CIVILIAN MEDICAL ADVOCACY PACKAGE

DoD Civilian Families in a Healthcare Crisis

7 December 2022

SUMMARY AND MODIFICATIONS

This is the third version of the Japan Civilian Medical Advocacy Package, written to request advocacy for more than 10,000 Department of Defense employees and family members [56, 64] serving in Japan who had access to medical care and medication management stripped from them with the implementation of Defense Health Agency (DHA) protocols.[1, 52, 54, 56, 63, 73.] Those affected include mission-essential staff, teachers, veterans, engineers, designers, hospital providers and staff, logistics, and more. This letter compiles research on the health and security risks associated with reliance on the Japanese healthcare system for medical care. It also proposes short and long term solutions.

Japan Civilian Medical Advocacy is a grassroots group of volunteers currently stationed in Japan on behalf of the DOD who realized the massive risk to U.S. government operations and to individual families due to the DHA administration reorganization of Military Treatment Facilities (MTFs) in Japan. Our mission is to regain and improve access to quality healthcare for all members of the DoD serving abroad, to uphold the standards of practices set forth by the Joint Commission, and to protect the personnel that support the mission of the U.S. Armed Forces and National Defense Strategy (NDS) of the United States of America.

BOTTOM LINE UP FRONT:

Both DOD civilians and active duty military members stationed in Japan are dependent on a foreign nation for access to medical care. The recent deterioration of access to care for civilians in particular means that patients are exposed to greater risk of denials of medical care even in life threatening emergencies, maternal and fetal mortality risks, improper pain management protocol, negative effects from being forced to halt prescribed mental health medications, price gouging, exposure or espionage of personal medical information, and more. DOD programs, policies, and laws which afford DOD civilians healthcare are currently being violated.

Modifications in this version include:

- An updated list of denials of medical care by Japanese facilities in 2022.
- Information on emergency care obstacles including Japanese reluctance to perform resuscitation or provide medication in ambulances.
- Information about the lack of labor and delivery options in Japan, particularly regarding vaginal birth after cesarean section (VBAC).
- Research on the negative effects of the Japanese custom of separating parents and guardians from their children for pediatric medical procedures.
- Information on the essentiality of civilian employees in Japan and their rights to medical care.
- Additional information on lack of pediatric mental health resources in Japan.
- Personal impact stories and testimonials from civilians and active duty military members stationed in Japan regarding medical care.

BACKGROUND:

MTFs on U.S. bases in Japan have stripped access to routine medical care for civilians in accordance with the 2018 National Defense Authorization Act and DHA initiatives which were supported by Congress and implemented in Japan in FY22, including DHA PI 6025.11.[42-47, 50-56, 61, 63, 73] This understaffed MTFs by provisioning them only for the amount of Active Duty military and beneficiaries,[56, 67,] leaving over 10,000 DOD civilians and their family members without access to healthcare at the U.S. bases where they live and work. Though DOD civilians have been intermittently restricted to obtaining medical care on a Space-Available basis at MTFs in the past, DHA protocols implemented in 2022 aim to "cease providing healthcare to Space-Available beneficiaries,"[73] and "offer minimal or no space-available primary care,"[73] since offering Space-Available appointments indicates to them that MTFs are over-manned, incurring resource cuts.[73] Simultaneously, the Status of Armed Forces Agreement (SOFA) does not guarantee American citizens the right to medical care in Japan. Japanese medical facilities can legally refuse care to anyone, to include both Japanese and American citizens, without recourse.[1-12, 72] This situation has already contributed to two civilian deaths [1, 14] and culminated into four areas of concern:

- Access to routine medical care,
- Access to emergency medical care,
- Access to prescription medication, and
- Poor quality of care at MTFs.

The civilian community has engaged with Medical Group Commanders in Japan, the DHA, Military Leadership, the U.S. Ambassador to Japan, the Government Accountability Office (GAO), the Joint Commission, and Congressional representatives, but no solutions have been implemented. We have run out of options and are desperate for help.

DETAILS:

Not only was civilian medical care stripped without notice at Yokosuka Naval Base, violating U.S. Termination of Care standards[66] and DHA statutory requirements[42], it was stripped in opposition to DHA's caveat that resource changes be made contingent on availability of quality medical care in the local community and impact to installation mission requirements.[42, 44] Medical Group Commanders and leadership at U.S. Bases including Yokosuka (Navy), Zama (Army), Atsugi (Navy), and Yokota (Air Force) instructed civilians to go off base for these services in 2022, claiming that these restrictions were put in place due to staffing shortages and DHA-mandated metrics.[50-56, 63] However, they neglected to inform civilian agencies and employers, implement transition plans for patients already under their care, and research the Japanese healthcare system, laws, and limitations that make access to equivalent care challenging, and in some cases impossible.[1-41, 72.] According to our research, there was no risk assessment conducted for impact to civilians and operations overseas, particularly in Japan,[44, 48] before policies stripping civilians of care were enacted. Additionally, these policies were enacted and enforced despite the Government Accountability Office (GAO) finding that civilian healthcare "was not yet adequate to support MTF restructuring".[48]

DENIALS OF CARE AND CULTURAL BARRIERS:

By Japanese law, patients can be turned away when a Japanese facility does not believe they have sufficient resources (whether medical, language support, or other), to conserve resources for their own residents, or due to preference for Japanese Health Insurance (JHI).[1-12, 72] DOD civilians do not qualify for JHI as they do not have permanent residence status.[65, 71] Civilians have been denied care in both routine and emergency situations as a result. A DOD civilian who suffered a fatal heart attack on Yokota Air Force Base in 2021 was denied admittance by 10 Japanese hospitals over the course of 5 hours. He died because he never received the medical care he needed. Between February and November 2022, civilians were denied treatment for the following medical needs:

- Emergency stabilization
- Fracture stabilization and management
- Infection treatment
- Diabetic ketoacidosis
- Cardiac arrest
- Routine infant exams
- Routine and emergent pediatric concerns
- Thyroid medication
- Asthma medication
- ADHD medication
- Anxiety medication
- Depression medication
- EpiPen medication
- Emergency EpiPen administration
- Routine behavioral therapy
- Lab work
- Postoperative cancer evaluation
- Cardiovascular disease screening
- Gynecologic exams and pap smears
- Prenatal care
- Epidurals during delivery
- Labor and delivery services
- Birth control
- Breast cancer symptoms requiring breast MRI
- Multiple Sclerosis
- Seizures
- Jaw pain
- Carpal Tunnel Syndrome
- Ear infection
- Neurological evaluation after severe fall
- Dermatology concerns
- Anesthesia dosage modifications due to patients' size or phenotype

All of these treatments and services were also inaccessible at their assigned U.S. military base. Multiple facilities including the International Medical Center of the University of Tokyo stated that no foreigners would be accepted as patients. One facility terminated care for a patient at their 20th week of pregnancy, stating they do not accept patients who take medications which could be prescribed for mental illness.[1]

Patients have a reasonable expectation that their medical needs can be met in the case of an emergency. However, in reality there is no MTF in Japan capable of handling major emergencies [64, 68, 94] and the MTFs are not well-versed in the capabilities of the local Japanese hospitals.[1] The potential for significant threat to civilian life is likely to occur under the current system. For example, there is no cardiologist on any U.S. base in Japan, so if a civilian has heart disease (the leading cause of death in the U.S.) they must be transferred to a Japanese facility and can be denied care.[1, 68] This risk also applies to all active duty military stationed in Japan. An active duty military member was denied care in a medical emergency by three consecutive hospitals as recently as November 2022[1]. This situation is not a symptom of the Covid-19 pandemic, which could resolve itself in time. Even in 2010, 16,381 Japanese patients in serious condition were refused admission by hospitals three times or more during ambulance transport.[7] Subsequently, options for care in Japan are limited in a healthcare system that has struggled to meet demand for years and routinely denies patients based on language barriers, residency status, and insurance.[2-12, 72]

Cultural differences between U.S. and Japanese medical care present challenges.[17-21, 72] Japanese doctors are not required to share medical information with a patient, including medical records, options for treatment, or itemized bills.[21,22] Common cultural practices include not sharing terminal or serious diagnoses with patients, preventing parents from visiting hospitalized children, and selecting care strategies without consulting patients.[21] While medical history is protected by Japan's major data privacy law, the Act on the Protection of Personal Information (APII), almost no HIPAA-equivalent protections exist, exposing patients to security risks associated with a lack of protection of personal information.[17, 23] Additionally, Japanese hospitals may set pricing for foreigners with no cap[12] and routinely charge foreign patients at least twice that of what a Japanese patient would pay, making U.S. patients vulnerable to price-gouging.[4, 78] Because DOD civilians are beneficiaries of federal plans, inflated claims and redundant visits end up costing the policyholder, and in turn, the U.S. Government (who pays on average 72% of premiums[13]). Considering the DHA was incepted as a cost-reduction measure, forcing DoD civilians to endure costly, risky medical care while simultaneously announcing DoD agencies must constantly monitor, report, and assess the healthcare situation for incoming employees for every deploying zone negates the notion that eliminating civilian care is a cost-effective or warranted decision.

Pain management practices in Japan allow for colonoscopies, sutures, and other procedures to be done without anesthesia and limited pain medication after surgery.[1, 19] Ambulances in Japan are reluctant to practice resuscitation and regularly do not involve patients in do not attempt resuscitation (DNAR) decisions.[83] Even when staffed with paramedics, ambulance staff will not administer medication to patients without prior authorization from a doctor licensed in Japan. [86] In 2022, a civilian patient reported that Japanese ambulance staff refused to administer an EpiPen to a child in anaphylaxis because they were unable to reach a Japanese doctor to authorize it. The parents resorted to pleading with other community members for an EpiPen and administering it themselves.[1]

The relatively homogenous Japanese population suffers from far rarer instances of conditions like sickle cell anemia, obesity, and some cancers, meaning they lack important experience with common health conditions for Americans, increasing the risk of medical errors. Foreign residents in Japan experience a higher mortality from diseases such as diabetes and renal failure than do Japanese citizens.[72] As noted by the U.S. Embassy in Tokyo, "English-speaking physicians and medical facilities that cater to U.S. citizens expectations are expensive and not widespread…Medical caregivers in Japan require payment in full at time of treatment or concrete proof of ability to pay before they will treat a foreigner…psychiatric care for foreigners in Japan is difficult to obtain at any price".[20]

LABOR, DELIVERY, and PEDIATRIC CONCERNS

Of particular concern are differences in labor and delivery, which may contribute to fetal and maternal mortality.[24-41] Americans suffer from different health conditions than the Japanese population, which extends to childbirth complications. For example, 16.2% of America's maternal mortality rate is due to cardiovascular disease.[37] Episiotomies are more common in Japan, in contrast with American standards where episiotomies are only recommended when absolutely necessary.[31, 40] Epidurals are not available at most hospitals and clinics in Japan, whereas an epidural is the most common pain relief utilized in labor in the United States.[32,33] In the United States, vaginal birth after cesarean delivery (VBAC) is a supported practice. Women who proceed with VBAC are less likely to experience birth-related morbidity than women who have repeat cesarean sections.[80] DOD civilians in Okinawa, Japan, were stripped of access to on-base obstetrics services without warning in October 2022, requiring them to give birth at Japanese facilities. Consequently, pregnant patients discovered that there is not one Japanese hospital capable of or willing to support a VBAC delivery, forcing VBAC candidates to assume the risks of unnecessary surgery if they do not elect to medically evacuate.[63] Many Japanese hospitals do not allow husbands, partners, evidence-based professional support persons such as doulas, or translators in delivery rooms. Skin-to-skin and allowing the baby to remain in the room with the mother is also uncommon.[83]

Prenatal vitamins are not typically recommended despite their prevention of neural tube defects.[27, 31, 35] Japanese facilities do not offer Vitamin K injections; they provide oral Vitamin K, which is far less effective in preventing neonatal brain bleeds.[24] Neonates are typically submerged fully in the water after birth in Japan, in direct contrast to American standards where an infant's umbilical cord site is not bathed until the umbilical cord falls off to prevent infection.[31] Detailed ultrasounds are not performed at prenatal visits in Japan (or read by radiology), causing concern that significant prenatal diagnoses could be missed in utero.[32, 39, 41] Additionally, Japan offers only half of the pediatric development wellness checks recommended by the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP). Well child evaluations are essential for assessing growth and development, for ensuring early access to interventions, and for maintaining compliance with theCDC vaccination schedule.[73, 75, 76]

The difference in pediatric emergency care in America versus Japan is also striking. The AAP recommends allowing family members to be present for procedures in an emergency setting (such as suturing, stapling, etc). This has been demonstrated to decrease distress in pediatric patients.[81] Parental presence during pediatric procedures in the emergency setting is neither guaranteed nor encouraged in Japan. This has been reported both in case studies and anecdotally by DOD civilian patients in Japan in 2022, where children have undergone suturing without parental supervision or presence. One study on

parental presence during pediatric emergency procedures found that in Asian cultures, "the majority of physicians and nurses preferred to perform invasive procedures in children without parental presence".[84]

INACCESSIBLE PRESCRIPTIONS & MENTAL HEALTH CHALLENGES:

Many ADHD medications are illegal in Japan, as are OTC medications including Tylenol Cold, Nyquil, and Sudafed.[20, 70] Japanese facilities refuse to prescribe legal ADHD medication such as Concerta, claiming that it is illegal to provide it to a non-Japanese citizen.[1, 16, 18] Japanese facilities have also denied EpiPens to non-Japanese citizens due to a years' long shortage.[1] Note that when approached, facilities often agree to provide services but later rescind.[77] Resources for pediatric mental health are sparse; a 2020 UNICEF report found that Japanese children were rated as second-worst in mental well-being among 38 developed and emerging countries, with suicide remaining the leading cause of death for children and adolescents, a shortage in child psychiatrist and child behavioral pediatricians, and little progress made in access of care for children needing psychiatric services.[85] Yokota Air Force Base recognized obstacles to getting ADHD medicine and re-instated access to it, but this service is subject to change, is only available for existing diagnoses, and is only available at Yokota, which serves only ~3,000 of the affected 10,000+ civilians.[64, 62]

MTFs allow civilian patients to fill prescriptions written by a U.S. licensed doctor at their pharmacies, but the new policies do not allow them to make an appointment with an MTF doctor to get the initial prescription or request refills for current medications.[52, 54, 56] Some prescription medications cannot be mailed to Japan from other providers due to customs and legalities.[58, 70] Some prescription medications can be brought to the country by people traveling from the states, but only in 30-day supply. Common insurance companies cannot provide long term prescriptions.[57, 59] Civilians and their children are rapidly running out of critical supplies.[1, 56] MTFs also allow civilian patients to access some specialty clinics, but the new policy ensures that civilians cannot see a primary doctor to get the referral required to see any of these specialists.[52, 54, 56]

Civilians reported these challenges back to medical leadership at U.S. Bases across Japan, who are well-aware of the possibility for denials of care. Yokota leadership response was that since COVID-19 has improved they have noted "fewer" denials and that civilians should continue to seek care off base.[56, 64] Yokosuka leadership was not aware of the legal issues of mailing medications which are controlled or illegal in Japan, despite the Status of Armed Forces Agreement (SOFA) clause which states that the United States will ensure that controlled or illegal goods not be imported to Japan by or for members of the U.S. armed forces or civilian component.[65] Additionally, they instructed patients to utilize their private insurance policies to secure telehealth appointments for routine care and prescription medications. However, according to insurance companies Blue Cross Blue Shield (BCBS) and the American Foreign Service Protective Association (AFSPA), this is a non-viable solution due to U.S providers' state licensing regulations, Japanese law, and provider contracts.[56-59, 62, 95, 96] Neither insurance company's providers can diagnose or prescribe in Japan, nor can they ship controlled medications to Japan, even on plans tailored for federal employees living abroad.[62, 95, 96] The Deputy Commander of Yokota's Medical Group noted that creating agreements with local hospitals to guarantee acceptance of civilian patients without changes to SOFA would be "a miracle", and though they are working towards one, an agreement would not be enforceable.[64] The XO of the Yokosuka Naval Hospital noted that no warning was given to the local community prior to the policy

change.[56] Local facilities were unprepared for the influx of new patients and patients are reporting denials of care in haste.[1]

CIVILIAN WORKFORCE ESSENTIALITY AND RIGHTS TO HEALTHCARE:

DOD civilian employees have performed essential roles and inherently governmental functions in support of U.S. government and military operations in Japan for decades. It is DOD policy to identify and rely on a mix of military members and DOD civilians to meet global national security requirements.[92] According to the 2008 National Defense Strategy (NDS), "Greater civilian participation is necessary both to make military operations successful and to relieve stress on the men and women of the armed forces. Having permanent civilian capabilities available and using them early could also make it less likely that military forces will need to be deployed in the first place".[93] NDS objectives serve as links between military activities and those of other government agencies in pursuit of national goals. Therefore, it is imperative to remember that the National Defense Strategy goes beyond assuming control of military health operations. DHA announced it was "fully responsible for health care delivery in the Department of Defense" in 2022[74] and the DHA mission statement states that it supports the NDS,[67] yet it neglects civilians despite their irreplaceable role in the NDS. During the 2011 Japan earthquake and tsunami, teachers were unable to leave the country due to their status as mission essential personnel. However, under the current policy, these mission essential personnel are not being provided the necessary medical care to stay in-country in the event of a natural disaster or other major crisis.[79]

The research of this volunteer group indicates that civilian employees must be afforded medical care according to DOD programs and instructions including Force Health Protection, Force Health Protection Quality Assurance Program, Comprehensive Health Surveillance, and Individual Medical Readiness, which state that the DOD will promote, conserve, and restore the mental and physical well being of civilian personnel and, to the extent required in contractual language, contractors, to include comprehensive, continuous, and consistent health surveillance in support of military activities and operations.[87-92] According to DODI 6000.19 and section 717 of the NDAA for Fiscal Year 2017, primary care services may be provided to non-military patients by civilian or contractor personnel if they are necessary to maintain DOD medical education and training programs or to accomplish operational requirements.[87, 93] Finally, according to DODI 6025.23, DOD civilian employees can be designated as eligible for occupational health care services required by the DOD as a condition of employment or involvement in any particular assignment.

QUALITY OF CARE ISSUES:

The immediate resolution to access issues would be to allow civilians full access to medical care on base, similar to the support services they receive for housing, groceries, and recreation. While this action is requested by the civilian community, MTFs on bases across Japan suffer from such extreme quality control issues that receiving care at MTFs can be life-threatening. For example, in a survey of 80 patients about their care MTFs in Japan during the last 18 months[78], misdiagnoses and administrative errors resulted in the following medical issues:

- Overlooked breast cancer requiring immediate mastectomy.

- Misdiagnosed eye disorder requiring immediate surgery.
- Heart failure misdiagnosed as allergies requiring emergency surgery and resulting in life-long disability.
- Misdiagnosed ectopic pregnancy resulting in major dysfunction.
- Misdiagnosed and mistreated joint pain causing permanent and irreversible bone damage and loss of function.
- Misdiagnosed stomach pain which required emergency surgery for removal of a 12-inch tumor.
- The aforementioned fatal heart attack patient initially had his morning chest pains triaged by a non-medical professional manning the hospital appointment line as "probably covid, just stay home." When he suffered a second heart attack, violations of emergency transfer protocol ensured that transfer was not initiated for more than an hour after he arrived at Urgent Care.
- Medical records were not updated despite several corrections from patients.
- Lack of responses from MTFs to dozens of patient-initiated communications.
- Finally, a patient committed suicide after being denied mental health care or referral when requested.

These experiences indicate a high probability of other unreported misdiagnosis and malpractice within our base communities. Many of the above patients attempted to contact their medical leadership with concerns but did not receive any response, which violates the facilities' most basic standards.[69, 97, 98] Some patients reported violations to the Joint Commission, which accredits the MTFs, but it is exceedingly rare for the Joint Commission to remove accreditation even in the event of confirmed major malpractice.[79]

POSSIBLE SOLUTIONS:

Because no single solution addresses all four issues mentioned above, implementing multiple changes is necessary to secure quality medical care equivalent to American standards for the affected population. Below are solutions that could alleviate the current risks to civilians and their families. Whatever solutions are enacted, they must not detract from the services available to active duty military members, nor should they place strain on the hard-working medical professionals supporting the base population. Rather, sufficient resources must be provided for all parties.

- Change the mission of DHA to include civilian populations overseas, addressing access to routine care and prescriptions.
- Renegotiate the SOFA agreement with the Japanese Government to include guaranteed medical care for civilians, addressing access to emergency care.
- Designate Japan as a post provisioned with annual return travel due to lack of adequate medical care via the State Department's Office of Allowances. Some civilian commands currently provide return travel from Japan on a two- or three-year cycle, which is not sufficient to address routine care needs now that access on base has been stripped.
- Hire civilian healthcare providers to serve the civilian workforce in Japan, addressing access to routine care, prescriptions, and quality of care.
- Provide TRICARE benefits to civilians at overseas posts with poor access to medical care,

allowing them the same on-base access and off-base network that active duty and their dependents receive. This addresses access to routine care, prescriptions, and possibly quality as more TRICARE enrollees would afford more resources to the MTFs.

- Implement more strenuous quality care checks including monitored feedback requests sent directly to civilian patients after care.

Short-term solutions to bridge the gap while long-term solutions are implemented include:

- Create a dedicated pharmacy email or electronic system for stateside and telehealth providers to email prescriptions directly to MTF pharmacies. This will allow civilians and their dependents a stop gap option to get necessary medications refilled using established stateside providers and telehealth options.
- Create a process by which stateside and telehealth providers can place lab orders directly with individual MTF labs for management of chronic illnesses and medication management.
- Create monthly clinics for medication management and refill for civilians. An example of this can be found at Yokota where an ADHD clinic has been set up to receive medications not available on the economy.
- Allow self-referrals to specialty clinics that are available to civilian employees. The current referral-based system allows civilians to see specialists but prevents them from seeing the first-line providers necessary to get a referral to those specialists.

Please accept our deep thanks and appreciation for taking the time to hear our concerns.

Very Respectfully,

Japan Civilian Medical Advocacy Members

MEDICAL TESTIMONIALS

Below are specific examples demonstrating the barriers SOFA members have experienced obtaining quality healthcare on and off base in Japan.

1. Medical Request: 374 MDG at Yokota Air Base called 10 hospitals for assistance with a patient in cardiac arrest. 10 Japanese hospitals denied the patient medical care over the course of 5 hours, resulting in the patient's death. Quote from the widow of the patient: "I asked the doctor, 'if my husband had been active duty military, would they have saved him?' The doctor replied, 'No. The issue of Japanese facilities denying care has been a danger for decades.'

2. Medical Request: Yokosuka member required neurological evaluation for a severe, work-related head injury in Japan. USNH Yokosuka refused to provide follow-up treatment. All facilities on mainland Japan were contacted through Japan's international health line and through multiple, individual providers who attempted to assist after USNH Yokosuka's refusal. All facilities contacted denied any appointments, evaluation, or treatment. Patient's condition worsened to include loss of vision, loss of hearing, and decreased cognitive function.

3. Medical Request: A child at Camp Zama had an allergic reaction and required Epi Pen administration. A Japanese ambulance refused to administer any medication without doctors' orders. The child was experiencing anaphylaxis; the family pled with the Camp Zama community for assistance, and a SOFA member provided a spare EpiPen for administration.

4. Medical Request: A six-year-old child at Yokosuka required medical care for diabetic ketoacidosis (a life-threatening diabetic complication). Yokosuka ER has no pediatric endocrinologist on staff and did not have the capabilities to treat the child. They began an insulin drip and called Japanese hospitals on behalf of the patient. Five hospitals denied assistance over multiple hours before he was finally seen; the parent reported the child was severely ill and almost comatose.

5. Medical Request: A Kadena Air Base resident was experiencing possible breast cancer symptoms, including a growing lump and bleeding nipples, for 6 months. Patient ultimately obtained a mammogram and ultrasound (scheduled approximately one month after the initial request for imaging). Radiologist said results were unclear and recommended a surgery consultation. Referral was never placed and it took three months of self-advocacy to make the appointment with the surgery department. The consulting surgeon recommended an MRI. Camp Foster does not do breast MRIs, and referral management would not assist with off base referral. Patient found one Japanese facility that offers second opinions without requiring a referral, but requires the patient to hire a translator for the appointment, to fax or mail an application for a second-opinion request, to bring physical slides of x-ray and exam results to the appointment, and to bring a cash payment. Patient has yet to have this issue resolved due to barriers to medical care.

6. Medical Request: Multiple barriers exist for pregnant women in Okinawa to obtain medical care during their pregnancy and for delivery services, resulting in some women flying to the states for delivery or requiring medical evacuation. One Japanese facility terminated care for an established patient in their 20th

week of pregnancy because of the hormone medication the patient was taking, which was disclosed to the facility during the 7th week of pregnancy. The facility insisted that because the hormone medication can be prescribed for mental illness, they would not continue care because they do not accept ‘mentally ill’ patients. The patient hired two translators to contact approximately 50 Japanese facilities and was rejected by all but one. She is now scheduled to undergo a C-section despite her wishes to deliver via VBAC. Patient quote: “No family should have to hire a translator to contact approximately 50 Japanese medical facilities and desperately try to obtain pregnancy care. No patient should have to stop taking prescribed medication in order to get care. This family and this pregnancy have been negatively impacted by this situation.”

7. Medical Request: A patient at Yokota Air Base experienced myocarditis (inflammation of the heart muscle), and received medical care on base. Patient asked how to handle this issue in the future, as they live off base. Staff said "just call 119 and make noises and they will come get you eventually." Japanese ambulances cannot triangulate location and need to be given an address, often in Japanese. Patient informed Yokota's Medical Group Commander in a public forum of the inaccurate information and provided a correction; the commander did not take notes or indicate any action would be taken to correct misinformation, or provide further information for patient safety reporting mechanisms or quality of care review options. Personnel should have training on how to work with local hospitals, ambulances, and provide accurate information and expectations to inquiring patients. Patient quote: “The medical staff at Yokota didn’t bother to research or understand the medical system and climate that their patients often have to navigate, and the resulting misinformation that they negligently spread could cost someone’s life.”

SUPPORTING DOCUMENTATION

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