LEGAL CONTROL OF MEDICAL PRACTICE: A COMPARATIVE PERSPECTIVE, CANADA AND JAPAN

by

Tetsuya Aman

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF LAWS

Faculty of Law
University of Manitoba
Winnipeg

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

LEGAL CONTROL OF MEDICAL PRACTICE:

A COMPARATIVE PERSPECTIVE, CANADA AND JAPAN

by

Tetsuya Aman

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

of

MASTER OF LAWS

Abstract

This thesis defines the general nature of health care services and examines some issues of medical practice controlled by the state which are related to an individual right to health care. Occupational control of health care professionals, especially doctors, is the main focus of this thesis. Their legal liabilities are discussed, as well as medical licensure, from a comparative perspective that examines differences in health care systems between Canada and Japan.

First, a general framework for the scheme of medical practice control is established. Chapter 1 discusses rationales for controlling medical practice with reference to the quality of health care, as well as to the justifiability and efficiency of the health care system. It also analyses sociological aspects as background to legal control and to the actual functions of the controlling scheme. The influence of public health insurance on medical practice is discussed, as well as its inherent problems.

Chapter 2 discusses select issues in the control of medical practice. The first is the licensing of doctors and other health care professionals. The definition of edical practice is thoroughly examined. In addition, the different perspectives in judicial processes are made clear by reference to a case in Japan. The legal duties of doctors are discussed as involving quality assurance through judicial process and legal precedents. It compares the strategies of Canada and Japan in terms of constructing the duties, which reflect the differences between common-law countries (Canada) and civil-law countries (Japan), as well as differences of culture between the two countries.

Table of Contents **Page**

Abstract

This thesis defines the general nature of health care services and examines some issues of medical practice controlled by the state which are related to an individual right to health care. Occupational control of health care professionals, especially doctors, is the main focus of this thesis. Their legal liabilities are discussed, as well as medical licensure, from a comparative perspective that examines differences in health care systems between Canada and Japan.

First, a general framework for the scheme of medical practice control is established. Chapter 1 discusses rationales for controlling medical practice with reference to the quality of health care, as well as to the justifiability and efficiency of the health care system. It also analyses sociological aspects as background to legal control and to the actual functions of the controlling scheme. The influence of public health insurance on medical practice is discussed, as well as its inherent problems.

Chapter 2 discusses select issues in the control of medical practice. The first is the licensing of doctors and other health care professionals. The definition of edical practice is thoroughly examined. In addition, the different perspectives in judicial processes are made clear by reference to a case in Japan. The legal duties of doctors are discussed as involving quality assurance through judicial process and legal precedents. It compares the strategies of Canada and Japan in terms of constructing the duties, which reflect the differences between common-law countries (Canada) and civil-law countries (Japan), as well as differences of culture between the two countries.

Introduction

This thesis examines how medical practice[1] is controlled in relation to health policies of the state. Medical practice is, after all, nothing but a certain form of service provision for clients, *i.e.*, patients; however, its relevance to the life and health of a human being makes it outstandingly significant. This thesis, therefore, is intended to clarify this nature and to examine some issues of medical practice controlled by the state. In addition, differences between the health care systems between Canada and Japan are explored in order to add a comparative perspective.

Health policy is roughly divided into three categories: **health insurance policy**, which deals with financial matters such as health insurance; **health promotion policy**, which deals with such matters as campaigns against tobacco, drugs, etc.; and **health delivery policy**, which deals with such matters as planning a general framework for the health delivery system. Among several forms of legal control over medical practice, this thesis initially discusses the occupational control of health care professionals, particularly by licensing, which falls under the category of health delivery policy. Occupational control in the health care field has its own significance. Its regulatory aspect gives it the power to have direct influence on the quality of services provided by health care professionals unlike, for example, subsidies for certain fields of health care, that initially decide only the nature of its delivery system. Its universal aspect extends to the geographical area of its influence unlike, for example, hospital regulations that are

---

[1] The definition of "medical practice" or "practice of medicine" is discussed in Chapter 2. It is enough here to put it as what medical doctors do, with co-operation of other health professionals, in hospitals or clinics. An important point is that it is to be regulated by the state for the sake of public welfare, which is discussed more in detail in Chapter 1. In addition, in this thesis, the words "medical practice" and "health care" are used interchangeably in most cases, though "health care" is sometimes used in order to express a more general meaning. "Medicine" and "medical science" are purposely used when scientific aspects of medical practice have to be emphasised.

enforced only within hospitals.[2] Most importantly, regulations governing doctors are examined in this thesis because they take a major role in defining the nature and quality of health care services and to a great extent affect the direction of public health policy in general.

Occupational control of health care professionals is usually done by legislative and administrative bodies of the state, including delegated agencies, especially in the case of the licensing and disciplining of professionals. Statutory laws, on which they are based, are made by legislative bodies and are enforced by administrative organs through such measures as regulations.[3] However, this thesis also considers the role of judicial bodies contributing to quality assurance, not only through determining exact meanings of the provisions of legislation but also by imposing the duty of care and skill on doctors by way of legal precedents. This form of control is also discussed separately in the second chapter.

In addition, this thesis deals with the health insurance policy of the state. Extensive literature shows that the health care industry is very labour intensive; for example, on average, the personnel expense as a proportion of the total expense of health care costs in hospitals is 50.4% in Japan.[4] This figure indicates that occupational control is significant also from a financial point of view. And more importantly, any achievement of universal public health insurance inevitably has brought about a

---

[2] Ontario: Health Professions Legislation Review, *Striking a New Balance: A Blueprint For The Regulation of Ontario's Health Professions* (Toronto: Queen's Printer, 1989) at 5.

[3] Of course, there is also a role for courts in relation to licensing and discipline because they are the final place to authorise or reject actions of legislative and administrative bodies. However, this thesis focuses on legislative and administrative functions, in terms of such medical licensing and discipline, in order to handle their sociological aspects more easily.

[4] The Central Social Insurance Medical Council of Japan in 1991: Y.Hiroi, *Iryo No Keizaigaku* [Health Economics] (Tokyo: Nihon Keizai Shinbun Sha, 1994) at 150.

transformation of medical practices. This has been forcing medicine to adjust to economic realities, hard though they are to reconcile with one another.[5] As stated in Chapter 1, the budgetary control of medical practice enables the government, in some measure, to control health professionals, especially doctors, through its spending power. Thus, the public budget has become a significant part of controlling health care, over and above the licensing or discipline of professionals. It makes sense, therefore, to make an analysis on public health insurance as a supplemental issue, though it is not a legal control *per se*.

Therefore, while Chapter 1 deals more with what law *does*, Chapter 2 deals more with what law *is*. In Chapter 1, the functions and characteristics of law are examined, rather than the legal principles that actually operate in the health care field, which are discussed in Chapter 2. In a sense, Chapter 1 is based on a legal functionalist perspective. Law is defined as the use of the state coercive mechanisms in controlling society for the sake of certain goals, or as a tool of social engineering. Still, this thesis also examines the goals themselves and their relationships with the functions of law. More importantly, those functions of law are related to other disciplines: economics, sociology, political science, and medicine. They are to be integrated with a legal analysis of the control of medical practice for the sake of the national welfare. Gall writes:

> ...the legal process is part of an overall complex of interacting processes that form the lifeblood of modern, western, industrial society. ...Our society can be looked at in terms of our economic system and the economic processes inherent with that system, or it can be examined in terms of our political system, including the political processes which define the nature of our

---

[5] Y. Nakagawa, *I No Rinri* [Ethics of medicine] (Tokyo: Tamagawa Daigaku Shuppanbu, 1977) at 183.

political system. Even our individual interactions as well as our group and social interactions, according to the conventional wisdom espoused in the disciplines of psychology and sociology, are also part of this overall complex matrix that we call our society. ...[The legal process] cannot be separated from other processes in that all of the processes which define our society are highly interrelated and impinge on each other with assured regularity.[6]

---

[6] G.L. Gall, *The Canadian Legal System*, 3d ed. (Toronto: Carswell, 1990) at 4.

CHAPTER 1: RATIONALES FOR CONTROLLING MEDICAL PRACTICE

This chapter provides a general framework for the control of medical practices which must accommodate many complicated factors. The whole picture is first clarified in this chapter with reference to related disciplines such as economics and sociology. In general, there are the following questions: why medical practice should be controlled? how? in what ways? by whom? to what extent? These questions correspond to policy goals, analysis of the status quo, and policy decision-making respectively, from the viewpoint of the state, which will be the main perspective here.[7]

This chapter first examines the quality of health care services, as the most significant policy goal of state intervention. The definition of terms such as health, disease and illness is examined. The characteristics of medicine with regard to its imprecise nature are also described. Section 2 analyses the status quo. It discusses the actors in the scheme of controlling medical practice: the state (legislators, administrators and judges), doctors, patients, and health administrators.[8] In addition, the doctor-patient relationship is discussed in more detail, in order to clarify interactions between the two parties.

Sections 3 to 5 present important issues in the process of policy decision-making. Section 3 discusses three basic approaches to state intervention for controlling medical practice. It is followed by a discussion of possible modifications to these approaches. They clarify the various functions of the law in controlling medical

---

[7] Pal defines the three elements of public policy as "goals," "problem definition," and "instruments." They correspond to the above-mentioned elements of this chapter respectively: L.A. Pal, *Public Policy Analysis: An Introduction* (Scarborough: Nelson Canada, 1992) at 7-13.

[8] Allied health care professionals are also significant actors in the scheme of controlling medical practice. However, in order to make this thesis manageable, they are not discussed. Instead, materials reviewed for studying them are put in the bibliography.

practice, as well as strategies of the state in maintaining the health of the nation. Section 4 examines the influence of public health insurance on the scheme of medical practice control. Its origins and rationales are discussed, and its relevance to medical practice control, which has different implications from those of legal control, is explored. Lastly, in relation to the nature of public health insurance, section 5 discusses contemporary problems of rising health care costs and controversies over the efficiency of the health care system, as well as the legal implications in such difficulties.

Section 1 - Quality of Care

The initial reason for controlling medical practice must be attributed to the quality of health care services, which ensures the health of the community at large. From the perspective of individuals, it is closely connected to a right of access to health, one of the fundamental human rights. Health is an indispensable prerequisite for pursuing one's happiness. Therefore, it must be fully ensured through due state intervention. As the World Health Organization (WHO) constitution states, "[g]overnments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."[9] At the national level, the Constitution of Japan clearly declares, in Article 25, that "[a]ll people shall have the right to maintain a minimum standard of wholesome ... living. In all spheres of life, the State shall use its endeavours for the promotion and extension ... of public health."[10] Ensuring the quality of health care services is the direct and most important

---

[9] Preamble, World Health Organization Constitution, adopted by the Conference of the United Nations on July 22, 1946, came into force on September 1, 1948.

[10] There appear to be no exactly equivalent clauses in the Canadian Bill of Rights [S.C. 1960, c.44], except for Section 7 which protects "life, liberty and security of the person" by way of prohibiting harmful conduct to others. However, it still seems obvious that Canadians are fully aware of a right to

measure for the health of the community, and thus the initial reason for state intervention in that field.

In that way, ensuring the health of the community through state intervention seems to be quite straightforward. However, it leaves open many significant questions: the definition of health, illness and disease, specific measures for ensuring health, modes of state intervention, their legal implications, etc. The following section clarifies these points by exploring the nature and significance of ensuring the quality of health care services.

First, what is "health" anyway? How about "disease" or "illness"? The definition of these words seems to be taken for granted because everyone has his or her own conception of them. However, they must be objectified in order to decide the appropriate direction for state policy. Most importantly, it is necessary to assign an exact meaning to "health" because it is one of the policy goals of the state. For example, does "health" mean only the absence of disease? If so, policy goals for intervention should be concentrated on medical research and other measures which are beneficial for the scientific and technical improvement of medicine.[11] If not, other considerations should be included in deciding policy goals.

The WHO Constitution neatly explains its meaning of health. It defines health as a "... state of complete physical, mental and social well-being and not merely the

---

health that is ensured by the active interventions of governments.

[11] In North America, at least from the viewpoint of policy goals, "health" has been understood as an "absence of disease" rather than "physical, mental, and social well-being." The U.S. has, by and large, had this standpoint with respect to health policy. Money spent for medical research in the United States is by far the biggest in the world (Hiroi, *supra* note 4 at 178). These attitudes of the government interpersonal aspect of care have been an issue mainly in the courts, where medical malpractice cases are adjudicated.

absence of disease or infirmity."[12] This clearly includes, other than "physical" well-being (absence of disease), "mental" and "social" well-being in the definition of health.[13] This also reflects the difference between "disease" and "illness." Both words have meanings contradictory to "health," but their implications are different. Simply put, "disease" is an objective concept, while "illness" is a more subjective one. "Disease" is viewed solely from a scientific perspective; it suggests a certain degree of deviation from the biologically normal state of a body. By contrast, "illness" has more sociological connotations. For example, in the light of subjective self-evaluations by patients, disease has to be serious to some extent in order to be recognised as illness. Small scars on the skin, slight athlete's foot or nearsightedness. are usually not regarded as illness, though they certainly fall under some categories of disease. More importantly, because of its seriousness, illness leads to an opportunity for medical treatment, not only for scientific and medical reasons (*e.g.*, recovery from disease),[14] but also for social reasons (*i.e.*, the necessity of recovery as a social being).[15] Conversely, illness, or subjective suffering of the patient, is not sometimes regarded as disease because the symptoms do not relate to any scientific problems from the

---

[12] WHO, *supra* note 9.

[13] It is true that this definition by the WHO has been strongly criticised by many advocates, e.g., D. Callahan, "The WHO Definition of 'Health'". *Medical Ethics and Human Life*, ed. by J. E. Thomas (Toronto: Samuel Stevens, 1983)). However, I purposely employ the WHO definition because it clearly indicates that there is an "interpersonal" aspect of medical practice that doctors have to take care of, and which the following sections discuss more in detail.

[14] C. Boorse, "On the Distinction Between Disease and Illness" *Concepts of Health and Disease: Interdisciplinary perspective* ed. by A.L.Caplan, H.T.Engelhardt, Jr. and J.J.McCartney (Reading, Massachusetts: Addison-Wesley, 1981) at 553.

[15] This is not exactly a focus of this section, but it is worth noting here that the dominance of medicine, discussed more in detail in Section 2, has "medicalised" certain physical conditions into disease. This has also made lay people think that "illness" is what necessitates medical treatment. The case of hyperkinesis would be the most famous example: J.N.Clarke, *Health, Illness, and Medicine in Canada* (Toronto: McClelland & Stewart, 1990) at 169-72.

viewpoints of doctors.[16] The observation of the patients' position is left to Section 2, so it is enough to conclude here that, in the light of the discrepancy between illness and disease, the word "health" must connote not only a biologically normal state of a body, or the absence of disease, but also a value-ladened, socially constructed concept relating to illness.

Next, how to define the "quality" of health care? Consistent with the above definitions of health, disease and illness, this quality is defined through two approaches: with regard to "technical care" and "interpersonal care". Technical care reflects the scientific aspect of medical practice. Through the process of technical care, a doctor tries to solve some biological problems (disease)[17] of a patient's body with as little risk as possible.[18] Therefore, the quality of technical care is defined as: the benefit from the treatment (rate of recovery), as set against its risk (rate of adverse effect).[19] For example, coronary bypass surgery is a form of technical care for coronary artery diseases. In such a case, the benefits of the surgery should be examined, as well as its risks, through statistical data of recovery and of adverse effect (in general), and the skill and experience of the surgeon (in particular).

By contrast, interpersonal care is the process in which social interactions in a clinical setting are managed. The patient is regarded as a social being and deserves to be treated accordingly. In the same way as social relationships in general, relationships between health professionals and patients are also governed by general social values

---

[16] This discrepancy between illness and disease also juxtaposes the lay knowledge of patients with the professional knowledge of doctors. Also see Section.2-(3).

[17] See *infra*, Chapter. 2 1(3).

[18] Psychiatry would have to be discussed differently, and in detail, but this thesis focuses only on other areas of medicine.

[19] Or, considering more of the patient's subjective benefits, improved quality of life of the patient must also be included in the benefit from any treatment.

and norms, though they should be related to a particular clinical setting. In this sense, the quality of interpersonal care is defined as the degree of "conformity" to such values, norms and expectations. Significantly, as long as this interpersonal aspect of care is based on such criteria, the personal circumstances of patients must be among the important factors used in assessing quality. The scientific aspect of health relates more to the judgment of health care professionals, especially doctors; whereas the social aspect of health relates more to the subjectivity of patients, such as their own values and expectations, etc. As discussed in Chapter 2, informed consent supplies the best example of a value and norm in the process of interpersonal care. It is essentially not a matter of the technical assessment of professionals, but a matter of a patient's values and expectations in his/her own life.[20] In conclusion, these "technical" and "interpersonal" aspects of health care combine ultimately to maximise patients' health in a way which corresponds to the WHO definition.

In the actual setting of medical practice control, the next question should be how the quality of care may be evaluated or assessed. There are three major approaches in assessing quality: looking into the "structure," "process," and "outcome" of care, respectively. The first approach, "structure of care," includes the number and speciality of doctors, types of medical equipment, or other resources which form the "environment" of medical practice that helps to promote high quality practice. However, such an evaluation is only related to raising the possibility of high quality care, so it is not enough *per se* to ensure an overall quality of medical practice. In other

---

[20] A. Donabedian, *The Definition of Quality and Approaches to its Assessment*, vol.1, 1980 at 4-6, quoted in B.R. Furrow, *et al.*, *Liability and Quality Issues in Health Care*, 2d ed. (St. Paul: West, 1991) [hereinafter LQIHC] at 14. Donabedian also presents "amenity" as one of the definitions of quality of health care, but it is not discussed here because it is not directly related to the legal control of health professionals.

words, a sufficiency of specialists or expensive medical equipment only helps to ensure the quality of care; it is the "process" and "outcome" that are directly related to the quality of care and thus are more important.[21]

The second approach is in terms of "process of care". With this approach, it is the actual activities of health professionals that are examined. The technical aspect is assessed through scientific evaluation of the benefits and risks related to a specific element of practice (*e.g.*, diagnosis or treatment). The interpersonal aspect is assessed with reference to social values in general and to professional ethics. In both cases, norms of conduct are defined for a specific situation. These normative standards of conduct serve as a form of law in clinical settings, as discussed again in detail in Chapter 2.[22]

The last approach is in terms of "outcome of care". With this approach, one has to examine what has happened to the patient because of the medical practice. The outcomes would be, for example, recovery from disease, days spent until such recovery, and the happiness of the patient. This approach has some overlaps with the "process" approach because the process of care is also evaluated in the light of the outcome of the treatment, especially in the case of technical care. The difference is that the "outcome" approach directly examines what has happened to patients and evaluates the result, while the "process" approach rather looks into what the professionals did in a specific situation and evaluates it against more formalised norms of behaviour.[23] This is preferable from the viewpoint of patients because their ultimate aim is, of course, to

---

[21] *Ibid.*, at 79-84, quoted in LQIHC, pp. 18-20.

[22] *Ibid.*

[23] *Ibid.*

have their illness cured as soon as possible with the least expense. However, as discussed in Chapter 2, this approach is difficult to employ in actual clinical settings because it sometimes imposes unrealisable burdens on doctors.

Lastly, in terms of assessing the quality of medical practice, the inherently uncertain nature of medicine and its legal implications have to be noted. Simply put, there are no perfect, objectively verifiable answers to many questions in the field of medical science. White arguably says that "it is still the case that only about 15 percent of all contemporary clinical interventions are supported by objective scientific evidence that they do more good than harm."[24] This is reflected in the divergence between popular treatments for the same illness among different countries. For example, there are some drugs for dilating the cerebral blood vessels which are frequently prescribed in France but are considered ineffective in England and the U.S. The rate of coronary bypass surgery in the U.S. was six times as much as that in England, as of 1988.[25] The rate of radical mastectomy for breast cancer is still extremely high in some hospitals in Japan, even after other methods of breast-saving operations have been statistically proven to produce similar results in some cases.[26] All these examples illustrate that medical science is not an international, "purely scientific" science. If medicine was a "real" science, such as physics or chemistry, there would be no differences between

---

[24] K.L.White, "Foreword" in L. Payer, *Medicine and Culture* (New York: Penguin Books,1988) at 9.

[25] *Ibid.*, at 24-25. The author strengthens her argument, at page 18, by indicating that some of the statistics related to health (infant mortality, life expectancy, etc.) in the countries discussed are roughly the same, and concludes that the efficacy of medicine in the countries is at the same level, at least to the extent that its quality can be measured.

[26] M. Kondo,"Shujutsu Hencho Ni Igi Ari [Objection against operation-oriented treatment]" 73:4 *The Bungeishunju* (1995) at 356-57. He quoted a survey of civil organisations which reported that the rate of breast-saving operations in Japan in 1993 was 23 percent, but this figure varied very much among hospitals, from zero to over 90 percent.

countries, albeit the difference is often in the application of information. So, it seems to follow that such technical aspects of medicine are also affected by many other factors, such as the personal preferences of doctors, or customs among them. Payer tries to explain the difference by addressing reasons such as the national characters of countries.[27] Thus, such stereotyping factors might also be considered in assessing the quality of medical practice, even when an apparently technical aspect is examined.

The uncertainty of medicine, illustrated by the above examples, suggests some legal implications. Originally, legal control of the quality of medical practice was carried out through "drawing a line" between acceptable and unacceptable levels of quality, accompanied with prohibitions or disincentives against what is unacceptable. This prematurity of the medical discipline makes "drawing a line" a complicated and unstable process. This is hardly compatible with the regularity and predictability which are characteristics of law. Therefore, the legal control of medical practice is straightforward only when it is based on the above-mentioned "structural" approach in evaluation, which is the most formalised and measurable among the three approaches. For example, this approach is employed in hospital regulations, for which the "structural" approach facilitates routine inspection by the governing authority. In the case of Japan, the Medical Service Law (Law No. 205, 1948, hereinafter MSL) enforces "structural" requirements, such as the mandatory number of health care professionals in hospitals, which is decided by regulations according to the number of in-patients and out-patients. With respect to the "process" and "outcome" approaches of evaluation, the

---

[27] Payer, *supra* note 24, at 20-21.

inherent uncertainty directly affects the task of evaluation and there are many questions left to be examined.[28]

In conclusion, the quality of health care is the first reason why medical practice must be controlled. In addition, the interpersonal aspects of health care should be as significant as the technical aspect of care, which is still too often underdeveloped and uncertain. It also has to be noted that the uncertainty of medicine is a significant factor in controlling medical practice.

Section 2 - Actors and Their Interactions

This section discusses the status quo of medical practice control, or how the actors interrelate in the scheme of control at the present day. Importantly, the interactions discussed in this section are related to societal control of medical practice, as distinguished from legal control based on legislation and legal precedents. This mode of control is more like a political process which has an actual influence on the nature of medical practice. Still, it is important to examine this because any detailed analysis of the legal aspects needs a sociological examination of each related part.

The actors are: the state, doctors, patients and health administrators. They are the four distinct but inter-related parties.[29] Each actor is examined as one of the four parties under the following subheadings. In addition, in the last part of this section, the

---

[28] See Chapter 2.

[29] M.J. Trebilcock, C.J. Touhy & A.D. Wolfson. *Professional Regulation: A Staff Study of Accountancy, Architecture, Engineering and Law in Ontario prepared for The Professional Organisations Committee* (Toronto: Ministry of the Attorney General, 1979) at 35. It does not discuss the role of the state specifically, but this thesis does because the state is the third party that is the key to understanding the whole picture.

doctor-patient relationship is examined as an example of interaction between the parties.

(1) The State

The state is the only authority that has formal power to make formal laws, in a strictly enforceable sense. With respect to the scheme of legal control, the state controls others in the forms of legislation, regulation and legal precedent, which all within the jurisdiction are forced to observe. Therefore, analysing the functions of the state is the key to understanding the legal control of medical practice.

This thesis divides the functions of the state into "policy-making" and "adjudicating," discussed in subheadings (a) and (b) respectively. The former is more related to the legislative and executive functions, and the latter to the judicial function. The former takes a more dynamic role in medical practice control than the latter, as well as having different legal implications. After discussing the two modes of the state's function, they are integrated for the exploration of relationships which explain the overall position of the state in the scheme of controlling medical practice.

(a) Legislators and Bureaucrats : Policy-making

Legislators and bureaucrats are classified together as policy-making agents in this scheme. They function actively with their own policy goals, trying to direct the agenda of the country. They legislate a general framework of policy goals (legislators), or make regulations and execute those policy goals (bureaucrats). The national legislature is no longer the exclusive instrument for settling or implementing public policy.[30] The functions of legislators need not be directly discussed here, though their role and behaviour must be regarded as significant in terms of legislating medical

---

[30] Pal, *supra* note 7 at 3.

licensing schemes. The functions of bureaucrats are discussed in Section 3 in relation to institutions in charge of the licensing and discipline of health professionals.

One large difference between Canada and Japan is that Canada is a federation of ten provinces and two territories, and authority in terms of health care is held by each province and territory.[31] Therefore, strictly speaking, one has to analyse twelve health care systems separately, plus the policy role of the federal government overall, to examine the "Canadian" system. (In this thesis, the system of Manitoba represents the Canadian system, unless otherwise indicated.)

By contrast, Japan is a country of centralised power. In most cases, there is no discrepancy in areas across Japan. Therefore, it is possible to analyse the Japanese health care system as one uniform system. This difference is significant in some aspects: for example, the regionalisation of the health care system and a uniform standard of health care across the country. In Canada, conflict between federal and provincial governments in terms of health insurance is often the most significant issue. In Japan, the issue is simpler because the central government can uniformly construct a scheme of health insurance, resolving difficulties as they arise by discussion or negotiation with the national governing bodies of the health care professionals. However, in Canada, federal and provincial governments are in a conflicting relationship because the sources of funding (federal) are different from the authority with respect to health care (provincial). This relationship makes the Canadian health insurance issue a more complicated one, compounded by the relationship between the provincial governments and medical associations in each province. [32]

---

[31] The federal government is in charge of the health care system of two territories.

[32] See Section 4.

(b) Judges: Adjudicating

Judges take the role of adjudicating disputes that are brought into court. In controlling medical practice, judges play a relatively small role in terms of setting up the basic structure of health care delivery or deciding its policy goals. Instead, they formulate, by accumulating legal precedents, empirical rules that are applicable to the individual practice of medicine. [33]

Judges adjudicate between conflicting values and facts in specific cases. This necessitates the independence of the judiciary from the health care system point of view, because judges have to be strictly the "third party," a role requiring impartiality and objectivity. More concretely, the courts have to be able to act independently from other governmental policy-making agencies. In addition, individual judges have to be able to exert their authority following what they believe to be the objective meaning of the law.[34] This independence is assured in part by legislation, such as provisions restricting the grounds for removal of judges.[35] More importantly, this independence of the judiciary is followed by the system in which certain policy decisions, even if embodied in legislation, can sometimes be legitimately struck down by the court, after thorough examination of legislative facts and their evaluations, especially if not previously made clear in the record and process of legislation. This role of judges is important in the legal control of medical practice; but it cannot be initiated by them, only by persons or groups willing to go to court.

(c) Nature of State Intervention and the Relationship between Policy-making

---

[33] In terms of the role of judges, there is no substantial difference between Canada and Japan.

[34] K. Sato, *Kenpo*[Constitutional Law] (Tokyo: Seirin Shoin, 1990) at 296.

[35] Gall, *supra* note 6 at 226-45.

and Adjudicating

As mentioned above, legislators, bureaucrats and judges represent the three functions of the state that are involved in policy-making and adjudicating. What is the fundamental nature of those functions? How are they authoritatively interpreted for the legal analysis of state policy, and by whom?

Simply put, a fundamental consideration in state intervention derives from the fact that the state acts as a third party. This is well elaborated in the study of Aubert, a legal sociologist in Norway. Aubert presents the typology of "dyad" and "triad" relationships[36] and hypothesises that third-party intervention in the triad relationship offers the key to legal reasoning.

As examples of disputes between the first and second parties, Aubert presents two types of conflict: "conflict of interests," and "dissensus" over values and facts. Conflicts of interest can usually be settled by negotiation and bargaining between the related parties; while dissensus usually needs adjudication, in other words intervention of the third party applying certain norms to the case. This third party intervention, usually judicial, can form law in a simple sense, and thus holds many legal implications.[37]

Of course, conflicts of interest can take the form of dissensus when, for some reason, they are not eventually settled by negotiation but left to legal solutions. Once the conflict of interest is subject to law, and dealt with by the third party, the conflict between first and second parties inevitably becomes an objective one; they have to refer

---

[36] The "dyad" relationship is applied to interaction between doctors and patients, and the "triad" relationship refers to the situation in which the third party, especially the state, is also involved in the relationship.

[37] V. Aubert, *In Search of Law: Sociological Approaches to Law* (Oxford: Martin Robertson, 1983) at 63.

to related facts and norms in order publicly to justify their arguments. The third party, which usually means the judge, decides which side of the argument is justified upon the evidence presented. Thus, conflict of interest is ultimately settled in the form of adjudication.[38]

The analysis of Aubert basically looks into interpersonal conflict as adjudicated by judges, but his framework is also applicable to collective actions of the government.[39] In other words, legislation, as well as regulations made by bureaucrats, can work as third party intervention in conflict of interest and dissensus. Policy-makers (legislators and bureaucrats) need to play the role of judges when they design legal systems (legislation) and sub-systems (regulations). From the functionalists' perspective, law and regulation are initially recognised as instruments of policy implementation. What, then, are their characteristics? First, they function as the most coercive process of policy implementation. Secondly, because of this coerciveness, they can change existing social relationships totally. More importantly, they originate in certain fixed values in the society. For example, the statutory licensure of doctors is accompanied by a value judgment that it is risky to allow non-licensees to practice medicine, though they have are otherwise free to choose occupations. This means that the legislation of licensure functions like a verdict decided by judges, determining that one value (public safety) is superior to the other (occupational choice). It also becomes a value in society and most people cease to debate or doubt its wisdom. In these ways, such legislation defines what citizens ought to do and how society ought to be. Regulations made through executive functions are not as coercive as legislation; they

---

[38] *Ibid.*, at 69-70.

[39] *Ibid.*, at 58.

are supposed to derive their coercive force from the enabling legislation. However, they also do have truly coercive aspects as long as they "force" others to do something. Thus, law and regulations function as a verdict upon some conflict of facts or values, or both, which define the society. It also follows that policy-makers have to act like judges, comparing certain values based on facts and norms, in applying laws based on legislation and regulation.[40]

The above mentioned adjudicative perspective is a significant part of policy decision-making. However, this is only one side of a coin; the other side is equally significant, or sometimes even more significant, because it reflects the original role of the policy-makers as agents of the state. The adjudicative perspective signifies only the passive or reactive side of decision making. However, the policy-makers also need active ways of decision making based on the ends/means perspective, or the consideration of means as directed to certain ends. This necessitates the selection of both policy goals, and of appropriate and efficient tools for implementation. Elements of public policy are divided into three aspects: problem definition, goal setting and choice of instrumentality. The authorities recognise a certain problem to be solved among many public problems, reserving the power of definition and priority-making. A decision reflects what they are trying to achieve, as goal setters. And a specific measure is selected to solve the problem and to achieve the goal, *i.e.*, choice of instrumentality.[41] Adjudication is composed only of the passive side of problem defining and of an instrumental choice of legislation. However, the policy-maker duty

---

[40] Also, this analysis relates to quasi-judicial function of executive bodies, based on natural justice and the doctrine of procedural justice. See, D.P.Jones and A.S. de Villars, *Principles of Administrative Law* (Toronto: Carswell, 1994) at 178-228.

[41] Pal, *supra* note 7, at 7-13.

is not confined to that function; they also have to be active in identifying the final goals, as well as defining problems and choosing one of the various instruments.

By the same token, judges are also required to have the ends/means perspective. The traditional idea, which requires judges to apply only certain norms to acknowledged facts, still holds true as a normative model. However, there are many factors that cannot be explained by the traditional model.[42] Thus, the ends/means perspective is useful as an explicatory model for the judicial decision-making process. Judges also identify public problems to be solved, or find issues at stake among those which have been brought into court. They consider policy goals that are often based on certain provisions of the constitution or subordinate legislation, and find tools for achieving these goals in actual, written judgments.[43]

In conclusion, it can be said that the difference between the two perspectives is not as substantial as it might seem. Both policy-makers and judges have to have both perspectives. Their actual influence in decision-making is different. Policy-makers are fundamentally and literally engaged in "making policies" based on perspectives for the future and on consideration of ends and means, while their significant influence on society makes them think partly like judges. By contrast, judges, starting from an adjudicative perspective, have begun increasingly to get involved in policy decision-making, which requires adoption of an ends/means perspective.

---

[42] These factors have been stressed by many legal realists. They point out that "the outcome of a case depended largely, if not entirely, on the predilections of the judges who happened to be deciding it," not based on the necessary outcome of legal principles: S.Vago, *Law & Society*, 4th ed. (Englewood Cliffs, New Jersey: Prentice Hall, 1994) at 51. Also, in light of the cases in Japan, Hirai indicated the difference of "conflict-resolution-oriented" process and "policy-oriented" process of court procedure, which reflects that of the adjudicative and end/means perspectives: Y. Hirai, *Ho Seisakugaku* [Legal Policy Science] (Tokyo: Yuhikaku, 1987) at 8-10.

[43] See Chapter 2, Section 1-(4) for the actual case of those two conflicting perspectives in the judicial process.

Lastly, a particular characteristic of the judicial function has to be noted here. Policy-making, or more concretely the designing of a legal system dealing with specific issues, is difficult because the designer (policy-maker) has to take an all-things-considered approach, anticipating as many possible disputes and their remedies as one can, in order to make the system a stable one. Moreover, there is often no experiential guidance at hand because the system-designing has to be done on prediction. On the contrary, judges originally carry out an *ex post facto* style of control. They are allowed to decide individual cases arising out of past events, in light of the cases's individual circumstances. They also must consider the future effect of the verdict. This is especially true when awarding damages in tort liability cases against doctors or hospitals. Their primary duty is to solve the cases brought into court, by considering precedents and making their decisions fit into them.[44] In other words, they can decide individual cases more easily and precisely than policy-makers, because they have more points of reference to guide them in decision-making. For these reasons, it is sometimes important in designing a legal system to leave some complicated issues, especially the issues which need adjudicative discretion, to decision-making in the courts.[45] Most importantly, the field of medical control practice, which is much

---

[44] The difference of the two functions is also well described by Aubert in his explanation of the difference between doctors and lawyers. Lawyers signify the adjudicative perspective, while doctors signify the ends/means perspective. Lawyers are bound by past incidents and apply them to certain norms followed by legal decisions, while doctors are concerned with the future, and use scientific knowledge to weigh and estimate the whole range of possibilities and probabilities. Lawyers analyse the situation by a dichotomy such as guilty/not-guilty, while doctors content themselves with estimating probabilities. This difference can be applied to that between judges and policy-makers. Judges, like lawyers, basically apply the existing norms (legislation, legal precedents, etc.) to the facts presented by both parties and make judgments; while policy-makers, like doctors, actively define problems and look for measures to solve them. Though there must be some modification of the typology, as mentioned in the text, this difference still signifies important aspects of the difference between judges and policy-makers: V. Aubert, "Coercion, Resources and the Right to Participate in Decisions: Some Trends in the Legal Development," in *Equality & Freedom: International and Comparative Jurisprudence*, ed. by G. Dorsey, Vol. III. (Oceana Publications: 1977) at 858.

[45] Y.Hirai, *supra* note 42 at 180-81.

affected by the uncertainty of medical science, as noted above, needs this supplementing by the judicial function for its policy-making functions.[46]

(2) Doctors

Doctors primarily work as the first party in health care services. Also, they have always been regarded as "professionals." Their dominance, in Friedson's analysis, comes from the "professional" nature of medicine. He states that an "occupation" is regarded as a "profession" when it acquires "legitimate, organised autonomy." The autonomy includes the "... exclusive right to determine who can legitimately do its work and how the work should be done." In other words, once this autonomy is established, the profession (doctors) can officially avoid "outside" evaluation of the contents of their work. Thus, they organise groups of peers and control their work by themselves, as well as "professing" that they are a distinct profession, not just an ordinary occupation.[47] In addition, in order to profess that they are accountable to the public, they regulate themselves and discipline those who are not in compliance with the norms which are made by themselves.[48]

The autonomy of doctors is largely grounded in their scientific knowledge of medicine, which has become complicated and esoteric enough to establish its own

---

[46] Resort to the judicial function has to be originally confined solely to an individual adversarial process. Therefore, if they are involved in theoretical interpretation without any actual case, the court should not be given any power to enforce the decision. Canada has an interesting system of referring legal questions, both constitutional and non-constitutional matters, to courts regardless of the existence of the actual cases; however, this could lead to substantial legislation by courts, which do not have any direct accountability to the public. Therefore, it is undesirable for the courts to participate too much in the process of interpreting legislation if there are no specific cases: P.W.Hogg, *Constitutional Law of Canada,* 3d. ed. (Toronto: Carswell, 1992) at 214-19.

[47] E. Friedson, *Professions of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead & Company, 1975) at 70-71.

[48] *Ibid.*, at 137.

world" and vocabulary. In Canada, this scientification began with the Flexner Report,[49] which dealt with medical education in Canada and the U.S. in 1910. The proposals of this report promoted standardised medical education based on scientific knowledge. In addition, this advancement of medical education helped to organise medical knowledge which had formerly been individually taught by apprenticeship. This organised scientific knowledge of medicine helped to establish the autonomy of doctors and medical colleges.[50]

In Japan, the Meji Restoration in 1868 triggered the scientification of medicine. Before that, under the seclusion of the Tokugawa Shogunate, medical practice had been mainly performed by oriental practitioners who provided only low quality services. The oriental practitioners adhered to ancient documents of oriental medicine and showed no inclination to introduce scientific methods in their practice. The new government worried about the low quality of medical practice and proclaimed that it would license practitioners based on western medicine. This policy was put into effect with the promulgation of *Isei* (the Medical Regulation) in 1874. Most importantly, health policy in Japan at that time was part of *Fukoku Kyohei* (maximising the wealth of the state and enhancing its military power), policies directed to catching up with the western countries. Therefore, scientification of medicine must be considered in the context of the westernisation of modern Japan.[51]

---

[49] A. Flexner, *Medical Education in the United States and Canada* (New York: Carnegie Foundation for the Advancement of Teaching, 1910)

[50] B.R. Blishen, *Doctors in Canada* (Toronto: University of Toronto Press, 1991) at 18-19.

[51] A. Sugaya, *Nihon Iryo Seido Shi* [History of health care system in Japan] (Tokyo: Sanyo Sha, 1976) at 38-46. Also see Zaidan Hojin Kosei Mondai Kenkyukai [hereinafter Zaidan], *Koseisho 50 Nen Shi: Kijutsu Hen* [50-year History of the Ministry of Health and Welfare: Description of History] (Tokyo: Chuo Hoki, 1988) at 56-59.

The viewpoint of the state, with respect to the process of scientification, has to be clarified here. As mentioned in Section 1, the relative prematurity of medical science makes third-party legal control very difficult. Ironically, the scientific character of medicine has widened the gap of medical knowledge between doctors and the state, or more concretely, legislators, bureaucrats and judges. This has laid a severe burden on the government because, simply put, the gap of knowledge means that those who are controlled know better than those who control the subject matter of control. Thus, in Canada most aspects of the legal control of medicine are left to delegated agencies consisting of doctors themselves, or judicial bodies that can exert *ex post facto* control, as mentioned above. In Japan, the authority is not delegated to the professions themselves, but in effect the ministry cannot do without any profession's help in deciding many things.[52]

Next, the social status of doctors makes their organisations powerful and influential on policy decision-making. In Canada, doctors in each province have their own medical association; they function as labour or quasi-labour unions for medical practitioners, and handle such matters as fee setting, collective bargaining and discipline. Doctors are beginning to rely more and more upon their labour-union-like activities. In addition, each province has a licensing body of doctors which mainly consists of doctors themselves and is established by provincial statutes.[53] The licensing body also handles the discipline of incompetent or unethical practitioners, peer

---

[52] See Section 3-(4).

[53] The authority is usually called the College of Physicians and Surgeons in many provinces; other than that, it is sometimes called the Medical Board.

evaluation, and other quality assurance activities. Thus, the licensing bodies are given official power and responsibility regarding control over the quality of health care.[54]

In Japan, the licensing power is not left to doctors themselves. However, the Japan Medical Association (JMA) has been influential in governmental health policies and has acted as the major pressure group representing doctors, especially while Dr. Taro Takemi was president (1957-1980).[55] However, as membership of the JMA is not compulsory, and its original majority members are self-employed practitioners, [56] its influence is inevitably decreasing along with the increase of young and salaried doctors whom the JMA has failed to attract.[57]

Lastly, because this difference seems to have affected the doctor-patient relationship, the origins of Japanese doctors as health professionals are different from those of Canadian doctors. Doctors in Japan tend to be more authoritarian. There is a historical reason for that. The Japanese government introduced German medicine after the Meiji Restoration. In this process, the government did not invite ordinary doctors but army doctors from Germany. These military physicians taught the students in a strict and authoritarian manner. Thus, it makes sense to assume that this has helped to shape the characteristics of Japanese medicine, which remain largely authoritarian and

---

[54] R.W. Sutherland & M.J.Fulton, *Health Care in Canada: A Description and Analysis of the Canadian Health System* (Ottawa: The Health Group, 1992) at 207.

[55] One example may be noted to show the strong influence of the JMA when Dr. Takemi was president. Until 1961, public health insurance in Japan had had a system of restricting doctors' discretion in treatment; for example, the Ministry of Health and Welfare (MHW) had enforced a fixed priority in prescribing drugs. The JMA, led by Dr. Takemi, campaigned against the restriction, arguing that the responsibility for controlling treatment is on doctors, not on the MHW. In the end, he succeeded in making the MHW abolish this restriction: S.Tahara, *Nihon No Kanryo 1980* [Bureaucrats in Japan 1980] (Tokyo: Bungeishunju, 1979) at 407-8.)

[56] W.E.Steslicke, "Medical Care Security and the 'Vitality of the Private Sector' in Japan" *Comparative Health Policy and the New Right: From Rhetoric to Reality*, ed. by C.Altenstetter & S.C. Haywood (New York: St. Martin's Press, 1991) at 251-52.

[57] Also, see Section 3-(4).

paternalistic.[58] As will be discussed in Chapter 2 in connection with certain legal precedents, it seems to be an accepted conception that medical practice in Japan is authoritarian, not egalitarian.

(3) Patients

The role of patients in society has been described and explored by many sociologists, beginning with Talcott Parsons in his book, *The Social System*.[59] This thesis will not look into the detailed sociological analysis of the patient's role, because it is not directly related to the legal aspects of the control of medicine. Rather, significant aspects are chosen and examined individually.

One aspect is the discrepancy between professional knowledge and lay knowledge in terms of the treatment of disease. Lay knowledge is based on the patient's experience about illness, while professional knowledge is based on theories about disease. Thus, because lay people knowledge has not been systematised as useful knowledge in the practice of medicine, its position in the health care system is still a marginal one. Williams and Popay write:

> For the most part, however sophisticated and sociologically illuminating the knowledge expressed in lay beliefs may be, it remains disorganised and *ad hoc*, posing little if any direct challenge to the power of the medical profession. However much these beliefs are part of a shared culture and society, they are expressions of personal experiences which remain outside the worlds of science and politics.[60]

More importantly, as a sort of converse to the scientification of medical practice, patients' lay knowledge tends to be considered by professionals as more and more

---

[58] A. Kamiya, *Nihon Kindai Igaku No Akebono* [Dawn of modern medicine in Japan] (Tokyo: Iryo Tosho Shuppan, 1979) at 19, 106; as quoted in Y. Nakagawa, *Sugao No Isha* [True Picture of Doctors](Tokyo: Kodansha, 1993) at 50-52.

[59] T.Parsons, *The Social System* (New York: The Free Press, 1951)

[60] G.Williams & J.Popay, "Lay knowledge and the privilege of experience," *Challenging Medicine*, ed. by J.Gabe, D.Kelleher & G.Williams (London: Routledge, 1994) at 118.

unreliable, to be ignored because the scientification of medical practice helps to widen the gap between the two types of knowledge.[61]

However, the position of patients in society is also changing. There are some factors narrowing the status gap between doctors and patients. They are trends against paternalistic authority and trends toward an improved educational level of the public. Most importantly, in the age of mass-communication, it gets easier and easier for the public to receive information about health care through magazines, TV programs, popular self-help exercises and especially the internet. They help the public to acquire scientific knowledge about medicine, and also help to "de-mystify" what is going on during the process of professional medical practice. These trends are empowering patients when they go to doctors. They become less reluctant to ask questions about the treatment, even refusing some treatments which do not accord with their preferences.[62] The promotion of "informed consent" or other patient-rights movements are based on this growing awareness and concern among the public toward the control of health care.

(4) Health Administrators

Among those controlled by law, only health administrators are not immediately and directly relevant to actual medical practice, except in their roles in decisions about a doctor's permission of access to the hospital. They are only indirectly related to it through hospital management. However, their position is growing more and more significant in controlling more "team-based" medical practice, involving health professionals who have their own specialties: *e.g.*, anaesthesiologists, physiotherapists,

---

[61] *Ibid.*, at 121.

[62] B.G.Frankel, "Patient-Physician Relationships: Changing Modes of Interaction," *Health, Illness, and Health Care in Canada*, 2d ed. by B.S.Bolaria & H.D.Dickinson (Toronto: Harcourt Brace & Company, 1994) at 193-94.

respiratory therapists. In such a situation, the authority of any doctor in managing the team inevitably decreases. In addition, the hospital itself has acquired high-tech equipment which needs professional maintenance and co-ordination in its use. Also, the rising influence of public health insurance has necessitated professional economic co-ordination of hospital administration. Thus, the role of health administrators has become significant in the quality assurance of health care services. Furthermore, the rise of "hospital liability" in the field of medical malpractice cases is another significant factor tending to make hospital administrators influential in medical practice control. A recent judgment in New Brunswick held that:

> A hospital has an obligation to meet standards reasonably expected by the community it serves in the provision of competent personnel and adequate facilities and equipment and also with respect to the competence of physicians to whom it grants privileges to provide medical treatment.[63]

With respect to the role of health administrators, it must be noted that the system of hospitals and its historical background is different between Canada and Japan. The word "hospital" derives from the Latin *hospitium*, meaning "place of reception for guests." As this etymology indicates, hospitals in Canada have historically been "charitable institution[s] for the housing and maintenance of the needy" or "asylum[s] for the destitute, infirm, or aged."[64] In other words, the administration of the hospital has been developed separately from the medical practice done by doctors. By contrast, most hospitals in Japan have not been "hospitals" in that western historical sense. Hospitals in Japan are more like a larger form of doctors' offices with beds for

---

[63] *Bateman* v. *Doiron* (1992), 8 C.C.L.T. (2d) 284 at 290, per Creaghan J.: affirmed, (1993) 18 C.C.L.T. (2d) 1 (N.B.C.A.): quoted by Irvine, *infra* note 123 at IX-9.

[64] *The Compact Edition of the Oxford English Dictionary*, vol. I (A-O) (Oxford: Oxford University Press, 1971) at 1336. The word in Latin for a medical hospital is *valetudinarium*.

in-patients.[65] Typically, it is likely that a doctor running a clinic may eventually enlarge it into a hospital, after accumulating capital first.[66] Because of this peculiarity, many of the hospitals are managed by doctors who do not have knowledge of hospital administration.[67] Moreover, there is no functional distinction between a doctor's office and a hospital, so they are not in a referring-referred relationship, but are just competitors. Thus, even small clinics are heavily equipped with high-tech medical equipment.[68] Because of this institutional structure, there is little room for discussing hospital liability separately from a doctor's liability.

Moreover, in Japan the relationship between the hospital and the doctor is essentially different from that of Canada. In North America, doctors are usually not employed by hospitals, but are privileged to use the facilities of hospitals. That is one reason why hospital liability has developed. There is little chance of the Canadian hospital being vicariously liable for the conduct of doctors who are not its employees. However, in Japan, most doctors are employed by hospitals or clinics. Therefore, technically speaking, it is usually enough to impose vicarious liability on the hospital, which is operated by doctors, in terms of the conduct of their employees. [69] Thus, the

---

[65] In Japan, technically, *Byoin* (hospital) refers to a facility with 20 or more beds for in-patients, in which doctors or dentists practice medicine or dentistry respectively, for the public or a considerable number of specified people. *Shinryosho* (clinic or doctor's office) refers to a facility of the same purpose, but the number of beds is 19 or less (including zero). (MSL, Article 1-5, paragraph 1, 3)

[66] Hiroi, *supra* note 4 at 62.

[67] The extreme example is the case of a chairperson of the board of directors of *Iryo Hojin* (non-profit medical corporation). The chairperson is elected from the directors, and he/she has to be a doctor or dentist, unless the prefectural governor makes an exception under special circumstances. [MSL, Article 46-3, paragraph 1]

[68] Nakagawa, *supra* note 58 at 174-77.

[69] Rather, in Japan the role of hospital administrators has been recently emphasised in terms of economic cost.

role of hospital administrators in Japan has not yet come to the forefront in the legal control of medical practice.[70]

(5) The Doctor-Patient Relationship

Doctors and patients are fundamental actors in the controlling scheme. Therefore, this section explores the individual relationship between a doctor and a patient in detail. Kluge presents six models of the relationship: paternalistic, agency, collegial, contractual, friendship and fiduciary.[71] This section compares three of them: paternalistic, collegial and fiduciary.

The oldest of all is the paternalistic model. The doctor historically has the ultimate power of deciding the health care provided for the patient, though he is only officially held out as having technical expertise with respect to medicine. The patient should obey whatever the doctor orders, though the doctor is supposed to issue such orders with benevolence and sympathy for the patient. In other words, the doctor is presumed to be able to judge what is in the best interest of the patient, even better than the patient themselves. This presumed competence of the doctor sometimes even imposes the duty to decide for the patient.[72]

Secondly, the collegial model, unlike the paternalistic model, presumes that the positions of the doctor and the patient are equal. Both parties are considered as co-workers in dealing with the patient's illness. Therefore, this model is also called the co-operation model or participatory model. Though the two parties do not have the

---

[70] Y.Hiroi, *supra* note 4 at 60-61. Also see Nakagawa, *supra* note 58 at 142-48.

[71] E.W.Kluge, *Biomedical Ethics in a Canadian Context* (Scarborough: Prentice-Hall Canada, 1992) at 77-110.

[72] *Ibid.*, at 78-79. Also, as an example of paternalistic judgment on disclosing information to the patient, Kluge points out an example of the doctor who refrains from informing the patient about incurable cancer.

same authority in technical matters, they are presumed to have equal power in decision making on how health care should be provided to the patient. A popular example of this model would be "informed consent," which is discussed in Chapter 2. The doctor cannot decide what kind of treatment should be performed on the patient without participation by the patient.[73]

Lastly, the fiduciary model is analogous to the trust relationship. It is essentially the most realistic in that it starts with the assumption that the doctor and the patient are not in an equal position; but this still enables the patient's subjective values to be emphasised. Kluge describes this model as " a model of balance. The right of autonomy of the patient is balanced against the knowledge and expertise of the physician and the rights of the physician both as an individual and as a professional."[74] *Black's Law Dictionary* defines the word "fiduciary" as "a person having duty, created by his undertaking, to act primarily for another's benefit in matters connected with such an undertaking."[75] In other words, the doctor has a duty as a fiduciary, which does not assume the equal authority of the patient but still requires the doctor to act for the benefit of the patient.

In the recent case of *McInerney vs. MacDonald*,[76] this concept of fiduciary duty was well described. Citing precedents, the Supreme Court of Canada declared that the

---

[73] *Ibid.*, at 80. Kluge, in the last analysis, employs only the fiduciary model, denying the collegial model on the ground that the doctor and the patient are not in an equal position in actual settings (p.84). However, these models are not necessarily mutually exclusive. This thesis presumes that the collegial model is still persuasive as a normative model, for what the relationship between physician and patient *should* be, because it is possible to presume that both parties should originally have the same authority in deciding the direction of providing health care, even if they have differences of, for example, knowledge. The fiduciary model is, in this thesis, considered to be an explicatory model, for what the relationship actually *is*. It is useful for arguing that the doctor still has some inherent duties toward the patient, even if there is an imbalance of authority between the two parties.

[74] *Ibid.*, at 81.

[75] *Black's Law Dictionary*, 5th ed. (St. Paul: West, 1979) at 563.

[76] Also, see Chapter 2, Section 2-(2)(e).

doctor, over and above his basic legal duty of reasonable care and skill, is in the position of a fiduciary which is analogous to that of lawyers and parents. Though the contents of the fiduciary duty are not formalised and rather "shaped by the demand of the situation," certain duties such as the duty "to act with utmost good faith and loyalty" inevitably arise from the fiduciary relationship. With this reasoning, the Supreme Court has acknowledged the right of the patient to access medical records, saying that "the fiducial qualities of the relationship extend the physician's duty ... to include the obligation to grant access to the information the doctor uses in administering treatment."[77]

Section 3 - State Intervention: three approaches

The previous sections have presented a basic standpoint in controlling medical practice and a societal background for the actual control scheme, in each country. The next question would be: what kind of scheme should the state employ in order to control the whole health care system for the sake of national welfare? This section presents three alternatives of medical practice control, based on different social and economic theories, each with different legal implications.[78]

---

[77] [1992] 12 C.C.L.T. (2d) 225 at 234-35.

[78] The typology of social theories is often confusing, so it must be clarified here. In this thesis, the word "anti-collectivism" is used for the theory supporting the *laissez-faire* model; "reluctant collectivism" is used for the theory supporting the modified *laissez-faire* model; "collectivism" is used for the theory supporting the mediative-control model. The former two terms are employed from *Ideology and Social Welfare* by V. George & P. Wilding, (London: Routledge, 1985). "Collectivism" is not a term used in that book, but this thesis purposely uses it in order to include both Fabian Socialism and Marxism. "Anti-collectivism" is advocated by, for example, F.A. Hayek and Milton Friedman. They are also called "liberalists," and sometimes called "libertarians." "Reluctant Collectivism" is advocated by, for example, John Maynard Keynes, William Beveridge and John Kenneth Galbraith. They are also sometimes called "liberals" in comparison with "libertarians:" N.Barr, *The Economics of the Welfare State* (London: Weidenfeld and Nicolson, 1993) at 45.

The three approaches presented here are classified as the *laissez-faire* model, modified *laissez-faire* model and mediative-control model.[79] The *laissez-faire* model is first examined because it provides a good background for the discussion. With reference to the *laissez-faire* model, the second and the third models are compared and their advantages and disadvantages examined.[80]

Before examining the three models, two significant criteria for assessing their validity are noted. "Efficiency" and "justifiability" standards have to be considered in designing legal systems. Generally speaking, maximising the utility or elfare of the public is the primary goal of policy decision-making. To put this another way, resources for maximising utility are limited in society. Robbins says "[e]conomics is the science which studies human behaviour as a relationship between ends and scarce means which have alternative uses."[81] Scarcity is a limiting condition of human behavior and has to be considered from an economic perspective. Thus, how to use the resource "efficiently" for the maximisation of utility is the first standard.[82] Second, "justifiability" is also a factor to be considered. This standard is analogous to the adjudicative perspective discussed above. The efficiency standard does not compare

---

79 The "mediative-control" model is named after the typology of T.Johnson, in *Professions and Power* (London: Macmillan, 1972). He classified societal control of medicine into collegiate, patronage and mediative control, at 45-46.

80 In fact, the models are not mutually exclusive. In reality, their elements are mixed and employed in various forms by the state.

81 L.Robbins, *An Essay on the Nature and Significance of Economic Science*, 3rd ed. (London: The Macmillan Press, 1984)

82 It has to be noted that "efficiency" is assessed at two levels: individual and collective. At the individual level, one assesses how a person uses her resource (usually money) to receive commodities, services, etc. At the collective level, one assesses how society as a collective entity uses its scarce resources. The latter leads to so-called "Pareto Optimality," as defined in welfare economics. Roughly speaking, this principle means that individual efficiency and collective efficiency is interchangeable when free competition takes place. This thesis does not go further than defining them. For the purpose of this thesis, it is enough to confirm that "free competition" leads to the most "efficient" use of resources at an individual level, but more importantly, at the macro-level: K.J.Arrow, ncertainty and the Welfare Economics of Medical Care, *Collected Papers of Kenneth J. Arrow*, Vol. 6. (Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 1985), at 16-18.

the utility between people, but this further task is unavoidable when one tries to achieve patient equality and equity of care within the population. In other words, the state sometimes sacrifices the interest of some people to favour the over-riding interests of others. In that case, it is important to think of the most justifiable way to do it; in other words, what is the way that most people will regard as conformable to justice.[83]

In the analysis which follows, an interaction between a doctor and a patient is presupposed to be simple at first: that a doctor treats a patient for pecuniary return based on a private contract, without any governmental intervention, even if the viewpoint of analysis is solely that of the state. Other factors, such as health insurance, are not included at the beginning. They are introduced in Sections 4 and 5, when they are accorded the more detailed analysis they require. In addition, this scheme of classification does not explain every facet of state intervention. The three models are presented as basic structures, and their modification is discussed next.

(1) The *Laissez-Faire* Model

The first option that the state can take for intervention is, simply enough, to refrain from intervening at all. This thesis labels this approach the *laissez-faire* model. It is analogous to classical economic theory and anti-collectivism. Anti-collectivism is any perspective against collective action in society. Its advocates deplore collective intervention of the state on the ground that it is inevitably accompanied by external coercion. Thus, they prefer private solutions that are free from state intervention, albeit this may mean coercion from other economic, private interests, whether internal or external to the institution.

---

[83] Hirai, *supra* note 42 at 99-100.

When principles of classical economics can be applied to the doctor-patient relationship, there is to be no need for any state intervention. That is because there are what Adam Smith called "invisible hands of God,"[84] that is, the price mechanism in which the demand of a patient and the supply of a doctor meet at the optimal point, which is of the highest utility for the cost that consumers pay to receive the most effective performance.[85] This model supposes that free competition in each party, and interaction between both parties, are enough for medical practice control, because such free competition should produce the most efficient health care system, from the viewpoint not only of individuals but also of society at large.[86] In other words, state intervention is nothing but an obstacle against the most efficient form of free competition. Significantly, this model sometimes even denies the necessity of legislated medical licensure, on the ground that the prohibition of practice to non-licensees hampers free competition and only increases the income of the professionals. For example, Milton Friedman admits that medical licensure has contributed to some extent in helping to ensure the quality of medical practice; but in the last analysis he still denies the necessity of medical licensure from the above reason, with reference to his economic theory and anti-collectivist belief.[87]

Therefore, in the *laissez-faire* model, a possible form of legal control would be carried out only through the judicial function of the state. This is the least aggressive

---

[84] A. Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations* (New York: P.F. Collier & Son, 1909).

[85] The price mechanism is usually discussed in relation to price and amount of purchase, but it is also applied to quality assurance because it is assumed that the patient can negotiate with the doctor to improve the quality of care in return for paying more money.

[86] *Supra* note 82.

[87] M. Friedman, *Capitalism and Freedom* (Chicago: The University of Chicago Press, 1962) at 135-60. Also, see R. Hamowy, *Canadian Medicine: A Study in Restricted Entry* (Vancouver: Fraser Institute, 1984).

style of intervention, because the judicial function is usually passive, and only allowed to process the case brought by the plaintiff within the civil liability system.[88] This private character fits into individualism, one of the rationales of an anti-collectivism which despises coercive, collective state intervention.[89] Also, Hayek states that the judge " serves, or tries to maintain and improve, a going order which nobody has designed, an order that has formed itself without the knowledge and often against the will of authority,"[90] and thus helps to build a free market, free from the coercion of the state. In that way, this form of legal control " mitigates any undesirable features associated with the creation of a public monopoly over the law enforcement function."[91]

The *laissez-faire* model seems, on its face, to lead to the ideal situation. However, is it really credible? A significant flaw in this model becomes clear if we examine some of the assumptions that it is based on. Fundamentally, the model presumes that both parties negotiate with each other and reach some compromise which guarantees the highest utility for the patient with the least expense; however, this model is based on other assumptions, one of which will now be examined, and none of which are compatible with the real situation.

Information imbalance between the doctor and the patient would be the best example indicating that the *laissez-faire* model cannot be applied to the health care field. In order for negotiation to be workable, both parties are supposed to have the

---

[88] There are of course some cases in which doctors are subject to criminal liability for their malpractice, but this thesis does not deal with them because the number is very small. Rather, this thesis discusses, in Chapter 2, the difference between liability based on legislation and on legal precedents, which reflects the difference of strategies in state intervention.

[89] V. George & P. Wilding, *supra* note 78 at 21-22.

[90] F. A. Hayek, *Rules and Order: Law, Legislation and Liberty*, Vol.1 (Chicago: The University of Chicago Press, 1973) at 118-19.

[91] Trebilcock, *supra* note 29 at 68.

same information for decision making. Most importantly, the patient is supposed to be able to judge the competence of the doctor against a background of sufficient and comparable information, and to consent to the treatment of his or her own free will. However, as discussed in Section 2 above, patients typically do not have enough knowledge about technical matters of medicine. Moreover, it is the doctors who first gather the information about the disease. This makes it difficult for patients to be informed enough for the purpose of attaining a negotiating equilibrium, even if the gap between the two parties is becoming narrower. Therefore, this assumption of sharing the same information cannot be verified with respect to health care services.[92]

Thus, the *laissez-faire* model cannot be accepted as a realistic alternative to state intervention in the health care field. Anti-collectivists would argue that the patient has to change the imbalance for herself, for example by studying medicine, because individual action for the solution is what the *laissez-faire* model implies. However, such a theoretical argument to bolster the *laissez-faire* principle cannot sensibly be endorsed because it is simply not workable as a universal system.

(2) The Modified *Laissez-faire* Model

The reality of any health care situation precludes free competition in the health care field. Therefore, the second alternative for medical practice control attempts to eliminate obstacles against free competition. This approach is more interventional than the *laissez-faire* model, though still based on free competition. Here we will call it the modified *laissez-faire* model.

This is based on reluctant collectivism. Reluctant collectivists seek goals similar to those of anti-collectivists; however, their beliefs are more pragmatic. They

---

92 See Section 2-(3).

do not have unqualified faith in an unregulated free market system and agree, to some extent, on the ability and the duty of the state to manage parts of the economy. As a result, they literally admit, with reluctance, governmental intervention on a limited basis.

Reluctant collectivists mainly discuss state intervention in the economy, but would take the same attitude to intervention in the provision of health care service. In general, they advocate measures which maintain free competition by eliminating its obstacles, such as the imbalance of information between doctors and patients, as discussed above. The following are some examples of measures they would favour.

"Certification" would be the first measure to correct the imbalance. It means a system in which an authority gives the right to use a certain title exclusively to those who have satisfied formal requirements of training for a certain occupation.[93] By this certification scheme, patients can judge the competence of the doctor, to some extent, merely by confirming his/her title. In addition, once the patient is involved in the treatment, a right to access medical records is also important to correct any information imbalance. The patient can access her medical record and evaluate the treatment directly, regardless of the judgment of the treating doctor.[94]

Another important measure to correct the imbalance between the doctor and the patient is "informed consent." This principle is usually discussed from the viewpoint of the patient's autonomy, but it also helps to maintain the patient's position in the health care field which will promote the desired free competition. Having the right to decide

---

[93] "Certification" is also used for granting a title by voluntary organisations. However, it is not included here because it does not give the certified person the right to use the title exclusively. This exclusive use of the title is the key component of certification as a legal control.

[94] Also, see Chapter 2, Section 2-(2)(e).

what can be done to their bodies, together with the right to *refuse* the specific treatment, patients can exert authority in the course of the therapy. In addition, having the right to have the necessary information as to the nature and risks of the treatment and alternative therapies, before consenting to any treatment, places them close to being in the same position as doctors, at least from the viewpoint of information.[95]

Thus, in the modified *laissez-faire* model, the actual imbalance can be corrected and free competition can then take place. Such measures are not acceptable to anti-collectivists, but they are pragmatic solutions to maintain a measure of free competition in the health care field.[96]

(3) The Mediative-Control Model

The former two models are both based on free competition. Again, that means that both presuppose that free negotiation between a doctor and a patient makes for the highest-quality service and corresponds in service value to the money paid by the patient. However, even if the price mechanism works fine under the modified *laissez-faire* model, its mechanism for setting the quality of care has its own flaw. That is, as the definition of these two models shows, the quality of care is governed in each only by the amount of money that the patient pays, which is a matter free from state intervention or involvement. In other words, in both models, the quality of care is set,

---

[95] See Chapter 2, Section 2-(2)(c). Also, it is worth noting here that the "reasonable patient" standard for the scope of disclosing information is also justified from this standpoint because the information has to be enough for the patient to make an autonomous decision.

[96] Though this is not exactly a focus of this thesis, it is worth noting here an example from the U.S. The Health Care Quality Improvement Act of 1986 established a data bank of doctors involved in medical malpractice. The information is gathered through imposing the duty to report on insurance companies, hospitals, etc. However, the information is primarily for employers or the doctors themselves and is not accessible to patients in advance of treatment for reasons of confidentiality. This drawback is strongly opposed by the Public Citizen's Health Research Group, for example. This example shows another possibility for correcting information imbalance and also its difficulty because of the doctor's interest in confidentiality: S. L. Horner, "The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications" (1990) 16:4 *American Journal of Law & Medicine* 453 at 471-76, 485.

not according to the patient's need but rather by the patient's resources, on the assumption that the patient can afford to pay for necessary treatment. What does this mean? Simply put, it raises the problem of accessibility to high-quality and long-term care. Patients may have to put up with low-quality or no care if they cannot afford a higher quality. Free competition provides high-quality care to the rich, and low-quality or no care to the poor. Though this may depend on where the state intends to draw a line between the acceptable level and the unacceptable level, it will always be entirely possible that some people will not be able to afford an acceptable level of health care, as long as quality assurance is left to the market mechanism. This situation is totally incompatible with the aims of quality assurance of medical practice related in some way to need, so there must be another mechanism that can assure accessibility.

There is another, perhaps more important, reason why the modified *laissez-faire* model is not enough for protecting the public. Because the system of certification has no scheme for forcing consumers (patients) to choose adequate services, it cannot prevent bad effects, if any, on other people who are not involved in the particular medical situation.[97] A case of treating contagious disease would be the best example. In such a case, incompetent services would harm people other than the patient because they might be infected with that disease. Thus, the possibility of such externalities[98] necessitates a more interventionist method of control than mere certification.

The mediative-control model, referred to as the third model in this thesis, does not leave the attainment of desirable quality to the market mechanism. The state is assumed to have the power and responsibility for deciding the quality of care that

---

97 Manitoba Law Reform Commission, *Regulating Professions and Occupations* (Winnipeg: Queen's Printer, 1994) at 14.

98 Trebilcock, *supra* note 29 at 56-60.

should fulfil a universal and uniform right to health care. The concept of licensure can be understood in this context. Unlike the price mechanism, licensure works by drawing a line between the acceptable level of care and the unacceptable, which it prohibits. In doing so, licensure assures quality of care on a collective level.[99] This is also the strongest form of consumer protection, working on the assumption that consumers have no expert knowledge about medicine. It is the safest option because there is officially no practitioner, under the licensure scheme, whose competence is below the acceptable level. This "collective" character is the key component of the mediative-control model. Individual solutions are not workable in the health care field as mentioned above, and the state intervenes for the sake of public welfare.

The quality discussed so far in this section refers to what is measured through the "structural" approach discussed earlier in Section 1. Medical licensure only ensures that there are conditions sufficient to achieve high-quality practice by excluding those who are regarded as providing an unacceptable level of health care services. After the licensees enter the health care field, they are subject to norms of behavior assessed in a "process" approach. More importantly, the state active involvement in medical practice control is in the disciplinary process dealing with incompetent professionals. Also, in cases where there are statutory duties imposed on professionals, the government actively gets involved in medical practice control through imposing criminal or tort liability on doctors. In addition, there are also some rare cases in which the "outcome" approach is employed in performance assessment, and the licensee who cannot achieve desirable results is penalised. As discussed in Section 1, all these

---

[99] Also see Chapter 2 Section 1.

schemes aim at ensuring quality of care by prohibiting an unacceptable level of practice and promoting the acceptable.[100]

(4) Modification of the Models: Matter of Feasibility

The advantages of the mediative-control model, however, must be balanced by problems with respect to its feasibility. The scientific aspects of medicine, along with its uncertain nature, make the "outside" control of medical practice difficult, as discussed in Sections 1 and 2. Most importantly, to discipline doctors one needs medical knowledge and a sense of professional ethics to assess what the doctor did in a specific situation. Therefore, there needs to be a system in which the skill and knowledge of the professionals themselves are rigorously attended to, in the official administrative procedure. With this, there is a difference between the Canadian and Japanese systems. In Canada, each province has its own delegated agency. The majority of them are named he College of Physicians and Surgeons. Japan has a centralised system of licensure, and the Ministry of Health and Welfare (MHW) has authority in the licensing and disciplining of doctors.

In the Province of Manitoba, the regulating power is held by The College of Physicians and Surgeons of Manitoba, the council of which consists mainly of doctors. According to Section 31(1) of the Medical Act (R.S.M. 1987, c. M-90), only four lay people are elected as members of the council, which has about twenty members. This council wields a tremendous power over practitioners. Among other things, it has responsibility in establishing and maintaining professional standards of medical

---

[100] See Chapter 2.

practice, as well as exercising disciplinary jurisdiction over doctors.[101] Historically speaking, the College was established in 1871, as the "Provincial Medical Board of Manitoba". The 1871 act did not give much power to the College for regulating the profession, other than the provision which prohibits medical practice without registering with the Board; but later amendments have increased its power[102] and a substantial measure of the occupational control of doctors has been left to the College. This empowerment has enabled doctors largely to regulate themselves.

In Japan, there is no scheme of official self-regulation by doctors. Most power for licensing and disciplining health care professionals is held by the Minister of Health and Welfare.[103] For example, Article 2 of the Medical Practitioners Law (MPL) provides that doctors have to be licensed by the Minister after passing the national licensure examination. In addition, paragraph 2 of Article 7 provides that the Minister has the power of suspending or revoking the licensure.[104] This is a huge difference, at least apparently, from the Canadian system because the Minister does not delegate his power to other agencies or self-governing organisations of doctors.

There is a historical reason why self-regulation of doctors has not been established in Japan. Simply stated, there had been a conflict among doctors themselves before the first MPL was legislated. The conflict was between those who

---

101 The Medical Act, s. 36(1).

102 For example, an amendment of 1877 changed its name to the present "The College of Physicians and Surgeons", and enabled it to appropriate, in its budget, a part of any fine for unlicensed practice. In 1886, the College was given a power to revoke a license, or restrict issuing the license on a non-academic ground: E.G.A.Schollenberg, he Discipline of Doctors in Manitoba (LL.M. Thesis, The University of Manitoba, 1993) at 56-57.

103 Other than the Minister, each governor of 47 prefectural governments has power to license assistant nurses. See Articles 8, 14-2 and 18 of the Law for Public-health Nurses, Midwives and Nurses (Law No. 203 of 1948).

104 Paragraph 1 provides that the Minister has responsibility to revoke the licensure in some cases, for example where the licensee has become blind, deaf, etc.

had been educated through apprenticeship, who had to go through a licensure examination, and those who had been licensed only by graduation from medical schools, especially that of the Imperial University of Tokyo. The Medical Practitioners Law was first proposed by the Tokyo Medical Association (TMA), which consisted of practitioners in the Tokyo area. The proposal provided that the medical association was to be created by statute and that doctors had to belong to the association in order to practice medicine.[105] It was submitted to the Imperial Diet in 1897, but did not pass because of the dissolution of the House of Representatives. Even after that, the association was not able to pass the original proposal because of the opposition of a group of doctors who were mainly graduates of the medical school of the Imperial University of Tokyo. This group established the Meiji Medical Association (MMA) in 1899. As discussed above in Section 2(2), this school was the first to teach western medicine, after the Meiji Restoration, and invited doctors from Germany. They therefore had great pride in themselves as university trained doctors, and regarded it unacceptable for the legislated medical association, which consisted of various doctors including those trained through apprenticeship, to govern the whole profession to which the university trained doctors also belonged. The counter-plan of the MMA was different. They intended to leave the licensing power to the Minister of Home Affairs, which dealt with health policy at that time, and to ask for authoritarian control by the state. In the end, the first Medical Practitioners Law came into force in 1906, without any scheme for delegating the self-regulating power to doctors in general.[106]

---

[105] It is noteworthy that the proposal was alleged to be a duplication of the Attorneys Law which was legislated in 1893. Sugaya (*supra* note 51) quotes an article alleging the duplication. The article was written by Dr. Ogai Mori, who was a main member of the MMA.

[106] Sugaya, *supra* note 51 at 245-60. Also see Zaidan, *supra* note 51 at 138-40.

However, professional organisations still have significant influences at both formal and informal levels. For example, there are two major official councils which relate to the occupational control of health professionals: the Medical Ethics Council (MEC) and the Medical Professions Council (MPC). The MEC is a primary agency in the disciplinary process against incompetent doctors. Paragraph 4, Article 4 of the MPL requires the Minister to refer to the MEC when he suspends or revokes the license of a doctor. The MPC has authority, for example, to research and discuss all matters with respect to licensure examinations. Cabinet orders require the attendance of the president of the JMA in both councils[107] In addition, the JMA has worked as a major pressure group in Japan. Thus, even in Japan where doctors are not self-regulated, they have a great deal of influence on the health policy which governs their activities.

In these ways, there are huge differences in the systems of regulating doctors in Canada and Japan. Each has its own problems. A self-regulating scheme in Canada has problems of accountability. The public can never extricate themselves from fearing that they might be asking foxes to guard the hen-coops.[108] On the contrary, in the Japanese system, its bureaucratic lay control tends to be less flexible and hard to reconcile with the rapid evolution and improvement of medical science. Therefore, the government cannot after all avoid heavy reliance on the councils, themselves manned by professionals. It is difficult to judge which system is better. However, "it seems to be contradictory to expect accountable doctors to be fostered under the system which

---

[107] Article 2 of the Cabinet Order for MEC, No.273 of 1955; Article 3 of the Cabinet Order for MPC, No.268 of 1969

[108] There has been a comprehensive proposal for ensuring accountability of such self-regulating bodies. See Manitoba, *supra* note 97 at 56-67.

recognises them as unaccountable"[109] to the public, as in Japan. Therefore, it would be desirable to leave the regulating power to the professionals, if the functioning of the regulating body can be established in a way that is accountable to the public.[110]

Section 4 : The Role of Public Health Insurance

This section discusses public health insurance schemes, in terms of legal implications. The mediative-control model only concentrates on the quality control of the supply side. That would be enough in the case of governmentally operated health care services like the National Health Service in the U.K.. However, if health care services are provided by the private sector, patients still have to "buy" the services each time they become ill. More concretely, the quality of the health care service itself can be maintained with the mediative-control model, but there is no guarantee that the patient can afford the services when all is said and done. Moreover, "[l]icensing tends to drive up prices, not only by restricting the supply of practitioners, but also by increasing the costs of obtaining or maintaining a license."[111] Therefore, the next duty of the state is to make the health care services affordable to everyone, especially in a fee-for-services system.

In addition, it has to be noted that the need for health care is unpredictable by nature. It is not practical to suppose that the patient can wait until a satisfactory level of care is available for the amount of money one can pay, considering the patient's risk in delaying the treatment. Therefore, some scheme of hedging the risk is needed, as well as making health care generally affordable.

---

[109] S. Utsuki, "Ishikai no arikata [How the JMA Should Be]" *Nihon no iryo: Korekara* [Health Care in Japan: For Future], Jurisuto Zokan No.44. (Tokyo: Yuhikaku, 1986) at 164.

[110] *Ibid.* at 164-65.

[111] Manitoba, *supra* note 97 at 16. Also see S.L.Carrol & R.J.Gaston, "Occupational Licensing and the Quality of Services: An Overview" (1983) 7 *Law and Human Behavior* 139 at 140.

One measure apt to fulfil these requirements is insurance by private companies. Such an arrangement can hedge the risk of massive spending for unpredictable health care needs, and will also save those people who could not realistically pay for the service without insurance. However, private insurance has a fatal flaw called "adverse selection." Simply put, it refers to the situation in which the profit motive of an insurance company and the interest of low-risk groups tend to exclude high-risk groups from the insurance scheme. The insurance company decides the rates of premium and benefit for the insured by considering their risk of becoming ill. Therefore, the low-risk group, usually the rich, can pay less if they can exclude the high-risk group, usually the poor. In real-life settings, this situation will encourage the low-risk group to quit membership in the insurance plan which insures the high-risk group. If this happens, the high-risk group has no choice but to form its own insurance group which will inevitably pay a higher rate of premium.[112] Such a tendency could make private health insurance unaffordable to the high-risk group. This is totally incompatible with the initial aim of health insurance.[113]

So, how can this flaw of private insurance be fixed? One direct way is the introduction of legislated public insurance. The problem of adverse selection is solved when everyone is legally required to join the insurance scheme regardless of the amount of premium or benefit. Then, there is no room for adverse selection. In this way, legislation for public health insurance imposes on everyone the duty to join that insurance scheme. For example, Canada and Japan boast their "universal" health care

---

[112] N.Barr, *supra* note 78 at 118-21, 297-98.

[113] Of course, it is possible to regulate insurance companies and make them fix premiums at a low rate. However, this is after all another form of state intervention aimed at consumer protection. This thesis rather employs the scheme of public health insurance, as stated below.

insurance schemes. This universality means that everyone can receive benefit from the insurance, while at the same time everyone has a legal duty to join the insurance scheme even if he does not want to, because the rate of benefit seems less than favourable to him. In this way, the law, as a manifestation of state coercion, works for the sake of collective public welfare.[114]

There are two significant characteristics of public health insurance with respect to controlling medical practice. First, alongside the introduction of the insurance scheme, medical practice has been transformed into a more formalised activity than before. Second, from the viewpoint of the state, the introduction of public health insurance has enabled the state to intervene in the health care field more flexibly than with purely legal control. These two factors have given to the state a more powerful tool of control, thus strengthening the mediative control of medical practice.

First, it should be noted that the existence of an itemised list of medical practices, especially for the fee-for-service[115] payment method, tends to narrow the room for doctors' legitimate discretion because, by this itemisation, medical practice becomes a more formalised activity. The doctor can choose the alternatives in the itemised list of insured services, but cannot resort to other alternatives if she wants to be

---

[114] It must be noted that, in many provinces in Canada, funding for public health insurance is mainly from general tax revenue, not from premiums.

[115] Three forms of related payment mechanisms are explained here. "Fee-for-service" means "[p]ayment per item of service - individual acts of diagnosis, therapy, pharmaceutical services and treatment are identified, added together and billed." "Case payment" is for "a package of services or an episode of care. The payments are not itemised and added up as in [the fee-for-service method]. The schedule may be unrelated to the actual cost of care given to a particular patient at a particular hospital, as when payments are based on 'diagnosis-related groups' (DRGs)." Lastly, "global budgets" means "[a]ll-inclusive operating budgets set in advance, designed to provide a spending ceiling, but allowing flexibility in use of funds inside this overall limit". (World Health Organization, *Evaluation of Recent Changes in the Financing of Health Services*, Geneva, 1993, at 37) The fee-for-service method is employed for paying doctors in most cases (some doctors get their income in other ways, such as salary) in Canada. By contrast, in hospitals, global budgeting is mainly employed. In Japan, the fee-for-service system is employed in most cases. In the U.S., the DRG system was introduced in 1983, as a payment scheme for hospitals which are eligible for Medicare (Hiroi, *supra* note 4 at 23).

paid for the service from the insurer. Importantly, this system is convenient for the government. It is less interventionist, at least in principle, than legal control, which formally "prohibits" a certain practice; the government just says it does not pay for it. However, especially under the scheme of universal health insurance,[116] such non-payment is a serious matter for doctors. Also, this formalised style of practice enables routine inspection by the government from the viewpoint of administration, accounting and payment.

Moreover, the control of medicine through public insurance can be more flexible than legal control from the viewpoint of the state, while it is more formalised from the viewpoint of health care professionals. In essence, the legal aspects of medical practice control largely come from interventions of the state as a third party. The state intervenes in medical practice passively (judges) or actively (legislators and bureaucrats). In either case, the state is after all the third party because it does not have any direct interests in the specific cases. Rather, it has to be involved in affairs in a detached and impartial manner, examining the claims of everyone involved. Even when the state intervenes actively with its own policy goals, its discretion in doing so is restricted by legal principles. This impartiality of the state is the primary aspect of medical practice controlled by law.

However, the introduction of a public health insurance scheme has changed the situation greatly. Simply put, in Canada, "the 'monopsony' power of governments as

---

[116] More importantly, for example, Canadian doctors cannot do "extra-billing" to patients or charge user fees under the insurance scheme in each province. The Canada Health Act (1984, c.6) provides that the federal government can withdraw financial contributions for health care if a province permits the extra-billing and user fees for insured health care services (Section 18 and 19), which is what has been happening in Alberta and other provinces.

sole buyers of medical care services in Canadian medicare increasingly confers power over service provision."[117] Evans elaborates the situation as follows:

> In essence, a system of universal coverage uses the public sector as a sort of 'consumers' co-operative,' a collective organisation with which to bargain with providers and their organisations on behalf of all users collectively, not just those with few resources or exceptional needs. This 'consumers' co-operative' equalizes the bargaining power, compared with the situation in which individuals confront professionals directly, and thus permits the community to hold down the share of its income which it must make over to providers.[118]

Evans examines the issue only from the financial point of view; however, the quality of medical care service in return for payment is also an important aspect included in the Evans analysis. In other words, introduction of public health insurance is another measure to correct the imbalance between the doctor and the patient. The state becomes the largest, the most powerful "consumer" and negotiates with doctors (*i.e.*, doctors' organisations). This conversion of the role of the state is significant to the difference between "dyad" and "triad" relationships, discussed above. Namely, the state finds itself less obliged continually to justify itself, or to refer to fixed norms, in order to control medical practice. When the state is in the position of the third party, it is necessary to resort to some kind of norm. However, the conversion of its role into that of the second party enables the state to behave more like a consumer. Although it has to negotiate with doctors organisations collectively as the government, and its position is apparently different from that of an individual consumer, there is less necessity to apply fixed norms or principles. It becomes more like competition between interests;

---

[117] Battershill, C. "Social Dimensions in the Production and Practice of Canadian Health Care Professionals." *Health, Illness, and Health Care in Canada*, 2nd ed. (Toronto: Harcourt Brace & Company, Canada, 1994.) at 135. onopsony refers to a market situation in which the product/service of several sellers/providers is sought by only one buyer.

[118] Evans, R.G., "Hang Together, or Hang Separately: The Viability of a Universal Health Care System in an Aging Society" (1987) 13:2 *Canadian Public Policy* 165 at 168-69.

and the state can pursue its own policy goal more actively, in order to have doctors work more with less expense.

Section 5 : Quality vs. Efficiency, Individuality vs. Collectivity

With the mediative-control model, discussed in Section 3, the state can maintain the health of the nation collectively through ensuring accessibility to a desirable level of health care, by precluding the unacceptable level. The effect of this scheme of control is reinforced with the introduction of public health insurance, which collectively guarantees that everyone can afford to receive the acceptable level of health care. These seem to be good measures for the sake of national welfare. Unfortunately, such schemes are not without flaws. More importantly, the flaws of public health insurance are becoming more and more influential in the actual setting of policy-making. This Section examines these flaws and their legal implications.

What problems are actually presenting themselves with respect to the public health insurance scheme? First of all, a major trigger of the problems is rising health care spending in each nation. Canada presently pays 10.1 % of its Gross Domestic Product (GDP) for health care.[119] This is equivalent to each Canadian paying 10.1% of his/her income for health care. To make things worse, this figure threatens to go up further and faster because of the size of the aging population, improvement of expensive medical technology, and system personnel costs. Therefore, it is a logical response for the nation to try to pay as little as possible for the additional cost of health care services, or even reduce the payment. More importantly, this response is supported

---

[119] S.Sharpe, "Medicare on the Critical List," *The Financial Post Magazine* (Toronto: The Financial Post Company, May 1995) at 34.

by the notion that there is a limit to the acceptable amount of resources in society which can be spent for maintaining health.[120] This view is amenable to the notion of public health insurance, which makes it possible to control spending for health care services collectively. Thus, there is a trend toward pursuing the "efficiency" of health care services collectively, in other words, for trying to pay for health case services as parsimoniously as possible.[121]

This concern for efficiency in the health care system directly collides with the quality of care in some aspects[122] and with an inherent problem of medical practice control. Importantly, cost constraint could prevent a certain form of medical practice, which is technically verified to improve the quality of care, from being employed in the actual practice of medicine because of economic constraint.[123] In other words, there appear to be situations where the doctor's discretion, or clinical judgment, substantially collides with the economic considerations which concern hospital administration or the insurer of the public health insurance scheme. In that case, which path should the

---

[120] H.H.Hyatt, "Protecting the Medical Commons," *New England Journal of Medicine*, Vol.293, p. 235-241, 1975. Also see Hiroi, *supra* note 4 at 122-23.

[121] Health care spending in Japan is smaller than that of Canada, in terms of the rate against the GDP (6.5% in 1990). However, this low rate is largely attributed to the rapid growth of GDP itself in the 1980's (the so-called "bubble economy" in Japan): Hiroi, *supra* note 4 at 36-37. Therefore, conflict between "efficiency" and "quality of care" should be a significant problem also in Japan. However, because there was no material available about the legal implications of cost containment specifically in Japan, this Section focuses the discussion on Canada.

[122] Or, strictly speaking, quality of care and economic constraints do not initially collide with the fee-for-service system of paying a medical fee, which usually does not impose economic restrictions in actual practice. Rather, global-budgeting, employed in most hospitals in Canada, and case payment (especially, the DRG system employed largely in the U.S.) directly cause the problem of economic constraints.

[123] Other than this "process-approach" problem, efficiency concern is related to the problems assessed by the "structural" approach. For example, shortage of staff, equipment, drugs, etc., caused by cutbacks, have some significant legal implications, such as modification of the *locality rule*: P.W. Kryworuk, B.T.Butler, and A.L.Otten, "Potential Legal Liability in the Allocation of Scarce Health Care Resources" (1994) 14:4 *Health Law in Canada*. However, as discussed in Section 1, this "structural" approach primarily addresses only the abstract *possibility* of high-quality care. Therefore, this Section rather concentrates on the "process-approach" problem, which directly addresses the quality of care and related legal liabilities of doctors.

doctor take in order to avoid being subjected to legal liability: to stick to her own clinical judgment or to obey the decision of health administrators or insurance companies?

In that situation, there are some theoretical bases for providing the patient with a legal remedy if the doctor's deference to the economic considerations of hospital administration produce a bad consequence for the patient: breach of the duty of care, fiduciary duty, or sometimes the law of informed consent. The doctor could be judged to have breached his duty of care when, for example, because of economic considerations, he did not prescribe drug A, which is more effective than drug B. Or, he might be accused of having breached his duty as fiduciary, discussed above in Section 1. He might even be open to legal censure because he did not tell the patient of any alternative which she would reasonably have needed to know.[124] However, there is an obstacle which prevents the plaintiff-patient from winning the lawsuit: proof of causation-in-fact. In all three cases, the plaintiff has to prove, on a balance of probabilities, that the doctor's breach of duty caused the patient's non-improvement of a condition which would have been improved if the breach of duty had not occurred. Such proof is difficult because the improvement of medicine is incremental in most cases. Therefore, it is a rare chance that the difference between drugs A and B will make a statistically large difference in the recovery rate. Therefore, in the world of law where the decision is usually made by dichotomy (see Section 2, where the adjudicative

---

[124] However, in the case of the breach of fiduciary duty, the plaintiff could receive nominal or even punitive damages.

perspective in settling a dispute is discussed), the patient's success in suing would be unfortunately rare.[125]

Such hypothetical questions, though they have significant implications, are only now beginning to be brought into court in Canada.[126] However, there is an instructive decision in a case in California which deals with the question between doctors and a third-party payer of health insurance. In *Wickline* v. *State of California*,[127] a patient of Le Riche's Syndrome was discharged from the hospital earlier than the medically required period because of the administrative judgment of Medi-Cal, the public health insurance scheme in California. Because of the early discharge, the patient's leg had to be amputated. She sued Medi-Cal, not the treating doctors, and recovered in the trial court. However, the decision was overturned in the California Court of Appeal, which held that the doctors were responsible for the result because they could have challenged the decision of Medi-Cal administration with their expert knowledge. The court clearly declared that "it is essential that cost limitation programs not be permitted to corrupt medical judgment."[128] This part of the decision is arguably *obiter*, and this is not a Canadian case, but *Wickline* gives valuable guidance for doctors in the conduct of their practice.[129]

---

125 Irvine, J. "The Physician's Duty in the Age of Cost-Containment" (Paper presented to the Pitblado Lecture, held by the Law Society of Manitoba, 1994) [unpublished]

126 In *Law Estate* v. *Simice* (1994, British Columbia), Mr. Justice Spencer said as follows: "No doubt such sophisticated equipment (*e.g.*, CT scans) is limited and costly to use. No doubt there are budgetary restraints on them. But this is a case where, in my opinion, those constraints worked against the patient's interest by inhibiting the doctors in their judgment of what would be done for him. That is to be deplored. ... The severity of the harm that may occur to the patient who is permitted to go undiagnosed is far greater than the financial harm that will occur to the medicare system if one more CT scan procedure only shows the patient is not suffering from a serious medical condition." [explanation added] (21 C.C.L.T. (2d) 228 at 240) This statement is *obiter* and not related to the actual decision, but we can see the evolving attitude of the court toward cost-containment issues.

127 228 California Reports 661 (Ct.App., 1986), quoted in Irvine, *supra* note 125.

128 *Ibid.*, at 672.

129 Irvine, *supra* note 125 at IX-7.

Lastly, this issue of efficiency must be discussed from the viewpoint of policy-makers designing legal frameworks. To do so, an inherent problem in any public health insurance scheme must be clarified: the "collective" nature of public health insurance is not easily reconcilable with the "individual" nature of medical practice. In other words, the state has forcibly employed methodologically collective measures in order to solve essentially individual problems. Public health insurance aims at ensuring the reasonable quality and affordability of health care collectively. This policy goal benefits the poor, vulnerable and less informed because they, without private health insurance, would not be able to receive an acceptable quality of care which is also reasonably affordable. However, the nature of medical practice is originally "individual," not "collective." It is not what doctors do to patients collectively, but what a doctor does to a patient individually.[130] Also, as discussed above, the "quality" of medical practice is not measured by collective figures such as infant mortality rates but is based on the result or process of the individual treatment. Therefore, from the viewpoint of the state, the collective way of ensuring health is unavoidably like an allocation of a certain fixed amount of resources for health care services. However, from the viewpoint of the individual patient, the amount of resources used for his individual treatment should be decided by his individual need, not by the amount of resources allocated by the state. Thus, there is an inevitable conflict or tension between collectivity and individuality in ensuring the quality of care through public health insurance.

The conflict between clinical judgment and economic constraints must also be understood in the same context. In other words, a raising of the quality of care, which

---

[130] Of course, a team-based practice creates a totally different issue.

has an essentially individual nature, is prevented from being pursued limitlessly, under the scheme of public health insurance, because the amount of resources which can be utilised is finite from the viewpoint of the state. However, considering the initial aim of the public health insurance scheme, which was supposed to have been designed for maintaining individual quality of care, this conclusion is also unacceptable. To put this another way, as long as health care insurance is intended to serve the "collective" needs of the people, it would be unjustifiable to defer continually to clinical judgment and take a spare-no-expense approach in treating "individual" patients. However, it is also unjustifiable to defer completely to economic considerations of hospital management because medical practice is, in the final analysis, for the individual patient. What, then, can we do?

This problem is analogous to that presented by waiting lists for health care service. Because of cost containment, the number of operations or opportunities for major treatment is often restricted. Consider an example from Alberta, where "privatisation" of health care services is more vigorously promoted than in any other Canadian province. There, an ophthalmologist may charge patients, in the name of a "facility fee," $1,275 for cataract surgery on one eye. This is about 1.5 times as much as what the provincial government pays. However, there are a considerable number of people willing to pay that much money, even if they do not have to do so if they are prepared to wait for months or even years for the operation.[131]

When this case is considered against the conflict between clinical judgment and economic considerations, the public/private mix could be one solution to the problem. It would be desirable to decide the extent to which public insurance should maintain

[131] Sharpe, *supra* note 119 at 32.

quality collectively, and leave the extent of individual, personally perceived needs to the private sector where the patient has to pay out of pocket. In other words, "objective" needs can be fulfilled by public insurance, while "subjective" wants will be left to the private sector, governed by the modified *laissez-faire* model or the *laissez-faire* model. It is true that drawing a line between public and private burdens is often difficult, even virtually impossible to achieve perfectly. Also, this measure again causes problems inherent in the modified *laissez-faire* model or the *laissez-faire* model, as discussed above in Section 3. However, as long as the discrepancy exists between the collective approach of public health insurance and the individual nature of medical practice, it would be the most justifiable approach from the viewpoint of policy-making.

By the same token, the clinical judgment of medical professionals for improving the quality of patient treatment should not be obstructed; only the additional cost which cannot be covered by public insurance should be paid by the patient out of pocket. This again raises the problem of affordability.[132] That said, it seems clear that the resolution of these tensions as to whether the policy-makers, in allocating the burden between the public and the private, have created an objectively fair fee structure can only be achieved or determined in the context of the political process, rather than through judicial redress. The common law judges will use administrative law principles to intervene and quash unfair decisions in individual cases that is, unfair applications of prevailing policies to individuals. But equally clearly, the judges have made it plain that they do not see it a part of their role to second-guess governmental policy-making at any level. That, say the courts, would usurp functions delegated by the legislature to

---

[132] Note that the doctor's discretion in charging fees can be expected to some extent because this is the public nature of the profession. Actually, the ophthalmologist in Alberta, discussed above, is waiving the right to charge fees to some of the patients who cannot afford it (Sharpe, *supra* note 119 at 38.)

others. Governmental decisions and actions are currently analysed by the courts, both in England and Canada, and dissected into their "policy" (*i.e.*, discretionary) and "operational" components. The courts will not label as actionably negligent any governmental activity in the policy sphere, unless it is (a) outside the scope of the governmental agency legal authority; or, (b) represents a failure to address a question of policy, rather than the adoption of an apparently unwise one; or, (c) rather dubiously perhaps, where the policy decision is wholly unreasonable and indefensible on rational grounds.[133] However, once governmental action passes from the policy or discretionary phase into the operational (*i.e.*, actual implementation) stage, the courts will be far more ready to attach negligence liability to those who cause harm by careless acts or omissions. It seems plain that most complaints relating to the supposedly unfair denial of publicly financed health care will be directed against the unfairness of the policy itself; and with such complaints, the judges will usually decline to deal. Dissatisfaction with the level and allocation of public health financing will therefore have to find redress through the political process – in the last resort, at the ballot box.

---

133 In England and in Canada, the leading case and focal point of reference on these issues is *Anns* v. *Merton London Borough Council*, [1978] A.C. 728; adopted and explained in a sequence of cases in the Supreme Court of Canada, notably *Just* v. *British Columbia*, [1989] 2 S.C.R. 1228; *Brown* v. *British Columbia*, [1994] 19 C.C.L.T. (2d) 268; and *Swinamer* v. *Nova Scotia* [1994] 19 C.C.L.T. (2d) 233.

CHAPTER 2: EXAMPLES OF CONTROLLING MEDICAL PRACTICE

This chapter deals with two examples of medical practice control by the state: medical licensure and the legal duties of doctors. The former primarily relates to the legislative function of the state, while the latter relates to its judicial function. Both are directed to ensuring the quality of medical practice. Licensing of medical professions is an initial measure to ensure the quality of medical practice. This entry control into the medical care market helps to ensure high competence in the profession as a basis for high quality medical practice. [134] However, the presence of enough knowledge and skill does not necessarily translate into proper medical care in every case; complacency, overwork, laziness, greed and other emotional factors may prevent professionals from always practicing according to acceptable standards.[135] That is where the judicial sanction of civil and criminal liabilities works as a tool for quality assurance. Unlike licensing and discipline, which have evolved from medieval guilds to the recent empowerment of self-regulated licensing authorities, the judicial sanction over the professions has long been a primary method for public intervention in the quality assurance of medical practice. The purposes of the judicial sanction are different from those of administrative discipline, namely, punishment of the professional (especially in the rarely used criminal liability) and compensation by way of damages (civil liability). Both have the same motivational effect on professionals that administrative discipline does: to act competently and ethically.

---

[134] Manitoba, *supra* note 97 at 12.

[135] The disciplinary process carried out by the licensing authority is thus important to motivate professionals to act competently and ethically, as well as to dismiss those who in the last analysis cannot act in that way. However, this chapter does not discuss this further because it is an actual function of public administration rather than a body of norms set out expressly for ensuring the quality of health care, which will be the main focus of this chapter.

This chapter examines these two significant systems of quality control, comparing the Canadian and Japanese systems. The focus is on doctors, because they are still the primary professionals in the health care field. However, other professionals are also discussed because the same theoretical and procedural approaches can be applied to their situations. Section 1 will discuss the licensure of health professionals, rationales for prohibiting medical practice and the actual applications of licensure. Section 2 examines the legal duties of doctors; these are presented with reference to legal precedents both in Canada and Japan, supplemented in Japan by legislated duties.

Section 1: Licensure and Prohibition of Medical Practice

In order to secure quality control of medical practice, it is initially important to prohibit such practice by non-licensees who cannot be officially guaranteed to be competent enough to practice. However, this approach is fraught with difficult problems because the scope of prohibited practice cannot be decided easily and needs to be justified objectively, case by case. More importantly, as modern society ensures the freedom to pursue one's own good by engaging in any occupation one chooses, any such prohibition of medical practice must be carefully constructed in order not to hamper unjustifiably that freedom to work.

The definition of medical practice must be discussed from the two separate perspectives that are within the words "medical" and "practice". The former relates back to the discussion in Chapter 1. The aim of maintaining the quality of medical practice must be materialised by defining the word "medical," as directly related to the scope of practice that non-licensees are prohibited from doing. By contrast, the latter definition

of "practice" has differing implications. It relates to rather technical matters that can be questioned in courts. However, it also relates in a significant way to policy goals in controlling medical practice, as discussed below. This section focuses on those issues and examines one significant precedent decided by the Supreme Court of Japan, a case which illustrates issues such as the discrepancy between the policy-making and adjudicating functions of the state.

Before going into detailed discussion, the general definitions of "medical practice" in each country must be made clear. In the Province of Manitoba, according to the Medical Act (R.S.M. 1987, c. M-90.), medical practice is defined as "the carrying on for hire, gain, or hope of gain or reward, either directly or indirectly, of the healing art or any of its branches." Also, Section 15 reads "[n]o person shall practice medicine in the province unless he holds a current license to practice, and then only to such extent as is defined in or authorized by the license." In Japan, Article 17 of the Medical Practitioners Law (Law # 201 of 1948, hereinafter MPL) prohibits *Igyo* (literally, medical practice), stating "those who are not medical doctors shall not conduct medical practice." Surprisingly enough, there is no provision which defines the words "medical practice," let alone its specifications. With reference to the general definition by the Ministry of Health and Welfare, "medical practice" would be defined as all kinds of conduct, done with the intent of repetition, which is or can be harmful to a human body if not done with the medical judgment and skill possessed by medical doctors.[136] These literal differences in provisions between the two countries must be discussed in more detail.

---

[136] Kawabe, S. "*Ishi No Shikaku Wo Yushi Nai Mono No Iryo Koi* [Medical Practice carried out by those who do not have a doctor license] *Iji Hanrei Hyaku Sen* [100 cases related to health issues] (Tokyo: Yuhikaku, 1976) at 139.

(1) What is "medical"?

First, the definition of the adjective "medical" must be determined because it is the original reason why such practice must be prohibited to non-licensees. This definition decides the scope of practice assigned to doctors. It also clarifies the limitations imposed on non-licensees in doing similar works. How do both countries define it, in the light of its medical and legal implications?

First, section 2-(1) of the Medical Act of Manitoba defines details of the scope of practice as follows:

> "2(1) Without restricting the generality of the definition of practice of medicine, a person shall be deemed to be practicing medicine within the meaning of the Act who
> "(a) by advertisement, sign, or statement of any kind, written or oral, alleges or implies or states that he is, or holds himself out as being, qualified, able or willing, to diagnose, prescribe for, prevent, or treat, any human disease, ailment, deformity, defect, or injury, or to perform any operation or surgery to remedy any human disease, ailment, deformity, defect, or injury, or to examine or advise upon the physical or mental condition of any person; or
> "(b) diagnoses, or offers to diagnose, or attempts by any means whatsoever to diagnose, any human disease, ailment, deformity, defect, or injury, or who examines or advises upon, or offers to examine or advise upon, the physical or mental condition of any person; or
> "(c) prescribes or administers any drugs, serum, medicine, or any substance or remedy, whether for the cure, treatment, or prevention, of any human disease, ailment, deformity, defect, or injury; or
> "(d) prescribes or administers any treatment, or performs any operation or manipulation, or applies any apparatus or appliance, for the cure, treatment, or prevention, of any human disease, ailment, deformity, defect, or injury, or acts as a midwife; or
> "(e) acts as the assistant or associate of any person who practices medicine as herein set out."

These provisions are not exactly congruent with the word "medical"; however, apparently the word "medical" is recognised with reference to the contents of activities

which are usually done by doctors. The definition is itemised as much as possible, thus making the provisions rather complicated but offering many clues that non-licensees can refer to in refraining from performing acts which are harmful when done without that measure of competence which is prerequisite to a license.[137]

By contrast, in Japan there is no provision in MPL which defines the word "medical," or even "practice". The Ministry of Health and Welfare [HMW] explains that it is virtually impossible to define the contents of medical practice precisely because it is constantly changing. Thus, the specification of the word "medical" has inevitably been left to legal precedents in the courts and to the official interpretation of the MHW in individual cases.[138] Most specifications are the same as such items in the Medical Act as diagnosis, and prescription.[139] In more specific cases, eye exams (*Ishu* 426, 1954), ear piercing *(Iji* 123, 1972) and permanent electric depilation (*Iji* 69, 1984), have been designated as acts of medicine by the MHW.[140] In the legal precedents, for example, inquiries as to symptoms and the taking of medical histories, for the preparation of "fast therapy", have been judged to be acts of medicine.[141]

There is a significant difference between Canada and Japan in defining the word "medical". Under the Japanese system, a certain type of conduct might be impugned as carrying on medical practice, even if it is formally irrelevant to what doctors usually do.

---

[137] However, among the items, (a) is different from others because it does not define such medically harmful acts at all. This item is solely pre-emptive in character, designed to deter or punish acts which might indirectly result in harm.

[138] Actually, this difficulty of defining specifications of "medical practice" before individual cases arise was also pointed out in Canadian settings. See, *Re. Ontario Medical Act*, [1906] 12 Ontario Law Reports 501.

[139] 10 February, *Taishinin, Keiroku* 23, p.49. 14 November 1927. *Taishinin, Keishu,* 6, 11, p.453.

[140] However, these interpretations of the MHW are only official opinions about the interpretation of the MPL. The MHW initially enforces its policy along with the interpretations, but non-licensees cannot be punished for doing them until the interpretations are approved in the courts judicially.

[141] 27 September 1973, *Saikousai, Keishu* 27, 8, at p.1403.

For example, there was a case in which a uack was found guilty of violating the MPL, even though what he had done was extremely similar to massage, which is usually not regarded as an act of medicine. It was held that a certain act is judged to be an act of medicine when its substantial risk is raised to a level that only doctors can properly handle, even if the treatment is done by way of massaging.[142] This precedent indicates that, in Japan, what is punished as medical practice is not primarily acts that are usually done by doctors, but acts that carry substantial risk and cannot be handled without the skill and knowledge of doctors. This makes the definition of "medical" include more acts of medicine-related practices. By contrast, in Canada the definition of "medical" is interpreted strictly. For example, in the Alberta case of *R. v. Wong*,[143] an acupuncturist accused of practicing medicine was held not guilty because acupuncture was not literally prohibited by Section 64 (1)(a) of the Medical Profession Act (Alta.). In the verdict, the judge concentrated on the literal difference between "medicine" and "acupuncture," and did not consider the substantial risk inherent in acupuncture to signify something only doctors should handle. This attitude of the judge made him interpret the meaning of "medical" narrowly. This difference of interpretation between the two countries is rooted in fundamental differences in their respective goals for medical licensure, which are discussed below.[144]

Lastly, with respect to defining the word "medical," the strategy recently employed in Ontario has to be mentioned. In the preceding system of medical

---

142 24 May 1955, *Saikousaim, Keishu* 9, 7, at p.1093.

143 [1979] 6 W.W.R. 163

144 Theoretically, the opposite situations might occur. In Japan, practices usually done by doctors might not be regarded as "medical practice" defined in the MPL, because they carry no risks that necessitate a doctor's skill and knowledge; in Canada, a practice which is apparently not risky at all might be punished simply because it is usually done by doctors. However, this thesis does not pursue these questions further because there are no related cases available.

licensure, the scope of practice directly meant an area of monopoly enjoyed by the profession. The result of the system had been "the granting of unnecessarily wide and ill-defined monopolies."[145] That situation was beneficial to professionals themselves, but not to the public. Therefore, the new regulating system of Ontario employs a three-tier system. First, the scope of practice for each profession is decided by describing the content, method, and purpose of their actual practice. The key point is that the scope is not linked to licensure. At the second tier, twelve individual acts, such as "communicating a diagnosis identifying a disease or disorder as the cause of a person's symptoms," or "administering a substance by injection or inhalation,"[146] are defined in the Medicine Act of 1991 (R.S.O., 1991., c. 30). They are defined as "licensed acts," and the items (or a part of the items) are assigned to each profession according to their scope of practice. The third tier is for pre-empting non-licensees from doing possibly risky acts, even though they are not in the list of licensed acts.[147] Similar strategies are seen in some of the laws in Japan,[148] but Ontario has proceeded further. This new regulating system in Ontario is not a substantial and complete change, because the fact remains that the licensed acts and monopoly of practice would be the same. There is after all a discrepancy between what is defined in the regulation

---

145 Ontario, *supra* note 2 at 13.

146 There were originally thirteen items when the system was proposed (*ibid.*, at 230). However, in the actual legislation, the wording of some items was modified and one item of "[f]itting and dispensing fixed and removable prostheses and dental appliances for the oral-facial complex" was deleted from the list.

147 *Ibid.*, at 13-16.

148 For example, the Clinical Engineers Law (Law # 60 of 1987) defines the scope of practice of clinical engineers as operating life-support devices (respirator, dialyzer, etc.) under the instruction of doctors, and maintenance of the devices (art.2 para.1,2), while prohibiting to non-licensees only the operation of the devices (art. 37). This would be based on the same reasoning as in the legislation of Ontario.

and what must be prohibited as having a substantial risk.[149] However, that system has further clarified what is "medical" practice and what other non-licensees can do, or cannot do, when they are engaged in medicine-related occupations such as folk medicine. In addition, the defined scope of "practice" will facilitate quality assurance of the services without creating an unnecessary monopoly of practice.

(2) What is "practice"?

The next question in deciding the scope of medical practice is the definition of the noun "practice." This question is usually raised in courts, in the form of questions with regard to evidence. However, this issue is essentially related to the basic concept of prohibiting medical practice, and thus is very important. There is a huge discrepancy on these matters between the systems in Canada and in Japan. In the following, the repetitiveness of acts, and of reward, or hope of reward, are examined as elements of "practice."[150]

(a) Repetitiveness of Acts

In Canada, being accused of "practicing" medicine has required actual repetition of acts. This precedent dates back to the English cases. In *The Apothecaries Company* v. *Jones*,[151] the defendant was accused of treating three patients separately in the same day, but the court denied that three offences had separately taken place.[152] Mr. Justice

---

[149] See Lester, J. "The Health Professions Legislation Review: The Need for Greater Clarity in the Scope of Practice Scheme," *Health Law in Canada*, Vol.10, No.1. (Markham: Butterworths, 1989) and Bohnen, L.S. "In Defence of the Health Professions Legislation Review, *Health Law in Canada*, Vol. 10, No.2. (Markham: Butterworths, 1989), for controversy over ambiguity of the provisions proposed in Ontario, *supra* note 2. Also, with respect to the inherent "slipperiness" of language in law, see W.K.Olson. *Litigation Explosion: What Happened When America Unleashed the Lawsuit* (New York: Truman Tally Books, 1991) at 131-51.

[150] There are some other cases in which the meaning of practice becomes an issue; for example, how to deal with emergency situations? However, this thesis does not deal with this because there is no substantial difference between Canada and Japan.

[151] [1893] 1 Q.B. 89.

[152] *Ibid.*, at 93, 94.

Hawkins wrote: "To "practice" a calling does not mean to exercise it upon an isolated occasion, but to exercise it frequently, customarily, or habitually," and "though it is true each individual act would afford cumulative evidence of *practising*, yet bare proof of one individual act would not of itself amount to a "practising.""[153] This precedent was quoted in the Ontario case of *Regina v. Whelan*,[154] which accused a woman of practicing midwifery, a procedure prohibited by the provincial Medical Act. Other cases have followed these precedents.[155] Thus, in Canada, the word "practice" has long signified objective repetition of acts of medicine.

Such precedents fit into the literal interpretation of the word "practice." However, this requirement of objective repetition raises other questions. Does the practice have to be done on different persons to be recognised as repetition?[156] How much time is needed between the first act and the second act in order for them to be separate acts, not the repetition of an act? Also, the definition can be impractical in protecting the public from low-quality medicine; punishing even a single act and pre-empting the next is beneficial for protecting the public from the risk of receiving health care of dubious quality. Therefore, it is no wonder that the legislatures of the provinces have added a provision stating that proof of one single act of medicine is enough to accuse the uacks. For example, Section 70 of the Medical Act in Manitoba reads: "In any prosecution under this Act, it is sufficient proof of an offence under this Act if it is proved that the accused has done or committed a single act of unlicensed

---

153 This precedent is arguably *obiter*, because the actual word in question is "act," which is defined as "act or practice" in the Apothecaries Act, 1815 (55 *George* III, c.194), s. 20.

154 [1900] 4 C.C.C., 277.

155 For example, [1911] *Regina* v. *Armstrong*, 18. C.C.C. 72.

156 On this question, see *Regina* v. *Raffenberg* [1909] 15 C.C.C. 295. The judge decided that attending one patient continuously for two weeks amounts to offending the Medical Profession Act (Sask.).

practice, or has committed on one occasion any of the acts prohibited by this Act." Thus, in Canada, it is now possible to accuse the offender when he commits one offence.

The precedents in Japan in that regard are based on a different conception of "practice." They had been similar to the Canadian precedents until the beginning of the twentieth century, but they were overtaken in 1916 by the judgment of the Supreme Court,[157] saying that "practice" only means to perform acts of medicine with the *intent* of repetition.[158] This means that in Japan the actual acts of practice do not necessarily have to be repeated for the accused to be brought into court.[159] This precedent has been followed by later judgments.[160] Thus, unlike Canada, there has been no need to legislate this matter in Japan.

(b) Reward, or Hope of Reward

Medical practice is done by doctors as a form of health care service. Obviously, it is often the case that doctors receive some return, usually money, for their services. It follows that this return can be one key component of medical practice. However, conceptions on the necessity of this "return" are totally different as between Canada and Japan.

In Canada, precedents require a showing of reward or hope of reward as a prerequisite for prohibiting medical practice. In the Saskatchewan case of *Regina v.*

---

157 *Taishinin*, 5 February 1916, *Keiroku* 222, at p.109.

158 S. Shimono, "*Ishiho 17 jo ni iu "igyo" no imi*" [Definition of medical practice in Article 17 of the Medical Practitioner Law]. *Iji Hanrei Hyakusen* [100 precedents of medical affairs], *Bessatsu Jurisuto* No. 50. Tokyo: *Yuhikaku*, 1976, at p. 136-37.

159 However, it is obvious that the subjective "intent" is difficult to prove in court proceedings. Rather, it is often the case that the repetition itself becomes a significant proof of the intent.

160 For example, see *Kosai Keiji Hanketsu Tokuhou*, *infra* note 163 at 3.

Ornavowski,[161] the defendant, instead of the doctor for whom he was working, assisted a woman just after labour, and later examined another patient and prescribed medicine. However, he was held not guilty because he did not charge for his conduct nor had he any hope of reward. The judge clearly said "I think I am entitled to find these two instances did amount to practicing medicine. The accused was more than a mere messenger. But the charge is "for hope of reward.""[162] Thus, it has been established that such reward or hope of reward must be proved in order to punish a non-licensee who has practiced medicine, because the Medical Act in Manitoba requires conduct "for hire, gain, or hope of gain or reward" as a prerequisite of that prohibited "medical practice."

The precedents in Japanese courts are totally different. In the above mentioned 1916 decision of the Supreme Court, it is the *intent* of repetition that turns acts of medicine into "medical practice" in Japan. It obviously follows that reward or hope of reward is not required to punish non-licensees practicing medicine. For example, the Sendai High Court in 1953, in which the defendant appealed the decision of a district court asserting that there was no evidence that he had charged for the treatment he had practised, held that the "medical practice" in Article 17 of the MPL need not be with reward or hope of reward, because the meaning of "practice" is defined with reference only to the intent of repetition.[163]

(3) Safety of the Public vs. Interests of the Profession

---

161 [1941] 1 W.W.R., 103.

162 *Ibid.*, at 105.

163 Sendai High Court, 14 January 1953, 35 *Kosai Keiji Haketsu Tokuho* 3.

The above discussion reveals significant differences in medical licensure, or prohibition of medical practice, between Canada and Japan: the scope of prohibited "medical" practice, the requirement of actual repetition and of reward or hope of reward in defining "medical practice." What do the differences signify?

First, they reflect the original aims of medical licensure which are, at least officially, partly different as between Canada and Japan. Simply put, medical licensure is devised more to protect the profession in Canada, and more the general public in Japan. In Canada, in *Re: Ontario Medical Act*,[164] the Lieutenant-Governor-in Council referred the definition of medical practice, within the meaning of Section 49 of the Ontario Medical Act [R.S.O., 1897, c. 176], to the Ontario Court of Appeal. In the decision, Garrow, J.A. stated:

> [i]f the interests of the public had been the main consideration, as contended, the prohibition would scarcely have been confined to practising for hire, gain, or hope of reward, and some exception might in that case have been expected in the case of a practitioner with undoubted learning and skill, such for instance as an eminent physician from foreign countries.[165]

This was cited in the above mentioned case of *Regina* v. *Wong*. The judge clearly stated that the legal prohibition of medical practice should be limited because "[t]he prime object of the legislation was the 'protection of the monopoly of practising, and not the protection of the public against the quacks or unregistered.'"[166] On the contrary, in Japan, there have been no such opinions, though protecting the profession, in terms of their exclusive scope of practice, is an inevitable consequence of medical licensure.

---

164 *Supra* note 138.

165 *Ibid.*, at 511.

166 *R.* v. *Wong*, *supra* note 143 at 163.

In Japan, the following is the typical notion about the prohibition of medical practice to non-licensees:

> Medicine needs highly specialized knowledge and technique. It is hazardous to the life and health of the nation if a person without enough medical knowledge practices medicine. Therefore, it is a duty of the state, which ensures the nation right to health, to avoid this hazard and establish the system of proper health care delivery.[167]

This notion indicates the difference of the original aim in prohibiting medical practice. Although recent proposals for reforming the health care system in Canada have declared that the primary object of medical licensure is protecting the public,[168] it is an undeniable fact that the element of protecting the professionals has been one of the aims of medical licensure in Canada. The continuing requirement of "for hire, gain, or hope of gain or reward" in the Medical Act would be the best example, which also points to other substantial differences in the actual interpretation of laws prohibiting medical practice.[169]

(3) Public Regulation vs. Constitutional Rights: A Case in Japan

In Canada, the purpose of the medical licensure to protect the profession is a reason why related provisions should be strictly interpreted. In the case of Japan, this limitation of medical licensure comes from another reason: the right to choose one's own occupation, which is assured in Article 22 of the Constitution of Japan. The Supreme Court of Japan delivered a judgment about the medical licensure system in 1960.[170] This did not deal exactly with medical practice; the issue was about quasi-medical practice,[171] which was regulated by the Law for Massage Practitioners,

---

167 M. Ohya, *Iryokoi to ho* [Medical Practice and Law] (Tokyo: Kobundo, 1990) at 19.

168 Ontario, *supra* note 2 at 9, and 19.

169 *R.* v. *Wong*, *supra* note 143 at 163.

170 27 January 1960, *Saikousai*, *Keishu* Vol.14, 1 , p. 33.

171 Like the words "medical practice," there is no definition of "quasi-medical practice" in the legislation. However, it is defined as all kinds of medicine-related practice, for the purpose of curing disease or promoting health. (Midwifery is not included.) Article 12 of the LMAM includes all

Acupuncturists, Moxacauterists, etc. (Law #217 of 1947, hereinafter LMAM). The title was "the Law for Massage Practitioners, Acupuncturists, Moxacauterists, Judo Therapists, etc." when this case was brought into, and decided by, the court.[172] However, the decision has been influential in addressing other legislation concerning the health professions. Therefore, this section of the paper examines this precedent extensively.

Article 12 of the LMAM reads that no one except doctors, massage therapists, acupuncturists, moxacautarists and judo therapists shall engage in quasi-medical practice. In the case, a man who had been a medical orderly in World War II was prosecuted for violating the LMAM because repeatedly, and without any license, he used a machine which emitted high-frequency current for the purpose of treating patients.[173] In the appeal to the Supreme Court, he claimed that Article 12 of LMAM was void because it violated Article 22 of the Constitution of Japan, which reads "[e]very person shall have freedom to choose and change his residence and to choose his occupation to the extent that it does not interfere with the public welfare."

In this case, the Supreme Court judged as follows: First, the provisions of the LMAM, like those of other laws, have to be interpreted according to the principles evident in the Constitution. Article 22 permits restricting the freedom to choose one's

---

medicine-related practice including massage therapy or other individually legislated licensed practice. Electric therapy does not fall anywhere under the scope of legally licensed practices, so technically the defendant should have had the license of a doctor to practice, such as electric therapy, without any fear of prosecution.

[172] "Etc." refers, in this title, to other quasi-medical practitioners which the LMAM prohibited, but a special moratorium was given to those who had already been practicing before the legislation of the LMAM and filed his/her contents of work through the procedure defined by the LMAM [art.12-2, paragraph 1.] In addition, facility requirements for the practice are also defined in the LMAM. They are, different from the title in English, expressed as o (which means literally tc. in the title written in Japanese.

[173] There is no material to show why the defendant was not accused of practicing medicine, rather than quasi-medicine.

occupation if it interferes with the public welfare. It follows that the scope of prohibition in Article 12 of the LMAM should cover only practices which interfere with the public welfare; specifically the practices should not only fall under the category of quasi-medical practice but also carry an actual risk of harm to patients. Thus, the Supreme Court overturned the decision of the lower court and ordered it to examine the case again in terms of the actual risk of the electric therapy.[174]

This judgment was not unanimous. There were two major reasons for dissent. Judge Tanaka opposed on the ground that the aim of Article 12 is to prohibit acts which apparently fall under the category of quasi-medical practice, regardless of their actual risk of harm to patients, because the "risk of harming" depends on the condition of the patient as well as on the method of the therapy. He held that one of the functions of law is to prohibit the whole category of practice in that case, for the sake of the public welfare.[175] Judge Ishizaka pointed out the risk of losing the opportunity to receive "normal," licensed medical treatment, even if the practice in question carries no actual risk in itself.[176]

This discrepancy between the majority judgment and the objections in the Supreme Court reflects conflict between the adjudicative perspective and the ends/means perspective. The dominant opinion simply compared the provisions in the LMAM, regarding public safety, and those of the Constitution, regarding the right to choose one's occupation, and judged that the latter was more significant as a matter of course. This is obviously a "legal" way of thinking, or an adjudicative perspective.

---

174 Kawabe, *supra* note 136 at 36.

175 The same reason had been presented in the debate of the Diet before the LMAM was enacted. (Lower House. *Dai Ikai kokkai shugiin kosei iinkai kaigiroku* [Record of the debate in the health and welfare committee of the Lower House, the first session of the Diet], Vol.37, 5 December 1947.)

176 *Keishu, supra* note 170 at 37-39.

Conflicting values were compared and one of them chosen in the light of certain norms: in this case, the supremacy of the Constitution over ordinary legislation. By contrast, the dissenting opinions reflect the ends/means perspective; the dissenting judges acknowledged the significance of the end, to ensure public safety from quackery, and regarded the legislation as one of the means, to have a wider area of prohibited practice.[177] It is also noted that the latter perspective accords with that of the policy-making functions of the state. Thus, this discrepancy presents a good example of conflicting perspectives in the legal control of medical practice, as well as the difficulty in designing a legal system which is fully compatible with both perspectives.[178]

Section 2 : Legal Duties of Doctors

Judicial sanctions that apply to wrongdoing doctors, based on criminal liability or civil liability, have a motivational effect on practitioners to refrain from acting incompetently and unethically, and thus help to ensure a high quality of medical practice. The effect is the same as the disciplinary process discussed earlier. However, there is a certain difference between the disciplinary process and judicial sanctions. The disciplinary process is basically a follow-up sanction of licensing. It is done by a

---

[177] In addition, this difference would also be explained by different ideas of the influence of quasi-medical practice on the health of the nation; the dominant opinion took the influence less seriously than did the opposing opinion. Also, see Okudaira, Y. "*Eigyo no jiyu no kisei*"[Restricting the freedom of business], *Bessatsu Jurisuto*, No.39 (Tokyo: Yuhikaku, 1973) at p.20.

[178] Later judgments on similar matters also indicate that the judges are even now not all of the same mind on the conflict of individual freedom and public safety. In the Fujimi Hospital case in 1989 (Tokyo High Court, 23 February 1989, 691 *Hanrei Taimuzu* 152), non-licensees examined patients, under the instruction of doctors, with ultrasound devices and electrocardiographs, a practice which is technically a violation of Article 31 of the Law for Public-Health Nurses, Midwives and Nurses. With respect to the appeal that only those acts which have a risk of harming patients should be prohibited by the law (the appellant actually quoted the 1960 decision in her appeal), the Tokyo High Court ruled that there is no need to prove actual risk of harm, employing the opposing opinion of Judge Tanaka in the 1960 decision. That judgment is arguably *obiter* because it was also held that the alleged act did have actual risk of harm to the patient; but it is notable that a lower court was officially opposed to the dominant opinion of the Supreme Court.

licensing authority that is officially recognised as having the power and responsibility for supervising licensees. Because the authority functions as a policy-making body, as discussed in Chapter 1, it usually involves itself actively in the case. It also usually resorts to its own discretion in the final decision in any case, which frequently tends to be more severe than in judicial sanctioning. More importantly, this aspect is conspicuous when the disciplinary process is self-regulated as in Canada, because the active involvement and discretion of the authority is a key component for professional self-regulation. The College of Physicians and Surgeons takes a flexible role in sanctioning doctors. It sometimes works as a mediator in small cases, but usually it assumes a stern policing role with regard to wrongdoing doctors. By contrast, in terms of the judicial sanctioning involved in the court procedure, the court's involvement is passive and there is relatively little room for discretion in the final decision; judges objectively apply legal precedents and statutory laws to a specific case brought by the patient-plaintiff. Thus, the role of the norm, in the form of legal precedents and statutory laws, is greater in cases of judicial sanctioning.

The first part of the following analysis discusses the theoretical and procedural aspects of judicial sanctions. These sanctions are based on the doctor's deviation from a standard of quality practice. There are several questions: what are the elements of "quality" in this context? how should they be assessed? what is the "standard"? and who judges, based on the standard? The definition of quality, discussed in Chapter 1, imposes on doctors the duties of care, diligence, and skill, not the duty of assuring a successful outcome. It also constructs standards by reference to the skill and knowledge of reasonably competent doctors, which in turn is decided by custom in the

medical care field, rather than by governmental standards or other such kinds of universal measure. This substantial criterion prompts the next question: who evaluates the actual practice based on the norm? The role of the expert witness in the court is examined. In addition, related to the criteria used in assessing the quality of medical practice, the empowerment of the patient's position in the case of "informed consent" is discussed, as a significant exception to the "reasonably competent doctor" standard.

What are the strategies of the state in terms of judicial sanctioning? In common law countries such as Canada, the judicial sanction has meant imposing civil liability in most cases, a process based on legal precedents. By contrast, civil law countries like Japan place many statutory duties on doctors, duties which impose criminal liability. This difference of strategies leads to different consequences and brings different problems. This issue is also related to Chapter 1, where the administrative bodies implementing the disciplinary process were examined, because the issue is closely connected to the power of disciplinary authority.

The second part examines the individual legal duties of doctors in the light of comparison between the Canadian and Japanese systems. The duties are itemised in the following way: the duty of attendance, due care and skill in diagnosis, treatment and aftercare, keeping adequate and accurate medical records, referral or seeking advice, communication with other professions, and supervision of junior colleagues. The duty of explaining to the patient about the treatment and its risks is also examined as well as the duty of confidentiality. More importantly, the duties imposed in Canada and Japan are compared. This section also notes both differences and similarities based on

differing historical and cultural backgrounds. This whole discussion is also connected to the purposes of controlling medical practice, discussed in Chapter 1.[179]

(1) Theoretical and Procedural Approaches

What is the reason for imposing such severe judicial sanctions on doctors? One reason must be attributed to quality control. This leaves open some significant questions. First, what is the level of "quality"? Its definition must be made more specific in order to be assessed properly. Secondly, what is it that is assessed for quality, the process or the outcome? The difference lies in the uncertainties and imperfections of medical science. Third, how is the "standard" decided? This is also important because this is the direct reason for the sanction. Lastly, how do all of these issues fit into actual court procedures?

First, then, what is the definition of "quality"? As discussed in Chapter 1, medical care consists of "technical care" and "interpersonal care." The former means the application of science and technology to a specific disease and the latter means social interaction between doctors and patients. In addition, roughly speaking, the former relates to the competence of doctors, and the latter to ethical behaviour. These elements of quality are considered in assessing the practice of defendant doctors. Significantly, the interpersonal aspect of care is usually less emphasised than the technical aspect in evaluating the quality of care in the light of a doctor legal liability. This is because the technical judgment of a doctor has been regarded as the most

---

[179] There are some other significant issues with respect to the remedies available in medical malpractice cases through court procedure: calculation of damages, proof of causation, etc. However, this chapter focuses on the duties of doctors, which are the most fundamental legal norms that doctors have to refer to in their practices.

significant issue in the process of medical practice, even more important than the issue of "consent". However, it also must be noted that the interpersonal aspect is hard to reconcile with legal control because of the discrepancy between subjectivity (interpersonal care) and regularity and impartiality (legal control). Such subjectivity must of course be considered in ensuring the quality of medical practice, but it is also a fact that it is very difficult to control legally.

In the quality assessment procedure, it is always a problem to decide which will be examined, quality of process or outcome. In other words, in which cases are doctors subjected to liability: when they do not act adequately or when they do not succeed? Unlike the discussion in Chapter 1, quality of process, not outcome, matters when one analyses legal liability. This is because liability based on outcome means laying an unjustifiably heavy burden on doctors. Medicine is not a complete structure of science and always has tremendous room for improvement. In addition, because of the imperfection of medicine, general text book theories are often incapable of application in individual cases. The outcome cannot be a standard for assessing the quality of medical practice in terms of potential legal liability. Doctors must be sanctioned only when they do not act as they are supposed to.[180] Thus, in today's scheme of legal liability, doctors are not subjected to the duty of guaranteeing an outcome, but they are subjected to the duty of care and skill. This also corresponds to the principle of fault pervading civil liability, which aims at a motivational effect to make doctors act competently and ethically.

---

[180] Of course, it is also a possible option to impose on doctors a duty to assure outcome. Such an allocation of responsibility, laying a heavier burden on doctors, is especially advocated recently as a no-fault option in medical malpractice compensation, because of the prevalence of liability insurance. However, to make this thesis a manageable one, I refrain from looking into its detailed aspects.

This position is also confirmed in a precedent in Japan. In a case of medical malpractice dealt with in the Yokohama District Court, a doctor had to amputate a leg of a patient who had been injured in a traffic accident, because the leg generated gas gangrene in spite of the removal of foreign matter in the wound. The District Court held that the doctor was negligent because he could have saved her leg with more thorough treatment or even with a method of leaving the wound packed and open, so that the anaerobic bacteria, which cause gas gangrene, could not multiply in the wound. This judicial decision was overturned in the Tokyo High Court. It was held that the result, gangrene and amputation, should not be directly linked to the doctor's negligence, that is, improper treatment or non-performance of the open-wound treatment, because even the most thorough treatment cannot prevent gas gangrene and the open-wound treatment can be even more harmful because of other bacteria or too much bleeding. Also, it was held that the method of treatment was left to the discretion of the doctor and there was no general standard for treatment which might lead the judges to infer that the doctor was negligent. In other words, the High Court held that the doctor was not negligent, regardless of the result, because his treatment was not inappropriate, considering the standard of medical practice at that time.[181]

In Canada there is a rare exception to this assessment of process in terms of legal liability. In the case of negligence, the doctor only has a duty of care and skill because, as mentioned above, it is impossible for the doctor to guarantee the result. However, especially in cases of plastic surgery, doctors can sometimes be subjected to strict liability based on contract if they guarantee a result but fail to achieve it. If the

---

[181] Tokyo High Court, 14 May 1985. 1166 *Hanrei Jiho* 62. Compare *Challand* v. *Bell* [1959] 27 W.W.R. 182 (Alta. C.A.).

doctor guarantees a specific result, for example, saying that he can treat a scar on the patient's face and restore the face to what it was, with reward or hope of reward for doing so, he will be subject to liability when he fails to achieve that specific result.[182]

This liability based on contract is accorded a different effect in Japan. Simply put, a doctor is not necessarily subject to strict liability even if the action is based on contract. There is a distinction between *Kekka-saimu* (obligation to produce a result) and *Shudan-saimu* (obligation to attain a standard of an act), which is imported from the French civil law. The former, which is applied to such cases as sales of goods, is directed at the realisation of a result; therefore, breach of the obligation brings strict liability. By contrast, the latter, applied to the obligation to treat a patient, is only aimed at mandating a normally prudent action on the part of the person obliged, thus denying strict liability even when based on contract.[183] Having explained this, it is also a fact that the number of medical malpractice cases grounded on contract is increasing

---

[182] This strict liability based on contract in Canada is closely connected to the principle of informed consent, discussed below. Guaranteeing a specific result to the patient means that the doctor does not tell the risk of failure to the patient. There is another question of whether the risk is material or not; however, in cases of plastic surgery for a cosmetic purpose, the expectation of the patient is usually treated as highly significant and there is little room for regarding the risk as negligible. See, *White et al.* v. *Turner et al.* [(1981), 15 C.C.L.T. 81, affirmed 47 O.R. (2d) 764], and *Sinclaire* v. *Boulton et al.* [(1985), 33 C.C.L.T. 125 (B.C.S.C.)]. Also, *supra* note 47 at 59-60.

[183] Z.Kitagawa, *"Saimu Furiko Ni Okeru Yusekisei* [Imputability in the Non-Performance of an Obligation-Duty]" (1986) 118:4,5,6 Hogakuronso 100 at 104. Also, see H. Morita "*Kekka-saimu, Shudan-saimu No Kubetsu No Igi Ni Tsuite* [On the distinction between obligations for result and action]" *Minji Hogaku No Shin Tenkai: Suzuki Rokuya Sensei Koki Kinen* [New Development of Civil-Law Study: For the Commemoration of the 70th Birthday of Professor Rokuya Suzuki], ed. by T.Ohta & A.Arakawa (Tokyo: Yuhikaku, 1993).

in Japan,[184] because the plaintiff's burden of proof is alleviated to some extent, as compared with actions based on negligence.[185]

Having confirmed that the process is what must be assessed in deciding the quality of the practice, how is it to be evaluated? In the last analysis, it is virtually impossible to decide upon an absolute, universal standard of quality because of the uncertain nature of medical practice. The common law principle governing the standard of care in tort cases in general is based on the conduct of a reasonable person in the specific circumstance. Therefore, the standard of care imposed on doctors must be decided accordingly. In addition, some argue that the court should not intervene inappropriately in areas that require the special expertise associated with a specific profession. Thus, the standard has been established as to what reasonably competent doctors would do, based on the level of technology and custom among doctors at the time of the accident. This is clearly put in *Crits v. Sylvester* (Ontario 1956),[186] where it was held that doctors have to practise with "that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing."[187]

It is worth noting how the corresponding standard has developed in Japan. The precedents in this regard have been accumulated with respect to the cases of treating Retrolental Fibroplasia [hereinafter RF] of newborn babies. Photo-coagulation was

---

184 In the "contract" cases of medical malpractice in Japan, the defendant doctor has not only to cast a doubt successfully on the evidence submitted by the plaintiff, but also to prove actively that he is not liable in the case: H.Murakami, "*Iryokagososho Ni Okeru Saimu Furiko Kosei No Saikento* [Re-evaluating the "Contract" Approach of Medical Malpractice Cases]" (1980) 415 *Hanrei Taimuzu* 68 at 68-70.

185 Of course, the issue of "informed consent," and its relations to contractual liability, is differently discussed in Japan.

186 [1956] O.R. 132, 1 D.L.R. (2d) 502, affirmed [1956] S.C.R. 991, 5 D.L.R. (2d) 601.

187 *Ibid.*, at 143.

experimentally used as a method of treating RF in 1967, and it had gradually gained popularity among doctors. Accordingly, the number of cases increased which alleged that the doctor was negligent because he did not use photo-coagulation to treat RF.[188] In judging these cases, the Supreme Court declared that the standard of care that doctors have to achieve should be a practical standard of clinical medicine, not a highly academic or experimental one.[189] This principle was elaborated in a significant decision of the Fukuoka High Court. It was held that new, experimental treatment cannot establish a standard of care, even if it is published in certain professional journals. In order to become the standard of care, the treatment has to be double-checked again and again, be recognised as workable at the academic level and taught through the process of medical education.[190]

In relation to this "reasonably competent doctor" standard, there arises a difficult question of "geographically-considered" reasonableness, known as "the locality rule". In terms of how to assess the reasonableness of care, it has been thought in some cases that it is sensible to consider geographical differences, especially between urban and rural areas. Judges sometimes show apparent deference to this rule using expressions such as a "reasonable degree of learning and skill possessed by practitioners in similar communities in similar cases."[191] This can be justified to some extent by reference to the difference in access to medical resources in the course of practice, and in opportunities for post-licensure training through reading literature or discussion with

---

188 There was another ground for action: breach of the duty to refer the patient to specialists. This is also mentioned in Section 2 (2)-(f).

189 30 March 1982. (1982) 468 *Hanrei Taimuzu* 76 at 78.

190 21 June 1982. (1982) 479 *Hanrei Taimuzu* 172 at 176.

191 Justice Douglas Abbott, in *McCormick vs. Marcotte*, [1972] S.C.R. 18 at 21, 20 D.L.R. (3d) 345.

other doctors. Thus, this rule seems to have been justified as an excuse for substandard treatment, especially in the past when transportation and telecommunication was not so developed and there could be little interaction among doctors living in distant places. However, this notion is completely inimical to the aim of a legal duty to ensure a high and consistent quality of medical practice. Moreover, it can no longer be justified in view of the development of transportation and telecommunication. Lack of resources would be the only remaining reason, but this can be accommodated by using reasoning analogous to that used in regard to emergency operations in urban areas. Therefore, the locality rule should no longer be the rule in assessing the standard.

Other than the geographical problems of the standard, its definition raises questions of court procedure because it is based on medical technology as well as on customs among doctors. If judges or juries do not have enough expertise to judge the case properly, who does? That is where the role of the doctor as an expert witness comes into play. The expert witness is a "highly qualified, experienced and respected member of the medical community who practices, teaches, or does research in the branch of medicine at issue in the particular case."[192] He or she takes a significant role in the court procedure through presenting his or her opinion about technical issues in medicine. Such expert witnesses are actually called upon by both sides of the dispute as their "hired guns" in the adversarial procedure; however, in principle, the witnesses are supposed to assist the court process by showing their expertise objectively on specific medical matters.

---

[192] B. Sneiderman, J.C. Irvine, P.H.Osborne, *Canadian Medical Law: An Introduction for Physicians and other Health Care Professionals* (Toronto: Carswell, 1989) at 8.

Related to the "reasonable doctor" standard and its proof in the court proceedings, there is a significant trend away from a paternalistic model and toward a participatory model in terms of the patient right to autonomy. The landmark decision in Canada is *Reibl vs. Hughes* (Ontario 1980)[193] which identifies one of the characteristics of the Canadian health care system in terms of informed consent. Needless to say, doctors have to disclose information about the treatment of the illness in order to obtain consent to a specific treatment; however, it formerly remained a question of what standard should be used to decide the specificity of the information. The standard had been the "professional" standard, enabling doctors to judge what would be best for their patients to know. The Supreme Court of Canada changed the professional standard, replacing it with the "reasonable patient" standard; that is, to see if the reasonable patient in the specific circumstances would want and need to know the information in order to give the doctor an informed consent to treatment. From the viewpoint of the quality of medical practice, this change is fully justified because the final decision to undergo a specific treatment is not a technical matter of medicine; it is a decision referable to and properly governed by personal preference or the policy of each individual. In other words, the issue is not one of "technical care" but of "interpersonal care". Therefore, there should be as little room as possible for the doctor's discretion in disclosing information. This standard is also significant because it is the only patient-oriented standard employed in assessing the legal duties of doctors. Thus, this "reasonable patient" standard is a significant element of high-quality medical practice.

---

[193] [1980] 2 S.C.R. 880, 14 C.C.L.T. 1, 114 D.L.R. (3d) 1, 4 L. Med. Q. 209, 33 N.R. 361.

Lastly, it is also important, especially in the comparative study of Canada and Japan, to clarify the difference in essential elements between duties created by legislation and by case law. The difference not only reflects the divergent legal systems of common law countries and civil law countries, but also a difference of strategies in terms of ensuring the quality of medical practice.

With regard to the case law of negligence in Canada, where civil liability is mainly employed in cases of medical malpractice, the elements of liability are divided into three parts: existence of the duty of care, breach of the duty, and resultant damage that is connected to the breach of the duty. The patient-plaintiff has to prove all three, with some ostensible exceptions such as *res ipsa loquitur* . In addition, doctors are sometimes exposed to liability based on battery, signifying an intentional contact with another human's body without his or her consent. In such cases, the patient-plaintiff only has to prove that the doctor-defendant intentionally contacted the body; thereupon the doctor has to prove that there was a valid consent. From the viewpoint of a plaintiff, battery is preferable because he or she does not have to prove that the doctor's conduct actually caused any damage; however, battery cases are rare now because of the Supreme Court decision in *Reibl vs. Hughes,* as discussed below. Moreover, in either case, patients have to initiate the action. The court only passively accepts the case and judges it. Thus, the quality assurance of medical practice through imposition of civil liability on doctors has its own flaw, because it is based on the individual action of the patient-victim. This system would not work well under a system involving

extreme imbalances of power between doctors and patients, such as was discussed in Chapter 1.[194]

In Japanese legislation, the active involvement of government becomes more conspicuous. The major difference is that patients do not have to take action by themselves; police and administrative agencies can work for them. In addition, in many cases, just as with the tort of battery in Canada, they do not have to prove that there is actual damage to the patient that relates to the doctor's breach of duty. Rather, they can prosecute doctors if they merely violate the norm provided in the specific legislation.[195] This feature is closely connected to licensing and discipline. Actual damage can be pre-empted by imposing sanctions on doctors in this way, where the statutory provision contemplates a risk of damage. Thus, statutory duties, involving functions of court procedure, work as one of the active tools of government to ensure the quality of medical practice.

However, this active involvement on the part of the government has its own flaws. This statutory duty scheme can never work unless there is enough preparation by the prosecuting bodies. This would inevitably lead to an increase in governmental spending compounded by the bureaucracy of such bodies. In addition, the technical aspects of medicine, as mentioned in relation to the discussion of court procedure, also prevent the government from assessing the case independently; after all, the

---

[194] However, recently, the number of medical malpractice cases is increasing also in Japan, compounded by the patients' growing inclination for coping with doctors' malpractice by way of lawsuits.

[195] In actual cases the violating doctors might not be prosecuted because public prosecutors, who have a power to prosecute criminals officially by themselves or when requested by the victims, can decide whether or not to prosecute the violating doctor, depending on the seriousness of the violation, the existence of excuses, etc. (Article 247 and 248 of the Criminal Procedure Code). Therefore, especially in the case of violating the Medical Practitioners Law, which imposes only small punishments, such as fines of up to 10,000 yen (about $130), the prosecutor would, as a rule, refrain from prosecuting the violator unless there are other reasons that increase the gravity of the violation.

government has to rely on the knowledge and customs of doctors when the statutory duties involve technical questions of medicine.[196] More importantly, the system never works to compensate for the damage suffered by patients because such statutory duties aim at the punishment of doctors and the pre-emption of such damage. Compensation for such damage must be considered separately.

Thus, the difference in roles between case law and legislation reflects many issues involved in the quality control of medical practice. In the next Section, where individual duties are examined, this point is further clarified, as are the theoretical aspects discussed above.

(2) Overview of the Duties: A Comparative Perspective

This section, rather than attempting a detailed discussion of each duty, tries to explain the whole structure of duties, comparing the Canadian and Japanese systems. There are four main categories of duties in connection with the doctor-patient relationship. First, the duty to attend patients is the preliminary one which relates to entering into or terminating the doctor-patient relationship. Secondly, the duty of due care and skill in diagnosis, treatment and aftercare, the duty of explaining to patients the treatment and its risks before obtaining consent to it, and the duty of confidentiality are all directly related to ensuring the quality of medical practice, based on the individual doctor-patient relationship. Thirdly, the duty of keeping the medical record may not directly affect the care and skill of doctors in actual medical practice, but it is an important supplementary duty for enhancing quality through ensuring the consistency and accountability of medical practice. Lastly, reflecting the growing role of a doctor

---

[196] This situation was discussed more in detail in Chapter 1, where disciplinary processes of Canada and Japan were examined.

as part of a collective or team-based medical care approach, a duty of referral and seeking advice, a duty of communication with other professionals and a duty of supervising junior colleagues, arise. What are these legal duties of doctors?

(a) Duty of Attending Patients

The principle of "freedom of contract" is well established both in Canada and Japan. Each party to a contract can freely decide the contents of that contract, including whether or not to make a contract. However, this principle does not fit easily into the medical care field. If doctors could freely reject the request of patients to attend them, the overall quality of medical practice would inevitably go down, from a patient's point of view. This would also conflict with the aim of medical licensing, which looks to ensure a high quality of medicine by qualifying only competent and ethical doctors to practise in the medical care field.

In order to solve this problem, one effective way would be to impose upon doctors the legal duty to attend patients. However, this is also problematic because it would be impossible to impose that duty on doctors without any limitation. It could infringe on the individual rights of doctors, as well as the principle of freedom of contract. In addition, as doctors are also human, they have to set, using of course their expert knowledge, a certain priority of attendance when they have many patients waiting. Therefore, patients' needs must be properly balanced against the doctors' freedom and expert judgment in order to make this duty workable.

In Canada, the amount of case law relating to this duty has been small and legislation on the issue non-existent. It has been taken for granted that doctors basically do not have any legal duty to attend patients before a doctor-patient relationship is

formed. However, this situation is difficult to justify as long as doctors have an exclusive right to practise medicine. Because others cannot practise medicine by themselves without a license, the doctor's freedom must be modified, from the viewpoint of quality control, through ensuring accessibility. It is therefore inevitable that the court will gradually recognise the doctor's duty to attend patients, balancing the interests of both parties.[197]

There are some cases about balancing the interests of doctors and patients. For example, in the case of *Smith vs. Rae* (Ontario 1919),[198] in which the doctor did not attend a woman in labour because he was occupied with other patients and judged her case as not urgent, it was held that he did not have to "drop everything" to attend the expectant mother because his judgment at that time was justified. Thus, accurate assessment of urgency is a significant aspect of the duty to attend, because it is only the doctor who can properly assess the urgency of care from a medical point of view. This is also related to the duty of due care and skill in diagnosis, discussed later.

When the duty to attend becomes an issue after the doctor-patient relationship is formed, it brings other problems. For example, as held in *Considine vs. Camp Hill Hospital* (Nova Scotia 1982), [199] the duty to attend and the duty to explain to the patient about the treatment are closely connected. Breach of the former usually leads to that of the latter. Next, in the case of *White vs. Turner* (Ontario, 1981), [200] it was held that the treating doctor can leave the patient when a proper substitution is arranged. This is also one example of balancing the interests of doctors and patients; it would be fair to say

---

197 Sneiderman, Irvine and Osborne, *supra* note 192 at 127

198 (1919), 46 O.L.R. 518, 51 D.L.R. 323 (C.A.).

199 (1982), 20 C.C.L.T. 260, 133 D.L.R. (3d) 11, 50 N.S.R. (2d) 631, 98 A.P.R. 631 (T.D.).

200 31 O.R. (2d) 773, 15 C.C.L.T. 81, 120 D.L.R. (3d) 269, 5 L.Med.Q. 119, affirmed (1982), 47 O.R. (2d) 764, 12 D.L.R. (4th) 319 (C.A.).

that doctors can seek to improve their standards by attending conferences, or refresh themselves by taking vacations, if they can arrange for an adequate substitute or *locum tenens* during their absences.[201]

In Japan, the duty of doctors to attend their patients is provided for in Article 19, paragraph 1 of the Medical Practitioners Law [MPL] (Law #201, 1948). According to the Article, "doctors being engaged in medical practice shall not reject requests to attend patients if there is no justifiable reason." This provision shows some differences between the duty in the Canadian and Japanese systems. In this provision, "being engaged" is meant to exclude licensees who are working in other occupations, such as civil servants. This means that, in principle, medical doctors in Japan always have the duty to attend patients but only if they are practicing medicine.

The content of a "justifiable reason" is another issue. According to the first official interpretation of the Ministry of Health and Welfare [MHW], this means "the case when attendance is practically impossible for reasons such as the doctor's absence or illness."[202] However, this definition is too narrow to be justifiable. It would arguably be appropriate to include "personal matters and interests in doctors' private lives, depending on the availability of substitutes and the situation of patients" [203] or other reasons such as a difference of specialty[204] or closed hours.[205]

---

201 Although, the definition of "adequate" is usually complicated. It may involve many factors: the reasons for absence, urgency of the patient's illness, etc. Also see *Videto vs. Kennedy* (Ontario, 1981)

202 Official notice of the MHW, Aug. 1, 1955

203 H.Nishihara, *Hanzai Kakuron* [Detailed Analysis of Crimes], 2d. ed. (Tokyo: Yunikaku, 1983) at 115.

204 Nagoya District Court, Aug. 19, 1983, *Hanrei Jiho*, 1104, p107

205 Official Notice of the MHW, Apr. 16, 1974, IHATSU 412. It said that the doctor can reject the request if the hospital is in the area which has substitute hospitals for closed hours, and he or she has told the patients about the substitution.

What is the sanction applicable to violators of the duty? Until World War II, violators were subject to fines for unjustifiable non-attendance. However, that aspect of the present MPL has not been enforced, because it has been thought that such enforcement of medical ethics through punishment is not appropriate. Thus, the duty has remained without any criminal sanction. Although the MHW has officially declared that repetitive violations could result in suspension or revocation of the license, this has never been carried out.[206]

In terms of civil liability, there has been a dominant argument that such a duty to attend is an obligation based on public law. This leads to the conclusion that the doctor is obligated to the state, and not to patients who are not given a right to sue the doctor for his non-attendance. However, recently this has been overtaken by the contrary argument, reversing the burden of proof, that the doctor has to prove that he has justifiable reasons in order to escape from paying damages to the patient-plaintiff.[207] There are some precedents which have employed this latter argument.[208]

In conclusion, it has to be noted that, in spite of the different approaches in imposing the duty to attend on doctors, the actual situation is not so different in the two countries. Canada is reinforcing the duty through legal precedent; Japan is weakening the duty which was originally legislated with a criminal sanction. In the end, the problem is the subtle balancing of doctors' individual rights and judgments with the patients' needs, so it can at least be said that actual court procedures and legal

---

[206] Ohya, *supra* note 167 at 42.

[207] K.Kanno, "*Kisarazu Shinryo Kyohi Jiken*" [Rejection of treatment occurred in Kisarazu City], *Iryo Kago Hanrei Hyaku Sen* [100 Cases of Medical Malpractice Cases] (Tokyo: Yuhikaku, 1989) at 235.

[208] Chiba District Court, 25 July 1986, *Hanrei Jiho*, 1220, at 118.

precedents are needed for this duty to evolve;[209] and statutes also have to be interpreted fully in order to be adjusted to individual situations.[210]

(b) Duty of Due Care and Skill: Diagnosis, Treatment, Aftercare

Here is the most primary duty of all, directly connected with the everyday work of doctors dealing with the illnesses of patients. The following analysis first examines the basic concepts of the duties, "care" and "skill", and connects them to diagnosis, treatment and aftercare in everyday medical practice.

As mentioned in Section 1, in actual practice the doctor involved in any treatment has to show reasonable competence. In other words, physicians have to have reasonable skill and knowledge of medicine, as well as a reasonable level of carefulness and the motivation to use them properly. Though the two elements are not clearly divided in the actual setting,[211] this thesis tries to classify the former as "skill" and the latter as "care". From the viewpoint of doctors, "skill" is a given factor at the very moment of actual practice. Before they are involved in practice, they had to acquire and maintain their knowledge of medicine and their ability to use it at the level of reasonably competent peers. In other words, their effort to acquire and maintain the

---

209 One other example of balancing doctors' individual rights and judgment and the patients' needs is a case of emergency care. The fact that the patient's illness needs immediate care will lay more burden on doctors, especially when he works in an emergency department. For example, in *Barnett vs. Chelsea & Kensington Hospital Management Committee* (England, 1968. [1969] 1 Q.B. 428, [1968] 2 W.L.R. 422, [1968]1 All E. R.1068.), a doctor in the emergency department did not attend patients who were poisoned with arsenic, and the court clearly declared that he broke the duty of care, though he was not held liable because causation was not proved between his non-attendance and the death of one of the patients. In this way, a doctor in an emergency department, which is originally designed for dealing with urgent cases, would be allowed virtually no excuse for non-attendance.

210 The difference in the medical facilities between Canada and Japan would be another issue with respect to the duty of attending patients. Under the chaotic system of competing hospitals and clinics (see, Chapter 1, Section 2-(4)) in Japan, even specialists in hospitals have to attend a great many patients in a day. It would be significant to evaluate how such differences in the system affect the doctors' legal duty to attend patients.

211 For example, reasonable carefulness and motivation in a specific case of practice can have an aspect of "skill" if they are the approved practice in medicine as received through medical education.

skill has made them "professionals," distinguishable as such from those who follow other occupations. In addition, skill is decided objectively, referring to the progress of medical science at the relevant time. The duty of "care" works at the very moment of the practice; it represents the emotional side of the practice, imposing on doctors the duty to be careful in thinking of appropriate methods of practice and in using them properly. Their duty of care is fundamentally the same as that of ordinary people, though it is more rigid and specific because it is related to their specific course of practice. In this way, "care" and "skill" together make up a norm of reasonable competence that comprises the legal duty of doctors.

In assessment of the duty of "care", competence in "skill" is considered as one significant factor. Those doctors who are incompetent in "skill" have to realise this deficiency and refer the patient to other doctors as soon as they find the treatment of the illness needs more skill and knowledge than they have. Those doctors who are more competent than other reasonably competent peers (this often means specialists) are subjected to a more severe duty of "care" in their dealing with patients. [212]

The first stage of the doctor-patient relationship is a diagnosis of the patient's illness. People go to see doctors for treatment of pain or for other symptoms that they may have.[213] The doctor, when so requested by the patient, must first try to diagnose the illness, in other words ascertain the name of the illness from various kinds of information learned from the patient or taken from the patient's body. How is the doctor's duty of due care and skill to be interpreted in the context of this process?

---

[212] See *Fraser vs. Vancouver General Hospital* (British Columbia, 1952, [1952] 2 S.C.R. 36, [1952] 3 D.L.R. 785.) for a case of interns, and *McCaffrey vs. Hague* (Manitoba, 1949 [1949] 2 W.W.R. 539, [1949] 4 D.L.R. 291 (Man. K.B.) for a case of a specialist.

[213] Of course, they go to see doctors for routine check-ups, but this thesis does not deal with issues concerning them.

The process of diagnosis is a scientific categorisation of symptoms into a specific illness; in this process, the connection between a symptom, or a set of symptoms, and the illness is usually clarified. However, due to the evolving nature of medical science, each symptom does not necessarily fall definitively under the category of a specific illness. Rather, it is more likely that there are many symptoms that do not usually come with the diagnosed illness. In this case, the doctor cannot avoid, to any reasonable extent, making a selection of symptoms used for the diagnosis; in other words, neglecting other symptoms even if they might be related to a more severe illness. Therefore, the doctor is not held liable for any wrong selection as long as reasonably competent peers might do the same. Instead, he is required to show "reasonable effort, a healthy measure of attention and inquisitiveness, an open mind, and a willingness ... to make use of any appropriate diagnostic resources which may be reasonably available."[214] This approach is well-reflected in the case of *Dale vs. Munthali* (Ontario 1977), [215] where the doctor was held liable because he mis-diagnosed meningitis for influenza, neglecting some significant symptoms that would have led reasonable doctors to conduct further examinations.

Reaction to a treatment is also one item of information useful in diagnosis. In other words, if the patient does not recover as expected after the treatment, it is likely that the diagnosis has been wrong. Therefore, it is also a doctor's duty to observe the situation of the patient after the treatment and to re-assess the initial diagnosis on a continual basis. Failure in this constitutes a basis for liability, as in *Layden vs. Cope*

---

214 Sneiderman, Irvine and Osborne, *supra* note 192 at 131.

215 (1977), 16 O.R. (2d) 532, 78 D.L.R. (3d) 588, L.Med. Q. 234, affirmed 21 O.R. (2d) 554, 90 D.L.R. (3d) 763, 2 L.Med. Q. 231 (C.A.).

(Alberta 1984),[216] where two general practitioners were held liable because they continually prescribed medicine for gout but did not re-evaluate the diagnosis, which should have been cellulitis. Of course, this re-evaluation should only be done on a reasonable basis. The doctor is not liable for not attempting to re-evaluate the initial diagnosis if reasonable peers also would not have done so, as held in *Wilkinson Estate vs. Shannon* (Ontario 1986).[217]

After diagnosis, the doctor attempts to cure the illness through treatment and aftercare. This stage for assessing the doctor's liability is clear. In the treatment, the doctor has to decide the method and do it with a reasonably competent level of skill. If he fails in doing what other reasonably competent peers would do, he is held liable. What is reasonable varies in each case, depending on "the peculiarities of the particular patient, the degree and predictability of inherent danger attending a particular mode of therapy, and the relative ease or difficulty of precautionary measures."[218] In the process of aftercare, the question is twofold. First, the physician has to observe the situation after the treatment with due care and skill. Secondly, he has to explain the result of the treatment to the patient and instruct her on how to care for herself after the treatment. These criteria fall under the same professional standard as mentioned above; however, the latter is also significant because it raises a broader issue in view of communication between a doctor and a patient.[219] This is explained in the case of *Brushett vs. Cowan*

---

216 (1984), 28 C.C.L.T. 140, 52 A.R. 70 (Q.B.).

217 (1986), 37 C.C.L.T. 181 (Ont.H.C.).

218 Sneiderman, Irvine and Osborne, *supra* note 192 at 137.

219 *Ibid.*, *supra* note 192 at 139.

(Newfoundland 1987),[220] in which the doctor was held liable because he did not tell the patient to use crutches after a bone biopsy.

(c) Duty of Explaining to the Patient the Treatment and Its Risks

As explained above, "informed consent" is one of the most significant norms in medical practice. The patient has the right to decide to permit or refuse a specific treatment, after due consideration of the information given by doctors. In other words, the doctor has the duty to obtain the patient's consent which is fully considered and based on true information. Theoretically, breach of the duty may make the doctor liable through two different approaches: battery and negligence. Battery focuses on the valid consent of the patient, while negligence is based on the doctor's duty of care. In Canada, some cases are presented as cases of battery, while others are cast in negligence. This difference was confusing until the Supreme Court of Canada established a clear distinction. In *Reibl vs. Hughes*, it declared:

> Battery should be confined to those cases where (emergency situations aside) surgery or treatment has been carried out without any consent at all, or has gone beyond or differed from the procedures to which consent was given; and to those cases where the consent given has been vitiated by the fraud or misrepresentation used to obtain it. In contrast, a failure to disclose attendant risks, however serious, should go to negligence rather than to battery. It relates to the breach of an antecedent duty of due care. It is not a test of the validity of the patient's consent.[221]

Thus, the functions of negligence and battery have been distinguished clearly since this decision. The application of battery has been limited to rare cases such as those of unconsented treatment. The law of negligence has been applied to many cases where

---

[220] (1987), 42 C.C.L.T. 64, 40 D.L.R. (4th) 488, 64 Nfld. & P.E.I.R. 262, 197 A.P.R. 262 (Nfld. T.D.).

[221] 14 C.C.L.T. 2.

the scope of disclosure becomes an issue in terms of the nature and risks of the treatment.

With regard to the standard of disclosure itself, in *Reibl vs. Hughes*, the Supreme Court employed the "reasonable patient" standard (see Section 1). Interestingly enough, this decision is opposite to that of judicial authority in Japan. The first decision by the Supreme Court of Japan in these matters was delivered 19 June 1981.[222] This was a case of civil liability of doctors who performed a risky operation on a child with a skull fracture, without explaining the surgery to the child's father, as a surrogate decision maker. In deciding this case, the Supreme Court of Japan declared that the doctor basically has the duty to explain to the patient or his legal surrogate what the treatment options are and their respective inherent risks. However, it conferred a large measure of discretion on doctors, saying that the content of the duty depends on the degree of certainty about the symptoms of the patient, the likely effect of the treatment, or the extent of the risk. In addition, in denying the doctor's duty in that case, it considered that the father could adequately understand the risk, without the doctor's explanation, from the apparent situation; also the patient's side did not ask any questions at the critical time.[223] Thus, in terms of the standard of disclosing information about the nature and risks of a specific treatment, the precedent in Japan is still confined

---

[222] 1011 *Hanrei Jiho* 54, 447 *Hanrei Taumuzu* 78.

[223] The patient's questions are not meaningless in Canada; they impose a greater burden on the doctor to disclose the information. The doctor has to answer all the questions that the patient asks, because the answers are assumed to be material to the patient's decision making. Failure in answering the questions constructs the doctor's negligence. See, *Sinclaire vs. Boulton* (British Columbia, 1985. 33 C.L.L.T. 125 (B.C.S.C.).

to the "professional standard,"[224] while at the same time, the responsibility is placed on patients to ask the right questions at the time of treatment.[225]

(d) Duty of Confidentiality

The duty to preserve the confidentiality of the patient is one of the oldest duties of doctors; the age of Hippocrates already established a burden upon doctors to keep the "holy secrets" of patients. It is also one of the key duties which has distinguished doctors and other health care professionals as members of a true profession, distinct from most other occupations, as discussed in Chapter 1, regarding the self-regulation of established professions. For example, the Canadian Medical Association has its Code of Ethics in which this duty is clearly stated. The Japan Medical Association also has defined the duty of confidentiality in its Code of Ethics. Because of these examples of self-regulation, the cases have been rare in which a doctor has breached this duty and has been sued for compensation. Rather, case law has evolved to deal with the question of the boundaries of this duty of confidentiality, for example, in cases of court proceedings.

In Japan, a duty of confidentiality is provided in Article 134 of the Criminal Code. This provision is not specifically for doctors; lawyers, midwives, pharmacists, who are likely to know matters involving the privacy of their clients are also subjected

---

[224] With respect to the cultural background of informed consent in Japan, see G.J.Annas & F.H.Miller, "The Empire of Death: How Culture and Economics Affect Informed Consent in the U.S., the U.K., and Japan." (1994) 20:4 *American Journal of Law & Medicine* 357.

[225] The recent survey of the MHW indicates that, in Japan, many doctors do not even explain to the patient what kind of disease she has, especially when the disease is severe and in the terminal stage. According to the 1994 survey of the Statistics and Information Department, the rate of patients who died of cancer, heart diseases and cerebro-vascular diseases who had been informed of the nature of the disease was 20.2%, 54.7% and 35.5% respectively: *Shukan Shakai Hosho* [Weekly Social Security] No.1838, 15 May 1995, at 14. These figures would be explained by the attitude of doctors reluctant to tell the truth to patients who might then be too depressed to undergo treatment; but still, such an attitude derives from their paternalistic, professional judgment, based on the notion that "doctor knows best."

to a duty of confidentiality by this provision. Any breach of this duty is severely sanctioned, in comparison to other duties defined in the MPL. Violators are subject to imprisonment for up to six months or fines of up to 100,000 yen. It is also possible that they may be prosecuted for defamation when patients are judged to have suffered judicially acknowledged damages. However, as in Canada, there is no case available which directly governs such a breach of confidentiality. Instead, there is a similar development of the theory about those situations in which the doctors are relieved from the duty.

There are several major exceptions in which doctors are not subjected to any legal liabilities, even if they disclose the patient's information in public. The typical case is when the patient consents to the disclosure.[226] However, there are other cases when the doctor can make disclosures even if the patient objects.

First, the doctor sometimes is ordered to disclose the information in the course of court proceedings. This duty to disclose goes back to the *Duchess of Kingston's Case* decided by the House of Lords in 1776,[227] in which it was held that "[i]f a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and a great indiscretion; but to give that information in a court of justice, *which by the law of the land he is bound to do*, will never be imputed to him as any indiscretion whatever."[228] Since this decision, cited by the Canadian courts, doctors basically have had to disclose confidential information about their patients if so ordered

---

[226] The doctor might be reluctant to do so from her professional judgment, when the disclosure apparently hampers proper treatment of the patient. This could sometimes be justified when professional discretion is needed to avoid more harm due to the disclosure (Sneiderman, Irvine and Osborne, *supra* note 192 at 186). However, as long as the patient consents to the disclosure, the matter would be only of professional ethics, not of legal analysis (Ohya, *supra* note 167 at 56).

[227] (1776), 20 State Trials. 355 (H.L.).

[228] *Ibid.*

by the court.[229] Secondly, there are some cases when the doctor is placed under a duty to disclose information about patients to the health authority for the sake of public health, especially for contagious diseases. In these cases, the duty to the public overrides the duty to the individual patient. Thirdly, there are some cases when the public has to know information about patients to protect themselves. For example, the doctor would have to disclose to the appropriate authorities that his patient is likely to harm members of the public, for example due to psychiatric disease. Also in this case, the public interest overrides the privacy of the individual patient.

In conclusion, the duty of confidentiality for protecting the patient's privacy is axiomatic in the context of professional ethics. However, the aim of the duty also includes fostering the public's trust in doctors. Therefore, even if the doctor initially has the duty to protect the privacy of individual patients, she also has the duty to apply the information appropriately for the public good when necessary, for the sake of ensuring the health of the community at large.[230]

(e) Duty of Keeping Adequate and Accurate Medical Records

The memory of a human being is not limitless. People forget many things easily, often conveniently. Doctors are no exception. Even if they have expertise in medicine, they probably cannot remember all the diagnoses and treatments which they perform in a day. This problem is crucial especially when the practice involves technical matters. For example, the dosage of drugs with severe side effects, such as anti-cancer drugs, could be fatal unless administered correctly. This is a primary reason why the treating doctor has to make and keep medical records. Their contents must also

---

229 Sneiderman, Irvine and Osborne, *supra* note 192 at 178. In rare cases, judges are reluctant to order the doctor to disclose specific information regarding psychiatric patients.

230 Ohya, *supra* note 167 at 52.

be adequate and accurate in order to ensure the consistency of medical practice, from one doctor to another. This duty is only indirectly related to everyday medical practice; for the records themselves do not necessarily affect the due care and skill of the practice. However, for the above reason, record maintenance is one of the most important legal duties imposed on doctors.[231]

In addition, this keeping of records reflects "sincere commitment to the well-being of the patient" as well as "self-protecting considerations."[232] This is shown in the actual court proceedings. First, the standard of record-keeping is an element in assessing the defendant doctor's sincerity and competence. Improperly made records with inaccurate information could persuade juries and judges to infer the incompetence of the doctor, leading them to adjudge him liable. There are some cases both in Canada and Japan in which slackness in record keeping has seemed to affect the decision of the case.[233] Secondly, medical records, made and kept by the treating doctors immediately after the treatment, are considered evidence, though not conclusive, in court proceedings. Most importantly, in the event that the lawsuit begins many years after the incident in question, such written evidence would be an invaluable tool to protect the doctor.[234]

---

231 There are of course many other clinical reasons why the doctor has to keep medical records: for "filling-in" doctors to grasp the situation of the patient, for the treating team of health professionals to discuss the direction of the treatment, etc. Also see H.Ito, *"Shinryoroku No Iryo Jo No Toriatsukai To Horitsu Jo No Toriatsukai Wo Megutte (jo)* [Analysing the system of keeping medical record: from medical and legal perspectives (I)]" (1973) 294 *Hanrei Taimuzu*.

232 Sneiderman, Irvine and Osborne, *supra* note 192 at 141.

233 In Canada, see *Reynard vs. Carr*, 1983, 50 B.C.L.R. 166, 30 C.C.L.T. 42, reversed in part 10 B.C.L.R. (2d) 121, 38 C.C.L.T. 217 (C.A.). In Japan, see the case of misdiagnosed Retrolental Fibroplasia, Nagoya District Court, Dec. 26, 1986, *Hanrei Jiho*, 1234, at p. 45.

234 Of course, this would protect the patient-plaintiff instead because it is the objectivity that makes medical records permissible evidence.

In Japan, the MPL states that the "doctor shall, after diagnosis or treatment, write down the related matters of the practice on medical records as soon as possible."[235] And, "in terms of the medical records in the previous paragraph, they shall be kept for five years by the administrator when the practice is done by the doctor in hospitals or clinic, or by the doctor himself in other cases."[236] This provision also aims at the above two objectives: high-quality, consistent medical practice, and utilisation as evidence in any court proceedings. It also clearly declares that the records can be abandoned five years after the treatment finishes, implying that in Japan record-keeping is primarily a matter of an other-regarding duty, rather than a self-protecting consideration.[237]

Lastly, related to this duty, the patient's right to access the medical record must be mentioned here. Interestingly enough, in terms of this issue, the legal precedents in Canada and Japan are completely opposite. A Canadian case is *McInerny vs. MacDonald* (Nova Scotia 1992),[238] in which a doctor was requested to disclose the medical record including not only those entries of her own making but also those made by other doctors. Canadian courts had admitted the right of patients to access medical records that were made by the very doctors giving the treatment, once the case has begun to be subjected to court proceedings. Also, some provinces had legislated statutes declaring the patient's right to access his or her own records. However, in this case the plaintiff sought the records made by other doctors, with whom the doctor-patient relationship was already terminated. In addition, the place was Nova

---

235 Article 24, Paragraph 1

236 Article 24, Paragraph 2

237 However, the MHW has officially declared that it is desirable to keep the records as long as possible even after five years has passed. (Official notice of the MHW, IHATSU 1113, 1 August 1972)

238 [1992] 12 C.C.L.T. (2d) 225.

Scotia, where there was no statute permitting the right. Therefore, it was especially noteworthy when the Supreme Court of Canada finally declared that patients have the inherent right to access their medical records.

In Japan, the matter was decided in the opposite way in the Tokyo High Court case[239] in which a patient, who had undergone an experimental treatment against chronic liver disease, requested the defendant doctors to show him his medical record. Other lawsuits had denied any right to access the medical record, based on the right to pursue happiness provided in the Constitutional Law,[240] and the Tokyo High Court also denied any right based on the private contract.[241] The judges acknowledged that, especially in such a case of experimental treatment, doctors have to report to the patient about the treatment. However, they concluded that such conditions do not overtake the principle that the patient does not have a right to access the very medical record which had been written for him.[242]

In this way, the judicial authorities of Canada and Japan show a huge difference. This comes back to the difference between a paternalistic model and a participatory model. In Japan, the notion that "the doctor knows best" still survives and his discretion is accorded far more deference than in Canada. It is difficult to decide which approach is better suited to the cultural background in Japan; but it can at least be said that the

---

239 Tokyo High Court, 28 August 1986, at p. 226. *Hanrei Jiho*, 1208, at p. 85. This is the final decision because the plaintiff did not appeal to the Supreme Court.

240 Article 13: reads "[a]ll of the people shall be respected as individuals. Their right to life, liberty, and the pursuit of happiness shall, to the extent that it does not interfere with the public welfare, be the supreme consideration in legislation and in other governmental affairs."

241 In Japan, a contract of medical care provision is regarded as *Jun Inin* [quasi-mandate], defined in the Civil Code. This type of contract provides the duty of the treating doctor to report to the patient about the diagnosis, treatment, etc.(Article 645). However, this duty does not mean that the doctor actually has to show the records to the patient. The method and occasion of the report is left to the professional discretion of the doctor.

242 This case show that the discretion of doctors on technical matters of medical practice are more emphasised than the patient's right to be informed.

trend is definitely toward a participatory model, and the doctrine in Japan will eventually change.[243]

(f) Duty of Referral or Seeking Advice

In the not too distant past, the treatment of patients was usually done with one practitioner. However, as medicine has developed, medical practice has tended to involve more than one doctor for each patient. Not only do general practitioners refer patients to specialists, there has also been a growing need for co-operation between general practitioners and specialists themselves. Thus, the duty of prompt referral and seeking advice has evolved. Such practices are now considered to be something that a reasonably competent doctor would do, and thus comprise part of a doctor's legal duties.[244]

The imposition of this duty relies on a highly technical evaluation of medical practice. Whether the first doctor has to refer the patient to or seek advice from other doctors significantly depends on how urgent the illness is and whether other doctors are readily available. The latter can be decided objectively with lay knowledge, but the former cannot be decided without referring to professional assessment. These elements are added to the ordinary convention of medical practice; and the judge decides, with

---

[243] There is also a trend, though still elementary, of empowering the patients' position in Japan. A number of people are seeking measures to establish patients' autonomy. One example is the Declaration of Patient's Right, announced by a group of lawyers on 14 October 1984. (K. Shimamoto, *The Physician-Patient Relationship: Jiko Kettei Ken in Japan and the Right of Self Determination in the U.S.* LL.M. Research Paper, University of Washington, Seattle, US, 1988). Another example is a group of doctors and other hospital workers in Japan who visited Henderson Hospital in Hamilton, Ontario, in order to learn situations of patients' directives in Canada: S.Morrison "Informed Consent" *The [Hamilton] Spectator*, 28 January 1995 at A16. Such attitudes should replace the present doctrine with the patient-oriented one in the future.

[244] The cases of the RF discussed in Section 2 (1) also bring this issue of the duty to refer and/or seek advice. As the photo-coagulation therapy was performed in a limited number of hospitals, the question was raised whether a doctor who did not have enough expertise in the therapy had the duty to refer the patient to specialists. See T.Aeba, "*Iryo Suijun To Setsumei/Tenso Gimu* [Standard or medical practice and the duty to explain and refer]" (1980) 415 *Hanrei Taimuzu* 54 at 64-67.

the help of expert witnesses, whether the defendant doctor had a duty to refer in the specific situation . For example, in the case of *Chipps vs. Peters*,[245] the plaintiff patient could not prove that the general surgeon was negligent when he carried out an operation that was normally performed by a gynaecologist.

This duty to refer or seek advice is closely connected to the efficiency of the medical care system itself. If the doctor treated the patient by himself, though he was not able to do so, it would be nothing but a waste of scarce medical care resources. This problem is compounded by specialisation in the profession. "Specialisation" means that the doctor in a speciality often does not have enough knowledge about any illness lying outside the speciality; this may be clarified if one thinks of a case in which a cardio-vascular doctor keeps treating patients who complain of chest pain because in truth they have cancer of the oesophagus.[246] More importantly, the fee-for-service payment system of public health insurance, which is employed for doctors in Canada and for the major part of the whole service in Japan, has an unfortunate tendency to pay more money to those doctors who are not competent enough and thus inevitably overtreat patients. Thus, imposing upon doctors the duty to refer is beneficial not only from the point of view of patients who can receive better medical care, but also for the whole nation which has scarce resources to be spared for health care.

This perspective from the state's point of view has been more and more indispensable since public health care insurance was introduced, as discussed in Chapter 1. This is well reflected in Japan because the duty to refer is provided not in the MPL but in the Regulation of Hospitals and Doctors Designated for Health

---

[245] Ontario Court of Appeal, unreported, 8 March 1979

[246] S. Sunahara, *Isha To Kanja To Byoin To* [Doctor, patient and Hospital] (Tokyo: Iwanami Shinsho, 1983) at 78.

Insurance (Ministerial Ordinance of the MHW, #15 of 1957, Article 16). Doctors must obey the Regulation in order to be eligible to receive payment from the public insurer. This provision is especially important because there is no clear distinction between hospitals and referring doctors' offices in Japan, as discussed in Chapter 1. Accordingly, there is no official distinction between general practitioners and specialists; specialists are only certified by academic organisations within medicine, without any privilege of exclusive use of the title. Thus, in Japan there is no clear structural distinction between the "referring" position and the "referral-accepting" position, in terms of both facilities and individual doctors.[247] Therefore, it cannot be certain that referral will be done properly if there is no clear obligation on doctors to refer the patients. Thus, in the case of Japan, the duty to refer is regulated within the domain of the health insurance policy.

(g) Duty of Communicating with Other Involved Professionals

Communication with other health care professionals who are involved in the treatment of a patient is growing more and more important, along with the development of the team approach to medical practice. Unlike the days when one doctor did everything, perhaps with the assistance of nurses, for the treatment of patients, there are nowadays many allied health care professionals, in and out of hospitals. They are in charge of the patients within their scope of practice. Doctors have to co-operate with them in the provision of care, as well as with other doctors. This duty has some overlap with that of referral to and supervision of colleagues, because these are also forms of communication within the profession. The duty of communication extends to

---

[247] Nakagawa, *supra* note 68 at 150-52 and 174-77.

communication among peers, which is as important as getting advice from seniors and supervising juniors.

In Japan this duty is not provided for in the MPL, because it has been considered that doctors fundamentally have the power and responsibility to regulate other health care professions, including nursing. This notion appears in some provisions of the laws regulating other professions; for example, most of the health care professions are supposed to work "under the instruction and supervision" of doctors. However, one can find related articles about horizontal co-operation in the laws regulating some of other newly-regulated allied health care professions. For example, The Emergency Life-Saving Technician Law (Law # 36 of 1991)[248] provides in Article 45 that "the emergency life-saving technician shall, in the course of his or her practice, closely co-operate with doctors and other health care professions in order to ensure appropriate level of medical care". The same provision is to be found in a few other recently legislated professions. This is only an ethical provision and is not attended by any judicial sanctions; however, this provision shows that this duty is recognised also in Japan.

(h) Duty of Supervising Junior Colleagues

Doctors sometimes are exposed to liability not only for their own conduct, but also the conduct of others. They are vicariously liable when other health care professionals whom they have hired, such as a nurse, are held liable for some misconduct. However, more importantly, they are held liable when they cannot supervise their junior colleagues properly in the course of medical practice. The latter is different from the former, for junior colleagues of the doctor are in no way their

[248] An emergency life-saving technician has similar status as a paramedic.

employees. In such cases, doctors are held liable for their own conduct in providing negligent supervision.

This principle is well reflected in *Considine vs. Camp Hill Hospital* (Nova Scotia 1972).[249] The head of the urology department and its resident performed an operation which produced a bad result. In that case, the head was also held liable for inadequately supervising the resident. This duty is closely connected to the above duties of communication, referral and seeking advice. All of them are duties for the purpose of ensuring the quality of medical practice which is provided by many health care professions collectively.

---

[249] (1972), 20 C.C.L.T. 260, 133 D.L.R. (3d) 11, 50 N.S.R. (2d) 631, 98 A.P.R. 631 (T.D.).

(3) Conclusion

The exploration conducted in this section is rather elementary because it is a mere overview of a complicated area of law which governs the whole domain of medical malpractice cases. However, it is notable that this section has shown an interesting contrast of doctors legal duties between Canada and Japan, within the historical and cultural contents of both countries. The authoritarian nature of medical practice enables doctors to have more power than patients in Japan, whereas emphasis on the patients autonomy in Canada gives less power to physicians. These aspects can be made still clearer in exploring the culture and history of these countries in more detail, as well as by examining differences in the technical aspects of medicine in both countries.

Bibliography

Aeba, T. *Iryo Suijun To Setsumei/Tenso Gimu* (Standard of medical practice and the duty to explain and refer) (1980) *Hanrei Taimuzu* 54

Annas G.J. & F.H.Miller. "The Empire of Death: How Culture and Economics Affect Informed Consent in the U.S., the U.K., and Japan" (1994) 20:4 *American Journal of Law & Medicine* 357.

Arrow, K.J. Uncertainty and the Welfare Economics of Medical Care," in *Collected Papers of Kenneth J. Arrow* Vol.6. Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 1985.

Aubert, V. *In Search of Law: Sociological Approaches to Law.* Oxford: Martin Robertson, 1983.

Aubert, V. "Coercion, Resources and the Right to Participate in Decisions: Some Trends in the Legal Development". *Equality and Freedom: International and Comparative Jurisprudence.* Vol. III. Dobbs Ferry: Oceana Publications Inc., 1977.

Bai, K., S. Utsuki & K. Hirabayashi. (ed) *Iryo Kago Hanrei Hyakusen* (Selected 100 cases of medical malpractice) *Bessatsu Jurisuto* No.102. Tokyo, Yuhikaku, 1989.

Bai, K. & Y.Narita (ed) *Iji Hanrei Hakusen* (Selected 100 cases related to health issues). *Bessatsu Jurisuto* No, 50, Tokyo: Yuhikaku, 1976.

Barr, N. *The Economics of the Welfare State.* London: Weidenfeld and Nicolson, 1993.

Blishen, B.R. *Doctors in Canada.* Toronto: University of Toronto Press, 1991.

Bohnen, L.S. "In Defense of the Health Professions Legislation Review" (1989) 10:2 *Health Law in Canada* 163.

Bolaria, B.S., H.D.Dickinson, *Health, Illness, and Health Care in Canada* (2nd ed.). Toronto: Harcourt Brace & Company, Canada, 1994.

Boorse, "On the Distinction Between Health and Illness." *Concepts of Health and Disease.* ed. by A.L.Caplan, H.T. Engelhardt, Jr. & J.J.McCartney. Reading, Massachusetts: Addison-Wesley, 1981.

Callahan, D. "The WHO Definition of 'Health'", in *Medical Ethics and Human Life*, ed.by J.E.Thomas. Toronto: Samuel Stevens, 1983.

Clarke, J.N. *Health, Illness, and Medicine in Canada.* Toronto: McClelland & Stewart, 1990.

Evans, R.G. "Hang Together, or Hang Separately: The Viability of a Universal Health Care System in an Aging Society" (1987) 13:2 *Canadian Public Policy* 165.

Flexner, A. *Medical Education in the United States and Canada.* New York: Carnegie Foundation for the Advancement of Teaching, 1910.

Friedman, M. *Capitalism and Freedom.* Chicago: The University of Chicago Press, 1962.

Friedson, E. *Professions of Medicine: A Study of the Sociology of Applied Knowledge.* New York: Dodd, Mead & Company, 1975.

Furrow, B.R., et al. *Liability and Quality Issues in Health Care.* St.Paul; West Publishing, 1991

Gall, G.H. *The Canadian Legal System*, 3rd ed. Toronto: Carswell, 1990.

George, V., P. Wilding. *Ideology and Social Welfare.* London: Routledge, 1985.

Hamowy, R. *Canadian Medicine: A Study in Restricted Entry.* Vancouver: Fraser Institute, 1984.

Hayek, F.A. *Rules and Order*: *Law, Legislation and Liberty* Vol.1, Chicago: The University of Chicago Press, 1973.

Hirai, Y. *Ho Seisakugaku* (Legal Policy Science). Tokyo: Yuhikaku, 1987.

Hiroi, Y. *Iryo No Keizaigaku* (Health Economics). Tokyo: Nihon Keizai Shinbun Sha, 1994.

Hirsh, H.L. "Medico-Legal Considerations in the Use of Physician Extenders," *Legal Medicine 1991*, ed. by C.H.Wecht. Salem: Butterworth, 1992.

Horner, S.L. "The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications" (1990) 16:4 *American Journal of Law & Medicine.*

Hogg, P.W. *Constitutional Law of Canada.* Toronto: Carswell, 1992.

Hyatt, H.H."Protecting the Medical Commons" (1975) 293 *New England Journal of Medicine* 235.

Irvine, J. "The Physician's Duty in the Age of Cost-Containment" (Paper presented to the Pitblado Lecture, held by the Law Society of Manitoba, 1994) [unpublished]

Ito, H. *Shinryoroku No Iryo Jo No Toriatsukai To Horitsu Jo No Toriatsukai Wo Megutte (jo)* (Analysing the system of keeping medical record: from medical and legal perspectives (I)) (1973) 294 *Hanrei Taimuzu.*

Japan. Health Policy Bureau, Ministry of Health and Welfare. (ed.) *Kenko Seisaku Roppo* (Compendium of Health Policy Legislation). Tokyo: Chuo Hoki, 1994.

Jones, D.P. & A.S.de Villars, *Principles of Administrative Law.* Toronto: Carswell, 1994.

Johnson, T. *Professions and Power.* London: MacMillan, 1972.

Katz, J. *The Silent World of Doctors and Patients.* New York: The Free Press, 1984.

Kluge, E.W. *Biomedical Ethics in a Canadian Context.* Toronto: Prentice-Hall, 1992.

Kitagawa, Z. *Saimu Furiko Ni Okeru Yusekisei* (Imputability in the Non-Performance of an Obligation-Duty) (1986) 118:4,5,6 *Hogaku Ronso* 100.

Kryworuk, P. W., B.T. Butler, A.L. Otten. "Potential Legal Liability in the Allocation of Scarce Health Care Resources" (1994) 14:4 *Health Law in Canada* 95.

Kelly, K. "Nurse Practitioner Challenges to the Orthodox Structure of Health Care Delivery: Regulation and Restraints on Trade" (1985) 11:2 *American Journal of Law and Medicine* 195.

Kodama, M. *Hipokuratesu No Gosui* (Siesta of Hippocrates). Tokyo: Bungei Shunju, 1994.

Kondo, M. "*Shujutsu Hencho Ni Igi Ari* (Objection to Operation-Oriented Treatment)" (1995) 73:4 *The Bungeishunju* 348.

Lester, J. "The Health Professions Legislation Review: The Need for Greater Clarity in the Scope of Practice Scheme"(1989) 10:1 *Health Law in Canada* 127.

Manitoba. Law Reform Commission. *Regulating Professions and Occupations.* Winnipeg: Queen's Printer, 1994.

Morita, H. *Kekka-saimu, Shudan-saimu No Kubetu No Igi Ni Tsuite* (On the distinction between obligations for result and action) *Minji Hogaku No Shin Tenkai: Suzuki Rokuya Sensei Koki Kinen* (New development of civil-law study: For the commemoration of the 70th Birthday of Professor Rokuya Suzuki) ed. by T.Ohta & S.Arakawa. Tokyo: Yuhikaku, 1993.

Morrison, S. "Informed Consent" *The [Hamilton] Spectator* (28 January 1995) A16.

Murakami, H. *Iryokagososho Ni Okeru Saimu Furiko Kosei No Saikento* (Re-evaluating the contract approach of medical malpractice cases) (1980) 415 *Hanrei Taimuzu* 68.

Nakagawa, Y. *I No Rinri* (Ethics of Medicine) Tokyo: Tamagawadaigaku Shuppanbu, 1977.

Nakagawa, Y. *Sugao No Isha* (True pictures of doctors). Tokyo: Kodansha, 1993.

Nishihara, H. *Hanzai Kakuron* (Detailed analysis of Crimes) 2nd ed. Tokyo: Yuhikaku, 1983.

Ohya, M. *Iryo Koi To Ho* (Medical Practice and Law). Tokyo: Kobundo, 1990.

Okudaira, Y. "*Eigyo No Jiyu No Kisei* (Restricting the freedom of enterprise)" *Bessatsu Jurisuto*, No. 39. Tokyo: Yuhikaku, 1973.

Olson, W.K. *The Litigation Explosion: What Happened When America Unleashed the Lawsuit*. New York: Truman Tally Books, 1991.

Ontario. Health Professions Legislation Review. *Striking a New Balance: A Blueprint For The Regulation of Ontario Health Professions*. Toronto: The Review, 1989.

Pal, L.A. *Public Policy Analysis: An Introduction*. Scarborough: Nelson Canada, 1992.

Parsons, T. *The Social System*. New York: The Free Press, 1951.

Payer, L. *Medicine and Culture*. New York: Penguin Books, 1988.

Robbins, L. *An Essay on the Nature and Significance of Economic Science*. 3rd. ed. London: MacMillan Press, 1984.

Sato, K. *Kenpo* (Constitutional Law). Tokyo: Seirin Shoin, 1990.

Schollenberg,E.G.A. *The Discipline of Doctors in Manitoba*. LL.M. Thesis, The University of Manitoba, Winnipeg, 1993.

Sharpe, S. "Medicare on the Critical List," *The Financial Post Magazine*. Toronto: The Financial Post, 1995, May.

Shimamoto, K. *The Physician-Patient Relationship: Jiko Kettei Ken in Japan and the Right of Self Determination in the U.S.* LL.M. Research Paper, University of Washington, Seattle, US, 1988.

Sneiderman, B., J.C. Irvine, P.H. Osborne. *Canadian Medical Law: An Introduction for Physicians and other Health Care Professionals*. Agincourt: Carswell, 1989.

Steslicke, W.E. "Medical Care Security and the 'Vitality of the Private Sector' in Japan". *Comparative Health Policy and the New Right: From Rhetoric to Reality.* New York: St. Martin's Press, 1991.

Sugaya, A. *Nihon Iryo Seido Shi* (History of the health care system in Japan) Tokyo: Sanyo sha, 1976.

Sunahara, S. *Isha To Kanja To Byoin To* (Doctor, patient and Hospital) Tokyo: Iwanami Shinsho, 1983.

Schwartz, A.M. *Striking a New Balance: a Blueprint For The Regulation of Ontario's Health Professions.* Toronto: Health Professions Legislation Review, 1989.

Sutherland, R.W., M.J.Fulton, *Health Care in Canada: A Description and Analysis of Canadian Health System.* Ottawa: The Health Group, 1992

Tahara, S. *Nihon No Kanryo 1980* (Bureaucrats in Japan, 1980) Tokyo: Bungeishunju, 1979.

Trebilcock, M.J., C.J. Touhy, A.D. Wolfson. *Professional Regulation: A Staff Study of Accountancy, Architecture, Engineering and Law in Ontario Prepared for The Professional Organisations Committee. January*, 1979

Utsuki, S. "*Ishikai no arikata* {How the JMA should be}" *Nihon no iryo: Korekara* (Health care in Japan: For Future) Jurisuto zokan, No.44. Tokyo: Yuhikaku, 1986.

Williams,G. & J.Popay. "Lay knowledge and the privilege of experience", in *Challenging Medicine.* ed. by Gabe, J., et al. London: Routledge, 1994.

World Health Organisation. *Evaluation of Recent Changes in the Financing of Health Services.* Geneva, 1993.

Zaidan Hojin Kosei Mondai Kenkyukai. Koseisho 50 Nen Shi: Kijutsu Hen (50-year History of the Ministry of Health and Welfare: Description of the History) Tokyo: Chuo Hoki, 1988.