was to clarify how training completers understand medical mediation while working in the medical field.

As shown in Table 1, Q2 indicates that, despite significant differences in satisfaction with this model with regard to educational satisfaction, the overall level of satisfaction was considered low. On the other hand, Q12 and Q13, which asked about the need for education

Table 1: Descriptive statistics for questions and P-value for Wilcoxon test.

Group	N	Mean	SD	95% CI	P value	
Q1	P	28	8.54	1.97	7.77, 9.30	0.0018
	No P	21	6.57	2.31	5.52, 7.62	
Q2	P	28	4.68	2.29	3.79, 5.57	0.0499
	No P	21	3.24	1.81	2.41, 4.06	
Q3	P	28	8.5	1.48	7.93, 9.07	0.0018
	No P	21	6.19	3.04	4.81, 7.58	
Q4	P	28	8.14	1.84	7.43, 8.86	0.0021
	No P	21	5.71	2.97	4.36, 7.07	
Q5	P	27	8.30	1.75	7.60, 8.99	0.0053
	No P	21	6.33	2.71	5.10, 7.57	
Q6	P	28	7.86	1.65	7.21, 8.50	0.3875
	No P	21	7.52	1.64	6.75, 8.29	
Q7	P	28	7.71	1.76	7.03, 8.40	0.3934
	No P	21	7.33	1.77	6.53, 8.14	
Q8	P	28	7.54	1.86	6.82, 8.26	0.0838
	No P	21	6.38	2.42	5.28, 7.48	
Q9	P	28	9.07	1.30	6.82, 8.26	0.0555
	No P	21	8.14	1.77	5.28, 7.48	
Q12	P	27	9.67	1.07	9.24, 10.09	0.0085
	No P	21	8.57	2.48	7.44, 9.70	
Q13	P	28	9.82	0.48	9.64, 10.01	0.0389
	No P	21	9.14	1.39	8.51, 9.77	

Group: P: Practitioner, No P: No-practitioner, SD: Standard Deviation, CI: Confidence interval.

The evaluation score was between 1 and 10 points. 1: no need at all. 5: neither. 10: the need is essential.

Q1: Awareness of medical mediation

Q2: Satisfaction with medical mediation education

Q3: Change in feelings due to medical mediation education

Q4: Contribution of medical mediation to resolving cognitive conflicts

Q5: Contribution of medical mediation to informed consent

Q6: Contribution of medical mediation to reducing psychological burden on patients and families

Q7: Contribution of medical mediation to psychological burden of health care providers

Q8: Change in the relationship between medical professionals due to medical mediation education

Q9: Contribution of medical mediation to daily medical and nursing care

Q12: Necessity of medical mediation in medical education for physicians

Q13: Necessity of medical mediation education for medical professionals

from a broader perspective away from the medical field, showed that respondents in both P and No P groups were strongly aware of the need for such education. These results suggest that there is a need for medical mediators to educate medical professionals and medical students about this model, as well as a need for specific guidelines and their contents when providing education in medical settings.

Significant differences in mean values were found between the P and No P groups for Q1 through Q5, which reflect specific situations in which medical mediators experience the evaluation of medical mediators. On the other hand, no significant difference was found in the observational evaluation items, Q6 to Q9, which were slightly removed from the medical mediator's own experience. It was considered possible that significant differences could be found somewhere in Q6 to Q9 from the practice of medical mediations. The reasons for the lack of differences may be that

the questions were not specific enough, or that the emphasis was placed on the results, which may have resulted in a slight psychological burden or a change in the relationship that was not noticed.

The scores of the No P group in Q6 to Q9, where no significant differences were also found, showed more than 6 points. This suggests that the psychological burden on patients/families and health care providers, the relationship between health care providers, and the possibility of contribution to daily medical treatment and nursing care are seen in the medical mediation model.

In this study, the decision of whether or not to practice medical mediation was made by the respondents themselves, a subjective judgment. It is assumed that this influenced the results. It would have been more appropriate to clarify the distinction between practicing and non-practicing and to ask respondents to answer each question.

The remaining 30% of the No P group thought that medical mediation would not be used at the end of life. The results of this study suggest that the usefulness and necessity of medical mediation can only be realized when it is actually used in medical practice. Even if the participants understood the necessity of medical mediation, there was a difference in their perception of its suitability for practical use. In addition, the study population was small, and further study with a larger number of subjects is needed.

This study revealed that awareness of medical mediation and evaluation of the necessity of medical mediation was high among practicing medical mediators. The study also suggested the possibility of a medical mediation model as conflict management that includes psychological content in the medical field.

Conclusion

Practitioners and non-practitioners differed in their perception and need for medical mediation education. Continuous education and training for those who have completed training is necessary. The content of the training should focus on specific issues faced in the field.

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