Medical paternalism: beyond paternalism and antipaternalism

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ABSTRACT

This paper argues that the concept of paternalism is currently overextended to include a variety of actions that, while resembling paternalistic actions, are importantly different. I use the example of Japanese physicians’ non-disclosures of cancer diagnoses to patients, arguing that the concept of paternalism better captures these actions. To act paternalistically is to substitute one’s own judgement for that of another person and decide in place of that person for his/her best interest. By contrast, to act maternalistically is to decide for another person based on a reasonable understanding of that person’s own preferences. The concept of maternalism allows for a more thorough assessment of the moral justification of these types of actions. I conclude that it is possible, at least in principle, to justify Japanese physicians’ non-disclosures, and that this justification must be based on an understanding of these actions as maternalistic.

INTRODUCTION

While a contested concept, paternalism can be most simply defined as deciding to act in an autonomous person’s best interests without taking that person’s will decisively into account (or deciding expressly against it). Whether for or against the defensibility of paternalism, most arguments about paternalism begin by assuming that the actions of concern fit the core features of this definition. This assumption is problematic because paternalistic actions are usually not considered to be normatively neutral. In the classic example of a physician who performs a transfusion on a Jehovah’s Witness despite their religious objection to transfusions, the physician violates the patient’s clearly expressed will. The burden of proof in such cases is on the side of the paternalist, who must explain why the benefit of the action overrides the harm of interfering with the person’s liberty, restricting his or her opportunity or disabling his or her will.

Due to this presumption against paternalism, asserting that an action is paternalistic occasions an immediate call for the action’s harm to be morally justified. Yet some actions with paternalistic features may nevertheless be different kinds of actions. Decisions might be made for autonomous others without directly asking them what they want but attending to what they most likely would want, based on knowledge about their character and preferences. It is morally significant that such a decision would not disregard the other’s will. If actions such as these are too quickly described as paternalistic, other morally relevant features may be missed.

In this paper, I use the example of Japanese physicians’ non-disclosures of cancer diagnoses directly to patients to show that an action that is assumed to be paternalistic and therefore morally problematic may in fact be ‘maternalistic’, and that a maternalistic action does not bear the same burden of justification as a paternalistic one. In my definition, paternalism is deciding to act in an autonomous person’s best interests and likely in line with that person’s will, but in the absence of the affected individual’s expression of consent or assent. Despite the fact that a poorly done maternalistic action is very similar to a paternalistic one, I show how paternalistic and maternalistic actions are distinct; they have different motivating factors and different bases for judgement, although the desired effect in both cases is the same (improved welfare or the prevention of harm).

Maternalistic actions are not necessarily justified—a poorly done maternalistic action violates a patient’s will, despite the intention to act in line with it. Nevertheless, paternalism offers a useful alternative to paternalism in conceptualising decisions made for others. Paternalism, based on one individual’s disregard for another’s will, focuses conceptual attention on a general form of relationship that is at once the relationship of anyone and no one. Maternalism, by contrast, is predicated on the existence of relationships in which one party can discern the will of another without explicit communication. Interrogating the requirements for ethical justification of a maternalistic action leads to further analysis of fundamentally relational concepts such as trust and interpersonal understanding. Maternalism offers a window into aspects of decision-making not often considered in analyses of paternalism in addition to describing a novel conceptual category.

This paper begins by considering normative arguments about paternalistic actions by medical professionals and moves to a conceptual conclusion. I argue that the concept of paternalism is often overextended to include a variety of actions that, while resembling paternalistic actions, are

While in Japan diagnoses need not always be disclosed to patients, they must be disclosed to someone, often the family. To focus on the paternalism/maternalism distinction, I do not deal with the inclusion of the family in medical decision-making directly. However, it is an important feature of decision-making that is recognised beyond Japan. For a more detailed examination of the role of the family in the Western context, see Nelson and Donchin.
different in morally significant ways. I introduce the concept of paternalism to better capture these actions and to more thoroughly assess the possibility of their moral justification.

PATERNALISM’S BURDEN OF PROOF
The modern concern with paternalism traces back to John Stuart Mill’s *On Liberty*, as developed by Gerald Dworkin, Joel Feinberg (*Harm to Self*) and others. Dworkin defines paternalism as interference with another person, against her will, defended or motivated on the basis of improving her welfare or protecting her from harm. To capture the intuition that paternalism is problematic not just because it interferes with another person, but because it disregards another’s will when making a decision that will affect them, I use a simplified version of Daniel Groll’s definition of paternalism in this paper. According to Groll, person A acts paternalistically towards person B when, for the sake of B’s good, A does not take B’s will decisively into account or decides expressly against it. While there are important differences between the Dworkin and Groll definitions of paternalism, at their core they share the intuition that paternalism entails a failure to take another person’s will decisively into account when making a decision that is ostensibly for that person’s own good. Here, ‘will’ is best understood as a reflectively considered want or desire. For such a will to be taken into account, most antipaternalist theorists agree that it must be explicitly expressed.

Paternalism’s core intuition can be otherwise described in terms of a conflict between the subjective expression of will and the objective assessment of welfare. For the antipaternalist, any decision based on the latter that affects autonomous individuals must also include the former—hence the antipaternalist’s exclusion of anything but explicit consent. To decide based solely on an objective assessment of welfare would be a violation of individual autonomy. As Gerald Dworkin writes,

> Any sensible view has to distinguish between good done to agents at their request or with their consent, and good thrust upon them against their will. So the normative options seem to be just two. Either we are never permitted to aim at doing good for others against their wishes, and in ways which limit their liberty, or we are permitted to do so.

Arguments that share this core intuition nevertheless dispute the conceptual distinctions between different types of paternalism and the normative justifications for various kinds of paternalistic actions. Some arguments distinguish state paternalism from paternalistic actions by individuals such as parents, teachers or physicians. Others suggest that libertarian or soft paternalistic actions that temporarily interfere with behaviour to determine whether an individual is acting autonomously are justified, while hard paternalist actions that interfere with autonomy based on best interests alone are not.

Despite this variety of arguments about paternalism, most agree that a paternalistic action would be justified if the good of the action overrode the harm of interfering with the person’s autonomy. This places the burden of proof on the side of the paternalist. As Coons and Weber note, ‘normative debates about paternalism... don’t usually concern *whether* it is problematic but rather *how* problematic it is’. While some have argued for normatively neutral definitions of paternalism, the dominant approaches remain normatively charged against paternalistic interventions.

The placement of burden of proof in the justification of paternalistic actions is tied up with the definition of paternalism as ‘interference with another person’ and the inherent value that is thought to attach to individual autonomy qua independent self-determination. Individual autonomy through independent self-determination is considered an absolute good, so any action that interferes with self-determination is wrong. This presupposition leads many arguments about paternalism to elide ‘absence of self-determination’ with ‘paternalistic interference with autonomy’.

The either/or justification of paternalism is conditioned by the definitions of paternalism as interference with another person’s autonomy and of autonomy as independent self-determination. If interfering with individual autonomy is justifiable or not, then paternalism is either justifiable or it is not. However, to better assess actions that seem paternalistic, autonomy and paternalism must be redefined such that a lack of autonomy via an unexpressed will does not equal a definitive judgement of paternalism. Indeed, as arguments in favour of relational autonomy point out, while some social relationships will impede autonomy, others, such as supportive family members and trusted partners, will enhance or develop capacities for autonomy.

In other words, interpersonal relationships are complex, and cannot be divided into cases where an individual decides for himself or herself and cases where someone else decides in his or her place; there are grey areas between the two. While much work has been done to redefine autonomy relationally, here I focus on how relational considerations might affect how we conceive of deciding for others beyond paternalism and antipaternalism.

The insights of relational autonomy suggest we cannot assume that if an individual is not expressly making his or her own decisions or is not explicitly expressing his or her will, then someone else is deciding for him or her without taking his or her will into account. There may be cases where one person decides for another person without substituting their judgement in place of that of the other person, thus depriving them of autonomy. This is not just a problem of allowing implicit rather than explicit consent—in some cases, there will be no clear expression of will through a statement of consent. While antipaternalists require explicit consent to protect against paternalism, here I suggest that lack of full self-expression at the moment of decision-making does not necessarily imply paternalism and lack of autonomy.

Traditional arguments about paternalism disregard these relational features of interpersonal decision-making. Whether for or against the defensibility of paternalism, most arguments about purportedly paternalistic actions begin with a brief explanation of why these actions are paternalistic before assessing whether or not the paternalistic features of the action are justified.

There is a general assumption that all actions that one person undertakes for another autonomous person, without express consent, are paternalistic.

These actions must be examined more closely. If the action in question includes more morally relevant considerations than those included in the definition of paternalism, then the ethical justification of the action must consider additional reasons for the action beyond its alleged paternalistic features. In such a case, an argument against paternalism will not suffice, and

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There is instrumental value to autonomy as well: autonomy may lead to greater emotional well-being, to social respect, and to a successful career. Paternalistic actions’ interference with these goods is harmful. However, for simplicity of argument, I set aside this instrumental value, as it does not contribute to the argument for paternalism’s prima facie harm.
whether or not the action is justified will need to be reassessed. Before determining degrees of justifiability, arguments should consider whether the definition of paternalism accurately describes the actions to which it is applied.

Consider the case of paternalistic physician behaviour in the USA. Informed consent policies were enacted to avoid paternalism in which physicians assumed their judgement of what was best for the patient was more reliable than the patient’s own judgement. These policies were designed to ensure that physicians did not interfere with the right ‘to determine what shall be done with his own body’, as in Justice Benjamin Cardozo’s famous 1914 decision in Schloendorff v Society of New York Hospitals. The elision of paternalism with lack of self-determination is first found in this particularly American development of informed consent as a safeguard against physician paternalism. Informed consent was, in many ways, a product of American case law and the particular social and medical conditions of the USA in the middle of the 20th century. Nonetheless, as a general policy, informed consent has been extended to other countries, where there is agreement that establishing ethical medical practices includes avoiding physician paternalism. However, it has not been established that protection against paternalism entails patient autonomy nor that lack of independent self-determination entails paternalism.

This is particularly salient in Japan, where the adoption of so-called American-style informed consent policy has not been universal. Despite arguments mounted in Japanese academia and the popular press favouring individual autonomy over paternalism, in some cases, physicians disclose diagnoses to families rather than directly to patients. As recently as 2006, the mean proportion of patients with cancer who had been told their diagnosis was 59.3% in hospitals with less than 50 beds and 83.3% in hospitals with over 500 beds.12 The Japanese Medical Association (JMA) endorses this practice. Their ethical guidelines state that:

‘in the case that informing the patient of malignant cancer or incurable disease would cause an extreme emotional shock, prudent consideration regarding disclosure is necessary for the physician. Also, if the patient does not desire to know the correct disease name or condition, and it is anticipated that it would be a hindrance to further treatment, it is permitted to refrain from disclosure. However, this judgment must be made prudently, and at times it is necessary to consult with another member of the medical staff. In principle, it is necessary to inform the appropriate family member involved in caring for the patient of the correct disease name and condition’.11

The possibility of such non-disclosure has also been upheld by the Japanese Supreme Court, provided that a family member receives the disclosure instead.14 When viewed from abroad, this non-disclosure is described as paternalistic and is often declared morally unacceptable.15-17 This may be because of the practice’s apparent similarity to the exercise of therapeutic privilege (withholding information that may be damaging to the patient), a practice allowed by Canterbury v Spence but absent in subsequent cases and currently disallowed by the American Medical Association.

In the Japanese context, however, many find these non-disclosures to be defensible. To counter arguments against these so-called paternalistic actions, some attempt to define a particular Japanese type of autonomy, such that the physicians’ non-disclosures can be described as respecting patients’ autonomy via a concept of family autonomy.18-20 Yet few have inquired into the reasons for Japanese physicians’ non-disclosures, and it has not been established that these actions are paternalistic in the terms given above. Accordingly, it is not certain that antipaternalistic arguments apply to Japanese physicians’ non-disclosures. If these non-disclosures of diagnoses to patients are paternalistic, they must: (1) ignore the patient’s will or decide expressly against it and (2) be motivated by a desire to improve patients’ welfare or protect them from harm.1 Do Japanese physicians’ non-disclosures meet these requirements?

NON-DISCLOSURES OF DIAGNOSES IN JAPAN

An inquiry into Japanese case law, the JMA’s ethical guidelines and studies of Japanese physicians’ policies and attitudes towards disclosure reveals three factors as yet unrecongnised in arguments about non-disclosure of cancer diagnoses.

The first factor is that non-disclosure of a diagnosis is restricted mainly to cases where the patient has not exhibited a positive exercise of self-determination, which is to say, in cases where the patient has not expressed a wish to know the details of his or her diagnosis and has not attempted to become involved in the decision-making process despite invitations to do so.21 Non-disclosure is also allowed in cases where the patient has expressed a desire for positive self-determination, but this self-determination takes the form of asking not to be told the diagnosis and to be excluded from the decision-making process.22 In both these situations, the patient’s will is neither ignored nor opposed. Rather, either the patient’s will not to know the diagnosis is respected or the patient’s communicative behaviour is interpreted as a withdrawal from the decision-making process.

Second, when Japanese physicians choose not to disclose a cancer diagnosis to a patient, they do so not because they believe that they know better than the patient what is in the patient’s best interests, but because they believe that non-disclosure is what the patient really wants. In other words, they (along with the Japanese courts and the JMA) consider it to be part of the physician’s role to determine ‘whether the patient needs to know, would want to know, and could deal with the information’.22 This suggests that despite what some may see as practical difficulties in discerning patients’ unspoken wants, Japanese physicians’ intentions are neither to supplant patients’ wills with their own nor to decide expressly against them. Rather, the Japanese practice of non-disclosure is understood as respecting patients’ wills by acknowledging that whether or not a patient should be told a diagnosis depends both on their current preferences and on what their preferences might be if they knew the nature of their diagnosis.

Finally, the third factor is that non-disclosure is only permitted when it is thought that disclosure of the diagnosis would cause such a great shock to the patient that the patient would be harmed and attempts at future treatment would be adversely affected.4 In other words, these non-disclosures are motivated by a desire to protect patients from harm (this harm is statistically evident—in April 2014, a national study found that the risk of death by suicide or externally caused injury among Japanese patients with cancer in the year following diagnosis was 20 times that of the healthy population).23

Based on these three factors—no positive signs of a patient’s self-determination, the physician’s intention to act in accord with the patient’s will and potentially harmful disclosure—Japanese physicians’ non-disclosures are not paternalistic. In cases where a Japanese patient explicitly asks a physician for non-disclosure, non-disclosure does not violate the patient’s will, and therefore does not fit the first condition of the definition of paternalism. Even when the patient does not make a positive assertion either
way, the physician does not understand himself or herself as making a decision in place of the patient, but as responding to the patient’s unspoken wants. In some cases, the physician may believe that the patient has communicated his or her will, although non-verbally. These are cases of implicit consent. In other cases, physicians may believe they know the patient and the situation well enough to know the patient’s will without it being communicated at all. These would not be cases of implicit consent. Nevertheless, they would still not fit the definition of paternalism, because in all of these cases the physician neither fails to take the patient’s will decisively into account nor decides against it. Japanese physicians’ non-disclosures do fit the second condition for paternalism, since they are motivated by a desire to avoid harm in the form of a significant psychological shock to the patient that could affect treatment.

If Japanese physicians’ non-disclosures of cancer diagnoses are not paternalistic, then in what terms might we describe them? They do not quite fit any of the fringe theories of paternalism, such as soft paternalism or libertarian paternalism, because they can be interpreted neither as interfering with patients’ choices to determine their level of autonomy nor as nudging patients in the direction of a certain type of choice (as even a ‘nudge’ disregards the patients’ will in order to facilitate a decision thought to be better for the patient by the ‘nudger’). Rather, these non-disclosures are the withholding of information from patients because it is thought that this withholding is in some patients’ best interests and is what they really want. As a foil to the concept of paternalism, I describe this type of action in terms of maternalism.\textsuperscript{14}

**MEDICAL MATERNALISM**

I define maternalism as deciding to act in an autonomous person’s best interests and likely in line with that person’s will, but in the absence of the affected individual’s expression of consent or assent. Defined as such, maternalism is not a new paradigm for physician behaviour to rival paternalism, but is a concept describing a category of medical professionals’ actions that are assumed to be paternalistic, but in actuality are not. While paradigmatic paternalism is for a father to decide what is in his children’s best interests and support his decision ‘because he said so’, paradigmatic maternalism is for a mother to select her children’s activities based on her understanding of their emerging interests. The distinction of maternalism from paternalism is meant to capture the significant differences between these two paradigms and the implications for justifying a variety of decisions and actions.

Despite the above association, the word *maternalism* is not meant to imply agendered dimension to the action in question; just as both women and men can act paternalistically, so can both women and men act maternally. Additionally, while this definition of maternalism draws from cultural tropes associated with motherhood and mothering that are familiar to an American audience, such behaviour is in no way necessarily associated with motherhood, and mothering need not include these types of actions. Furthermore, it is important to note that maternalism is a concept that applies to interpersonal relationships, not to relationships between an individual and a state.\textsuperscript{14} With these provisos out of the way, I suggest that a maternalistic action is any action that: (1) is thought to be in line with an autonomous patient’s will, (2) is motivated by a desire to improve the welfare of the patient and (3) is not based on the patient’s expression of consent or assent.

Although both aim for the improved welfare of or prevention of harm to the patient, paternalistic and maternalistic actions have clearly distinct foundations and orientations. The critical difference between paternalism and maternalism is that the former describes a general kind of medical judgement. Justification of a paternalistic action is independent of the form that the physician–patient relationship takes. A physician whom I have just met may refuse my request for an unnecessary procedure without first determining my reasons for wanting the procedure. Likewise, a physician whom I know and trust may nevertheless withhold information about a treatment option she knows I will find attractive, but which she thinks will not benefit me. Both of these physicians act paternalistically (one soft, one hard), yet whether or not their actions are justified depends on the balance between the benefit of the action and the harm of restricting my choice.

By contrast, maternalism is predicated on a long-standing personal relationship of trust and understanding between a physician and a patient. The concept of maternalism suggests that it is only the basis of such a relationship that a physician may make a decision on behalf of a patient. In the case of maternalism, justification depends on the form of the physician–patient relationship. A physician I have just met might think that my unwillingness to choose a treatment option shows that I do not care about the decision and that I want her to decide for me. Alternatively, a physician who knows me well might recognise that my persistent questioning about a procedure reveals not that I am interested in the procedure, but that I am anxious about it, and that I want her to take that option off the table. In both of these cases, the maternalistic action’s justification depends on the physician’s relationship with me (and, arguably, close members of my family), in addition to the balance of benefit and harm.

Based on different paradigms of deciding for others, the justification conditions for maternalistic actions are also different from those of paternalistic actions. I suggest that a maternalistic action, while affecting a patient’s life, would be morally justified if it were indeed in line with the patient’s will and if it either prevented the patient from being harmed or improved the patient’s welfare; such an action would both respect the patient’s autonomy and be in his or her best interests.

Fulfilling the second condition, that a given action is in fact in a patient’s best interest, requires case-by-case epistemic proof—does the action actually benefit the patient or protect him or her from harm?

Satisfying the first condition also requires an epistemic check—is this what the patient really wants? However, one may question the theoretical possibility of fulfilling this first condition by asking whether a medical professional can ever know for certain that his or her action is in line with the patient’s autonomous will without an explicit statement to this effect by the patient. I argue that it is not impossible for this first condition to be satisfied, for three reasons.

First, if a medical professional has known a patient for a sufficient length of time, he or she can have a sense of the patient as a person, including his or her interests, desires and values, on

\textsuperscript{14}I intend no relation to previous uses of maternalism in the medical context, indicating either women acting paternalistically or acting only with regard to a patient’s autonomy.\textsuperscript{14} Other references to the term are ambiguous, and do not develop it substantially. For example, Joan Tronto refers to ‘paternalism/maternaism’ in *Moral Boundaries* (1993, p. 170), and Nel Noddings suggests that there might be maternalistic/paternalist responses to drug addictions in addition to paternalistic ones (*Ties to Morality*, 2010, p. 202).

\textsuperscript{14}This ‘maternalism’ was a public policy initiative in the USA in the 1950s.
the basis of which he or she can carry out a maternalistic action responsibly. This means that a maternalistic action cannot be justi-
fied if enacted by someone whom the patient has just met in
the emergency room or the intensive care unit. However, a
family doctor, a nurse whom the patient knows well or a spe-
cialist whom the patient has seen for a good length of time, has
had sufficient time to get to know the patient such that their
maternalistic action could be morally justified.

Second, if the patient trusts the medical professional, he or
she can reveal himself or herself to the professional without
pretence or barriers. The requirement of a trusting relationship
ensures that the professional has a reasonably accurate under-
standing of the patient and that, in certain contexts, the patient
authorises the physician to act from that understanding. The
nature of this trust may differ based on the type of decision
to be made and how it is made. I may trust my physician to
determine which prescription best fits my lifestyle without
requiring her to describe every possible option, but expect that
she will discuss more complex surgical treatments with me
directly. If she decides upon a surgical treatment without con-
sulting me, then she has misjudged the nature of our trusting
relationship and her maternalistic action is not morally justified.
However, if she correctly appraises the nature of our trust and
restricts her maternalism to prescription-related choices, then
her action stands a good chance of being morally justifiable.

Third, while it may seem as though a professional can never
be certain that a maternalistic action is what a patient really
wants, even in cases where the patient has made an explicit
statement of his or her wishes, there is no certainty that this will
be what he or she wants at the time of action. For example,
even though a patient may fill out an advance directive instruct-
ing his or her physician to ‘do everything possible’ to keep him
or her alive, when he or she experiences the reality of mechan-
ical ventilation, he or she may regret the previous decision and
request to be taken off life-support. If it is difficult to determine
the patient’s decisional capacity, this may place his or her care
providers in a quandary. So while there is no certainty that a
maternalistic action is what a patient truly wants, a profes-
sional’s sense of a patient may at times be a better guide than a
pro forma signature by the patient. In both cases, the medical
professional is acting upon generally reliable, but uncertain,
data. Based on these considerations, moral justification of a
maternalistic action does seem possible.

Japanese physicians’ non-disclosures seem to fit the definition
of maternalism better than paternalism. Physicians make these
decisions when there are no positive signs of the patient’s self-
determination, they intend to act in accordance with the patient’s
will, and they believe that disclosure will be harmful. This is not to say that Japanese physicians’ non-disclosures are never problematic. The Japanese medical system keeps physicians very busy, so they may not have time to establish trusting relationships based on mutual understanding with their patients. In addition, Japanese medical schools may now stress technical skill to such an extent that physicians do not have the communi-
cation skills needed to pick up on non-verbal cues. Finally,
despite the support of the JMA and the Japanese Supreme
Court, physicians may fear legal ramifications if they perform an
action that is not explicitly consented to by the patient.
Nevertheless, it is possible, at least in principle, to justify these
non-disclosures by understanding them as maternalistic. If
Japanese physicians’ non-disclosures are not justified, it is not
because they are paternalistic, but because they are a case of
poorly done maternalism.

CONCLUSION
Deciding that an action will benefit a patient does not necessar-
ily mean substituting one’s own professional ideas in place of a
patient’s. Rather, a well-trained and sensitive medical profes-
sional whom the patient knows well may reliably know what his
or her patient wants, without the patient having to make these
wants explicit. This is best described as medical maternalism,
not medical paternalism. While the concept of maternalism
requires further work, including delineations of different forms
of maternalistic actions and explanations of possible dangers
associated with these actions, this does not indicate that mater-
malism is not a viable concept; rather, maternalistic actions have
been inadequately investigated and insufficiently explained.

Asking what a maternalistic justification requires further devel-
ops aspects of the medical decision-making process disregarded
by the paternalistic paradigm, namely the nature of the phys-
ician–patient relationship, the degree of trust and the extent of
interpersonal understanding. We should take care that we do
not condemn potentially justifiable actions by labelling them
paternalistic without due consideration of all the factors
involved.

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REFERENCES
6 Donchin A. Autonomy, interdependence, and assisted suicide: respecting
10 Mackenzie C, Stoljar N, eds. Relational autonomy. New York: Oxford University
11 Donchin A. Autonomy, interdependence, and assisted suicide: respecting
12 Satō RS, Beppu H, Iba N, et al. The meaning of life prognosis disclosure for
Japanese cancer patients: a qualitative study of patient narratives. Chronic Illn
2012;8:225–36.
13 Japanese Medical Association (JMA). Ishi no Shokugyō Rinni Shishin [Professional
14 Japanese Supreme Court, April 25, 1995, 49(4) Minshū 1163, 1530 Hanji 53, 877
Hanta 171.
15 Lefèvre RB. Informed consent and patients’ rights in Japan. Houston Law Review
1996;33:1–12.
16 Hashino K. Japanese and western bioethics: studies in moral diversity. Boston:
17 Macklin R. Doctor-patient relationship in different cultures. In: Bioethics: an
2016:642–53.
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