

*BEYOND “PHYSICIAN-PATIENT” RELATIONSHIP:
A CASE STUDY OF HIV INFECTION DUE TO TAINTED
BLOOD PRODUCTS IN JAPAN*

I. Introduction

Normally, physicians and patients are considered to be in a public role-relationship consisting of the patient who receives treatment at a hospital and the physician who examines and treats that patient. The physician approaches the patient with the altruistic attitude of a “physician” fulfilling the role of providing treatment; in contrast, the patient’s role is to concentrate on recovery as a “patient.” This type of role-relationship is common to many medical settings today, and normally, when the patient goes to the hospital, the patient has a few minutes of conversation with the physician regarding the diagnosis and treatment of their illness and leaves the hospital.

When the patient is in a so-called subordinate-superior relationship where they merely accept what the physician says, interactions where both the physician and the patient transcend their respective “roles” do not normally occur, as Parsons says (Parsons 1951=1974: 424-75; Fisher et al. 1985). However, there are cases where this type of physician-patient relationship is transcended and the physician exerts influence on the patient’s intimate sphere. This study presents one case of a physician-patient relationship by examining the relationship between Dr. Gd, who was involved in the treatment of hemophilia in the early 1980s as a physician specializing in hemophilia, and his patient Ip, primarily focusing on the physician’s narrative. From this, it is possible to demonstrate the multi-layered nature of the relationships between those who were infected with HIV due to tainted blood products, and physicians.

Dr. Gd was first in charge of leukemia patients in the hematology department, but after being in charge of coagulation disorders in the emergency medicine department, later treated hemophilia and HIV at a regional hospital from the 1980s. Ip was notified that he contracted HIV by Dr. Gd, and began treatment under him, in the mid-1980s, when HIV infections in hemophiliacs were discovered and there was pressing need for a response including treating HIV in hemophiliacs. Dr. Gd and Ip shared time together in the mid-1980s as a physician and patient in this kind of chaotic circumstances.

II. Background

A. Situation in Japan

In the mid-1980s, information regarding HIV was confused, and it was extremely difficult to secure adequate information for medical care all over the world. In Japan, particularly for regional physicians who had little information, it could not be obtained without making an active effort.

B. Circumstances around Physicians: Dr. Gd's case

1) Limited information on HIV treatment

Dr. Gd, who was employed at a regional hospital, was no exception; he was not in a situation where cutting-edge medical care could constantly be updated, and he had only limited information. Therefore, Dr. Gd collected information on treating HIV by participating in international academic conferences and obtaining the “latest” information from the sales representatives from several pharmaceutical companies.

Dr. Gd obtained information on HIV at an international conference in Rio de Janeiro in 1984. When he participated in the conference, he saw the “advanced” conditions in America, and recalled being “very surprised” at that time. i Also, he said that by participating in an international conference he first learned of the significance of the clinical trials of heat-treated products he too had been conducting thus far and “it was a shock.” ii

In addition to these circumstances at the time, what I wish to point out here is that under circumstances where physicians must proceed with treatment in an environment where information is inadequate, what is called a paternalistic attitude today was natural. However, Dr. Gd emphasized “a stance which removes paternalism,” and it can be seen that he attempted to follow through on this stance by relaying information to patients. For Dr. Gd, the stance of eliminating paternalism was a matter he constantly prioritized, and repeatedly said in his narrative that he followed through without change after that as well.

Gd: That's why, it was after...what was it...Rio de Janeiro that I have been relaying all of that information as well to the patients. (omitted) The patients are in pain, now. It is extremely painful. Also, they know that these are medications that were not heat treated. If you are already infected, this medication will make you feel better. But, if you are not infected, you may be infected if you are injected with this. I always said this.

***: To the patients?

Gd: Of course. Yes. ...this is also my thinking, but we thought from the beginning patients should eliminate paternalism. That is why I have been giving the patients their blood test results for a long time. I send them by mail. I tell them “This is your liver function test result when you came the last time,” or something like that. Of course, this is done with the patient's understanding. Now, we give back the results of HIV tests in this way. This was done from before HIV became a problem.

(Investigative Research Committee on the Problem of HIV Infection due to Imported Blood Products, 2009a: 556).

2) His Experiences around the Atomic Bomb

Although in a situation where medical care had to be advanced in a fumbling manner, Dr. Gd gave his patients information, and maintained a stance where he had the patient understand it, and make the decisions. The fact that Dr. Gd's idea of "eliminating paternalism" and "standing on the patient's side" is at the base of his stance in dealing with patients is narrated. Where did Dr. Gd's determination to become "a physician who stands on the side of his patients" come from? This can be seen in his background, in his experiences with the atomic bombing, and his experiences with the problems regarding adverse drug reactions in the process of becoming a physician.

First, regarding the atomic bombing, Dr. Gd tells the following:

** : Doctor, should that type of [thing] be called a kind of treatment policy...how is it that you came up with that policy?

Gd: I thought of becoming a doctor when I was in high school. I am a second-generation atomic bomb survivor. And, from when I was a child, that atomic bombing problem, my father and grandfather were both doctors (omitted). For the purpose of ending the war, they used this place to experiment on the atomic bomb, which killed civilians for other than military purposes. That is why naturally my grandfather died, and for that reason, I guess I thought that I wanted to become a person who helps people (ibid, 2009a: 557-8).

While being aware of that he was a second-generation atomic bomb survivor, he aspired to become a physician from the desire to "help people" in response to the fact that ordinary civilians suffered in the atomic bombing, including his close relatives. In other situations as well, Dr. Gd repeatedly cites his involvement with the atomic bombing as the root of his thinking, saying "I do not know if I spoke previously on the relationship between physicians and patients now, but for me, the roots are in the atomic bombing."

3) His Involvement with Adverse Drug Reactions

Dr. Gd elucidates the image of a physician that he aspired to through his involvement in adverse drug reaction cases, the Minamata issue, and the Morinaga milk arsenic poisoning incident during his medical school days. In particular, in contrast to his familiar professors who took the "side of the perpetrators, he tells how he and his fellow students exerted influence below.

Gd: And, well...as we were becoming doctors, first, there was the problem of the adverse drug reactions. At the time, there was a person named Kosei Takahashi (1918-2004, graduate of the Faculty of Medicine, Tokyo Imperial University who proposed stochastic medicine, and

promoted the movement to eliminate adverse drug reactions and food contamination) and he wrote many shocking things. Then, there was the problem with Minamata disease, and you know, I could see patients and various images of physicians. I also saw doctors who stood on the side of the patients. After that, I was involved in that as well, but what we poured our energy into after that was the Morinaga milk arsenic poisoning incident. Here too, you know, there were physicians who had fairly criminal roles, and there were some who stood on the side of the patients. There was a professor, I forgot his name – was he a professor of public health at Osaka University? — who worked to rally the patients’ association.— I too conducted interviews of many child victims in the prefecture at that time. Through this, I guess I thought that I did not want to stand on the side of the perpetrators, I wanted to become a doctor who stood on the side of the patients. (ibid, 2009a: 558).

It can be seen that his experiences with adverse drug reactions, Minamata and the Morinaga milk arsenic poisoning incidents truly served as an opportunity to Dr. Gd to think about “how a doctor should be.” With “various types of images of physicians” as reference, such as those who took the side of “perpetrators” like business or government, and on the opposite side, physicians who stood on the side of the “victims,” Dr. Gd harbored the desire to “become a doctor who stands on the side of the victims.” Then, he constructed his own image of a physician using the professors close to him who took the side of the “perpetrators” as examples of what not to be.

Gd: And, then, during my student days, the student movement was in full swing, and we discuss very intensely about what kind of doctor we would become. Nowadays, there isn’t anything like these kinds of class discussions, right? In fact, we students denounced our teachers at the time. We really strung up the doctors who took the company’s side during the Morinaga milk arsenic poisoning incident. Among us, there were those who the professors said “We will never let him be a doctor,” and among our classmates as well, there were those who were always followed by the police, and well, since we were trained in that kind of environment, what kind of a doctor we would become was a big matter. After all, at the time – this was true for Minamata, this was true for SMON (subacute myelo-optico-neuropathy) – at a time when there was pollution and whatnot, there is the side of the people who were harmed, and the side of the people who caused the harm. The question really was what side the doctors would stand on. In other words, if you took the side of the companies, that meant cutting off the patients, and even today there is still that problem with Minamata disease, right? With that, I swore to never, never become a perpetrator. Well, that was the intent I came with... (following omitted) (ibid, 2009a: 566).

As can be seen from this narrative, it appears that the movements by the students and Dr. Gd were not at all amicable, to the point that there were “those who were followed by the police,” and “among us, there were those the professors said ‘We will never let him be a doctor.’” Also, at the same time, Dr. Gd’s stance of rejecting becoming a doctor who takes the side of the perpetrators can be strongly felt even to this day.

From his awareness of being a “second generation atomic bombing survivor” and his experiences being involved with adverse drug reactions and the arsenic-poisoned milk incident, it can be seen that Dr. Gd embraced a firm “image of the ideal physician,” who “stands on the side of the victims.”

C. Dr. Gd’s Attitude toward patients

医師の血友病 HIV に対する姿勢（血友病の持つ意味、自立への思い）

How Dr. Gd constructed relationship with his patients created the basis of “new” type of “physician- patient” relationship. He has a “unique” comprehension towards hemophilia compared to other physicians in Japan at the time. Also, he expected hemophilia patients to have a strong sense of independence. These two kinds of attitudes affected his image of the “ideal” patients.

1) The Disease of Hemophilia to Dr. Gd

Dr. Gd specialized in leukemia in a hematology department before becoming a physician specializing in hemophilia. In his comparison to his experience in charge of acute leukemia patients who died shortly, it can be seen that his thinking toward hemophilia became clear.

Gd: The disease of hemophilia is completely different from what I did as a doctor treating leukemia. I was perplexed by this. But the principle is the same, they are both diseases where the patient does not die right way. It is a disease where physical disabilities form gradually, and either the patient cannot see this, or they are not learning about their disease. For that reason, from 1979 I started treated hemophilia, and at first I really did not know what to do. Leukemia patients spend their time in a condition where they spend their time completely in the hospital, or obeying a physician, and then they die. Hemophiliacs also obey a doctor, but they only come when they do not feel well. Or, they start to not feel well, and are in trouble because they are bleeding a lot, but were finally able to walk, so they came to the clinic with effort. I thought, oh my goodness. When they are bleeding, they need to have it treated, but coming to the hospital after feeling a little bit better, then there is nothing we can do for that. It started like this. (ibid, 2009a:567)

He came to understand hemophilia as a disorder with the characteristics of a “chronic disease,” unlike acute leukemia. For patients who have to receive lifetime medical care for hemophilia, as it is

chronic disease, Dr. Gd came to think that it is important for patients to be able to choose their physicians and medical care.

Gd: (Beginning omitted) Looking at the chart, various doctors have come, and in those days, when the patient had a sore knee they received “a shot of AHF.” Whether it got better or worse, no one, no one took responsibility. The patients did not even know themselves very well. I thought this was no good. Yes. That’s why, hmmm, hemophilia is a disease where it is not the same doctor that sees the patient from start to finish. If it were, we could tell the patients to learn more about their disease and learn about which physician to see when. I think that this is the best approach for the patients. That’s why I tell patients with hemophilia right away that they should not trust doctors when they come the first time. I tell them, “You can trust me when you think you can after seeing me. Until then, don’t trust me.” And, doing that, I tell them that they have to choose a doctor or nurse that they can trust, this is knowledge for living.” (Omitted) If a patient with hemophilia has had enough, they should go somewhere else and find a good doctor (ibid, 2009a:561).

Dr. Gd defines hemophilia as an “illness which requires the patient to autonomously assess their medical care and to choose what is necessary for them.”

2) Feelings toward Independence – “The Most Important Issue for Hemophiliacs”

Dr. Gd thinks that hemophiliacs should be able to take responsibility as adults and understand their own bodies, and should be able to choose their medical care. Below, while making comparisons to a pediatrician, Dr. Gd talks about how the “independence” to which a hemophiliac should aspire is from the viewpoint of a doctor of general medicine.

** : (Beginning omitted). Doctor, you talked about the way it is handled by a pediatrician and by a general practitioner. ” Are they different after all?

Gd: They are clearly different. (**: Is it different?) Yes. You see, pediatricians do not talk to patients with hemophilia. They talk to the parents. (**: Talk to the parents). A general practitioner talks to the patient with hemophilia. (**: No matter how young the child is?) Yes, yes, that’s right. For example, at a junior high school somewhere, at a Hemophilia Friends Association meetings and whatnot, I said to a junior high school patient, not mine, “Don’t think that your parents and money will last forever” and “You’ll get to be able to feed yourself.” However, they’ve been kind of spoiled, so when they are told “Don’t think your parents and money will last forever,” they say “Yeah.” But, then I say “That’s right. But looking at you, you look more like “Suck my parents and money dry while it is still there.”

(Laughs)

** : How old are the children who are told that?

Gd: Hmm. They are around junior-high age, I guess. You know, junior high school age boys are in the so-called “rebellious phase,” as we too have experiences, and as a man, they feel that they are not like their mothers. Then, while rebelling against their fathers, they end up becoming like their fathers – that time is a very difficult stage, but eventually they have to become independent. It is also at that time when they fail to become independent. If at that time they have a really hard time of it, or are hospitalized, they are soothed by their parents, which in the end is easy for them.

** : So when you said that you thought “hey, hey” when you observed the patients you mentioned, it was because you thought that they were still dependent on their parents?

Gd: Yeah. That’s why I say that for hemophiliacs, independence is the most important issue for them. In order to be independent, you have to be able to control yourself and take responsibility, and for their own lives as well, they have to take responsibility. I think that when there are things like this an independent mind can form. That’s why I say that independence is an issue (Ibid, 2009a: 579).

A pediatrician sees a patient as a “minor” who is not a full-fledged adult, and it is the parents who the pediatrician speaks to. Dr. Gd sees his patients as “adults.” The “independence” that Dr. Gd wishes for his patients is supported by his desire for them to understand their bodies as an individual human being, not as a child, and to assess what is necessary and unnecessary. Then, specifically, how did he promote independence in his patients? Dr. Gd discusses this below.

** However, what do you mean by “you have to control your own life by yourself?”

Gd: Of course, I tell them this when they are 18 years old as well. And when they are 20 years old. Yes.

** : For example, specifically, does this mean that when you tell this to someone around 18 years old, you tell them to understand on their own when to, and how much, they should inject themselves when they have what kind of bleeding?

Gd: There’s also that. That’s why when I ask them “What will you do?” they say “Give myself a shot.” I say, “One shot means how much? Factor 8? Factor 9?” They say, “Well, I don’t know” I say, “That’s no good.” 500cc is also one shot, and 1,000cc is also one shot.

** Are people who are around 18 years old also like that?

Gd: Everyone is like that. There are people over 30 who are like that. Anyway, they seem to have been told “Inject yourself with this when you bleed.”

** : In other words, that means they don’t clearly know what they are being injected with?

(ibid, 2009a: 580)

Patients afflicted with hemophilia, which is a congenital disorder, are involved with medical care from the time they are born. During that time, there is a long period where they receive treatment as directed by their physician or parents. There are many cases where this type of “passive” condition continues even after they are grown up, and it has been pointed out that it becomes difficult for the patient to understand their own body as a result. This is linked to the motivation for Dr. Gd’s stance to strongly request “independence” from the patients.ⁱⁱⁱ Also, the scope of the “independence” which Dr. Gd requires does not stop in the medical field, where the patient understands their own body and chooses the necessary medical care, he goes to the point of requiring that the patients be independent in their actual lives. In other words, for Dr. Gd, the “image of the ideal patient” is an independent patient who knows their body as a patient with a disorder, thus being able to choose the necessary medical treatment, and takes responsibility for their life as a whole.^{iv}

III. Relationship between Dr. Gd and Ip

A. “The Doctor That Does Not Run Away”

Dr. Gd implements his “convictions” by implementing them as actions reflected in his diagnoses, such as his stance of “eliminating paternalism,” which is embodied in the “image of the ideal physician” he has consistently carried out, and urging his patients to be independent, bringing about the “image of the ideal patient.” How are these acts by Dr. Gd received by the patients? Here, the case of Ip, a patient of Dr. Gd, will be presented. Ip says the following about his impression of Dr. Gd after being notified that he was infected.

Ip: If I had been betrayed by my physician, my impression probably would have changed quickly. But, from that point on, it was the same as always. I guess I do not think that I have been betrayed by my physician.

** : Hmmm.

Ip: It is not like, “I can’t examine you at my place, so go somewhere else.” Dr. Gd notified me of my infection, and he was the one who treated me after that. With him, there was hardly any treatment, though.

** : Hmmm.

Ip: Then, when it came time to take medication, someone named Dr. Ng came in. You know, Dr. Gd was already a big name. That’s why everyone goes there, right? The approach was that young doctors would not develop if no one went to them for examinations. Then, there was talk of being examined by him. Just when I was being treated by Dr. Gd, I started taking medication, but a short time later, I went over to the new doctor. In the end, for the entire time

Dr. Gd was dealing with HIV, right? That's why if he had said, "I treat hemophilia, but I don't treat HIV..."

** : So there was none of that?

Ip: No there wasn't, so he received criticism from everywhere, and there were rumors that his standing at the university had gotten bad. Well, I'm sure it really was like that. It was in the news and whatnot. Nonetheless, in the end he did not quit and stayed the whole time through. There was something there.

** : Something like a kind of trust.

Ip: Yes.

** : He stood his ground and did not run away.

Ip: Yes.

(Investigative Research Committee on the Problem of HIV Infection due to Imported Blood Products, 2009b: 687)

From the fact that Ip spoke of a kind of "sense of trust" toward Dr. Gd, this stance appears to be something brought forth from a kind of sense of trust toward Dr. Gd in his patients. Ip continued to be treated by Dr. Gd even after being notified of infection. Also, he speaks of Dr. Gd as "To me, he is a doctor I respect. He did not run away." From this, we can see that a physician-patient relationship which made it possible to continue to be involved was created between Ip and Dr. Gd when we consider that there have been many cases thus far of patients distancing themselves from their primary care physician when they are not treated in a sincere manner when their infection has been discovered or when they are notified. v

B. Influence on the Intimate Sphere – Dr. Gd's Impact

Dr. Gd's stance of requiring his patients to be "independent" is not limited to just the content of the treatment or the disorder, it extends to the patient's life.

Also, as Dr. Gd says, "In particular, for patients with hemophilia, how they are going to get married is a big problem," for patients who are hemophiliacs and at the same time victims of HIV infection, marriage and how to create a relationship with their partner is a large problem. Dr. Gd continues to be actively involved in what is a major problem for patients, and advised them on matters such as love, marriage and sex. Dr. Gd's reflections on this issue are presented below:

** : What kind of reaction was there when you explained it in that way?

Gd: Well, there were all kinds. There were those for whom the blinders came off, there were all types. I would ask, "Is your middle leg healthy?" straight away. I would talk to them about

whether they knew how to use condoms. They say, “What?” Well, after all, there are these kinds of things, and in the end I said “You’ve got to take responsibility.” I have condoms in the examination area.

** : You talk about that without regard to HIV?

Gd: I do.

** : In other words, umm...

Gd: That is a part of life, after all.

** : I see. There may be few chances where one can hear these kinds of things in ordinary words.

Gd: Well, they talk about those kinds of things at summer camp as well. In particular, for patients with hemophilia, how they are going to get married is a really big problem. Even though they are independent, there are those who think that they are still incomplete, and they by all means want a partner. And, it is difficult for me as well to ask them that, but I ask them anyway. Things like “Are you seeing anyone?” “How far have you gotten with them?” and “Have you told your partner?” The reality, after all, is that in the HIV generation there are few people who are married. It’s enough suffering from a difficult disease, and there are other issues too. . However, I already support them, and tell them that if it would be better if I told their partner, I will and “If you ask me, and it is better that I explain things, I will.” Among them, several couples have gotten married. I think it’s great.

(Omitted)

Gd: Yeah, at first I took his place and explained it to his girlfriend...

** : Now, it is best that the patient himself explain it, right? (Gd: Yes, yes, yes) If it is difficult for the patient to explain it, what are the circumstances where you can say to the patient relatively naturally that you will explain it for them?

Gd: No, it should be like that, from the very beginning.

** : From the very beginning.

Gd: Yes. From the beginning, our relationship is like that.

** : No, no, not the relationship with a certain patient (Gd: The relationship with the patient and me, from the beginning) But, do you have that kind of relationship with various patients?

Gd: Let’s see. This may be strange way of saying it, but there is a doctor and a patient, and it is not that they come down the stairs like this, from the beginning it is a relatively close relationship.

** : Well, on the other hand, you never put it like this? The patient sees you, and says “I’m begging you, be a doctor.” Don’t those kinds of things put the patients at ease?

Gd: No...it is necessary to not let them become dependent on you as much as possible.

(Omitted)

** : Sorry for asking the same question, but were these types of natural relationships with the patients like that for you from the beginning?

Gd: Yes, yes, yes. I can't change my attitude from being "I am your doctor," to then gradually asking "Are you using condoms?" From the beginning it was like that.

** : I guess one thing that I am curious about is why it was like that at first. From what I have heard from you, was it the student movement?

Gd: That was in the end due to the Hemophilia Friends Association meetings. Put simply, I guess I feel as though I have learned from the patients.

(Investigative Research Committee on the Problem of HIV Infection due to Imported Transfusion Products, 2009a: 581-2)

As can be seen above, regarding problems pertaining to sex and love, which are difficult to talk about with family and friends, in response to the question of how it was possible to create relationships where it was possible to advise and caution the patients, as Dr. Gd said without hesitation, it was because "there were relatively close relationships (with the patients) from the beginning," so for him, his attitude was the same from the beginning, and becoming deeply involved with the patients appears to have been extremely natural.

C. Toward Creating an Intimate Sphere: Possibility of the "New" Physician- Patient Relationship

Here, I will once again focus on Ip's narrative. Ip was given some rather "harsh," imposing advice on love and women from Dr. Gd. Ip looked back on that time and said the following.

Ip: (Beginning omitted) Dr. Gd would often talk to me about whether I "got a girlfriend." Hey, at that time, it was a little harsh, the doctor was being harsh. He would not give a second thought to saying things like "It's no good for people with HIV to have girlfriends, you know." and whatnot.

(Investigative Research Committee on the Problem of HIV Infection due to Imported Blood Products, 2009b: 693)

As a result of taking his hemophilia and HIV infection into consideration, Ip put some distance between the girlfriend he was seeing at the time for a short period. Afterward, he resumed his relationship with her, and is married. Ip has the impression that Dr. Gd's advice was "harsh," but he says that Dr. Gd's pushing was one of the things that led to him getting married.

** : What was the reason you took the bold step of getting married?

Ip: Well, I haven't told many people this, but the doctor pushing me from behind was big.

** : Dr. Gd?

Ip: Yes, yes.

(Omitted)

Ip: Coincidentally, I contacted her about something. "If you got free time, let's meet. Let's go on a day-long drive or something." And, she quickly responded "OK."

** : Ah.

Ip: After that, well, I had no intention of getting married, but it was like we would go out to eat once in a while with her as a female friend. However, midway through Dr. Gd came along and said, "Got a girlfriend?" Then, well, I honestly said, "Actually, with my old girlfriend," and he said something like, "Marry her." I said, "No way, how could I do such a thing?" and I'm going to die anyway, and I'll make her unhappy." Then he asked something like, "Have you asked her what her intentions are?" I said, "How could I ask her such a thing?" Then he said, "Well, since she is with you as a female friend, why don't you try telling her 'Actually, I've got AIDS.' (Laughs). But, well, in the end, though she was a female friend, once again the distance between us as friends gradually closed in. I didn't know if it would drag along again or not. Certainly, I would say this here, and this time it would truly be the end. I did not think that we would continue our relationship. My self-assessment was that low. I felt as though someone with AIDS and hemophilia was not worth marrying.

(Omitted)

** : Then to Dr. Gd?

** : In the hospital.

(Editor's note: Ip was concerned that if he directly told her that he was infected with HIV, she may be placed in a sticky situation, so out of consideration to her, Dr. Gd explained the situation to her in his place. If she said there that she wanted to separate, she would just leave the hospital, and when Ip came back, he would know the situation. However, actually she waited for Ip to return. Ip married her shortly thereafter (ibid, 2009b: 693-4).

Although Ip at first decided to separate, resumed the relationship later, and had hesitations about marriage, when Ip decided to get married, Dr. Gd provided a big push. In Ip's case, Dr. Gd informed the woman he was dating about his condition, and that became the impetus for marriage. Also, in other cases, it can be seen that Dr. Gd had a deep relationship with his patients, doing things such as giving them pharmaceuticals before going on overseas honeymoons. Dr. Gd is involved in the creation of the patient's intimate sphere in cases other than Ip's, which can be seen in his statement "I have been involved in the marriages of several couples."

IV. Conclusion

Dr. Gd, through his interactions in hospital examinations, crosses the role-relationship of physician and patient and exerted an influence on the intimate sphere of Ip, who was a patient. Dr. Gd's consistent stance was supported by his image of an ideal physician, which should "eliminate paternalism," and stand on "the side of the patients," not the "perpetrators." Also, for the hemophiliacs, he had a clear image of the ideal patient, who was "an independent patient," and put it into practice in medical care settings. "Patients' independence" for Dr. Gd was something that he strongly hoped for in his patients suffering from hemophilia, a disease characterized as one that has to be dealt with for life. By practicing these multiple "convictions" in his interactions, as a result it created the impetus for Ip to form his intimate sphere.

Thus far, criticism of Parson's regarding medicalization and professional dominance, etc. have been argued only within the context of the so-called public-sphere theory. However, as this section showed, the physician-patient relationship does not stop at the respective role-relationships, there are cases where it forms in a deep relationship which may have an influence on major life decisions. It is precisely the existence of the intimate sphere, which cannot be seen from Parson's structural-functionalistic role-relationships, that is a key vantage point in understanding how not just future physician-patient relationships, but also medical care should be.

References

ⁱ Dr. Gd learned in America that detailed information is provided to patients, and used that as reference in examinations afterward. About that time, he says, "And, during the Rio de Janeiro conference, various people set up booths. The American National Hemophilia Foundation set up a booth, and they put out pamphlets on hemophilia, HIV and AIDS, and I brought these back to Japan, and I saw the light. I was really surprised that in America patients were given this kind of information, and put out these publications wanting the patients to understand this much."

(Investigative Research Committee on the Problem of HIV Infection due to Imported Blood Products 2009a:541)

ⁱⁱ Dr. Gd conducted clinical trials on heat-treated products without understanding their significance, and later, he tells of his shock when he learned what kind of meaning clinical trials had when he later participated in the Rio de Janeiro conference:

Gd: All right, everyone do clinical trials. This was coming from the Ministry of Health, Welfare and Labor as well. In the beginning, those clinical trials were for an unclear purpose. They began with the feeling that they would be all right at least for hepatitis. I thought, we are already using these for hepatitis, what is the meaning of this? The people who participated in the clinical trials, they are people who already come frequently, so this is how it is, sorry, please participate, and in cooperating with the clinical trials, sorry, please ... this is how I did it. That all changed in September 1984, and for these people we can use the good medication, and for these people, since it is not a clinical trial there may be dangerous drugs inside. Panic at that time was really something. I thought, please, I'm begging you, end this.

**: Just at that time during the clinical trials you went to Rio de Janeiro on a business trip, right? The meaning of what you were doing became clear to you.

Gd: Yes. That was a shock. Later, a person from Tokyo got mad at me and told me that I had learned it late. But no one had told me about this.

(Investigative Research Committee on the Problem of HIV Infection due to Imported Blood Products 2009a: 542-3)

ⁱⁱⁱ The stance of having the patients take responsibility for themselves and be independent can also be thought of as paternalism at first glance, but for Dr. Gd, his medical stance which has the strong desire to “eliminate paternalism” for his patients can be seen throughout. However, in a situation such as one where there is no relationship of trust, this type of attitude by the physician would be seen as “imposing” and likely would probably be taken as a paternalistic attitude by the physician.

^{iv} Dr. Gd’s patient-centered stance esteems the patient’s independence, and the desire for the patient’s independence is connected to the reconstruction of the Hemophilia Friends Association as part of “patient education.” Dr. Gd’s involvement in the patients’ association will be left for another paper.

^v As mentioned in this paper, Ip spoke of his “trust” for Dr. Gd, but regarding notification, Ip is aware that he received a “false notification” from Dr. Gd. Refer to Yamada (2009) for more on this incident.