97 年人文教育革新中綱計畫
子計畫三 人文領域人才培育國際交流計畫

【國內活動類-東吳大學人權學程迷你課程】

【人才領域人才培育國際交流計畫－東吳大學人權學程迷你課程】

期末成果報告

指導暨補助單位：教育部

指導單位：教育部顧問室人文領域人才培育國際交流計畫辦公室

執行單位：東吳大學張佛泉人權研究中心

計畫主持人: 黃 默

執行日期：中華民國 97 年 4 月 1 日至 97 年 6 月 30 日

中華民國 97 年 7 月 10 日

目　次

東吳大學人權學程迷你課程計畫說明

一、 計畫說明

東吳大學人權學程以推廣人權教育為宗旨，主要工作為提供大專院校學生系統性的人權課程。人權學程的教學強調與國際社會的互動，注重與國際學界的研究趨勢接軌。

2006 年，人權學程開始邀請國際重要學者來台短期講學，以增進學生國際視野及了解國際人權研究趨勢。首位應邀開課的學者為荷蘭馬斯垂克大學法學 Theo van Boven 教授。Van Boven 教授專攻國際人權法，同時長期於聯合國擔任人權工作相關要職，包括曾任聯合國防止刑求特別報告員。Van Boven 教授與夫人於 2006 年 4 月 29 日至 5 月 13 日應邀來台，授課三個星期。講授內容包括人權基本概念、刑求的防止、種族主義、大規模的人權侵害、對被害者的賠償及人權保障機制的實務運作等等。報名參加的學生共 20 位，其中包括大學部學生、研究生以及非政府組的工作人員。

基於 2006 年的經驗，人權學程計畫於 2007 年 4 月 7 日至 4 月 18 日再次邀請英國牛津大學日產日本研究中心主任 Ian Neary 教授來台開課。

Neary 教授為牛津大學聖安東尼學院研究員，同時也是該校日本政治研究校級教授。Neary 教授長期關心亞非地區的人權問題，尤其關注日本、韓國以及台灣的人權發展，著有 *Human Rights in Japan, South Korea and Taiwan* 一書。除了亞非地區的政治與人權發展外，Neary 教授亦關心兒童權利及病人權利的問題，尤其是醫院中兒童權利的保障。

課程安排

本次迷你課程共計二週，每星期三次，分六次授課。課程方向分兩個主題，一是病人的權利，二是兒童權利的保障，這兩個主題都著重在日本、韓國及台灣三國的比較。課程主題如下：

・兒童的權利（The Rights of the Child- A History）
・日本兒童權利（The Rights of the Child in Japan）
・南韓與台灣兒童權利（The Rights of the Child in South Korea and Taiwan）
・病人的權利（Patients' Rights- the Background）
・日本病人權利（Patients' Rights in Japan）
・南韓與台灣病人權利（Patients' Rights in South Korea and Taiwan）

二、 修課學生遴選原則與方式說明

為推廣人權教育，只要對迷你課程之內容有興趣之東吳大學及其他大專院校學生都可參加。本課程亦開放部份名額予非政府組織人士加入。本次課程採英語授課，並搭配逐步口譯人員（Consecutive Interpreting），以協助學生吸收授課內容。達一定出席標準者，可獲頒 Neary 教授親筆簽名之結訓證書。

三、 預期效益及後續推廣

(1) 參與學生可不需出國就獲得聆聽國際重要學者授課之機會。除了解國際人權研究之發展，亦可增進國際視野。

(2) 了解國際上對亞洲人權保障的研究，尤其是與日本和韓國之比較。

(3) 推廣兒童權利保障之理念。在台灣，有關兒童之議題仍以福利的觀點為主流，較少從權利概念加以探究。Neary 教授的課程當能推廣兒童權利的討論。

(4) 探討對病人權利之保障。在台灣，已經開始討論醫病關係之相關議題，其中病人權利之保障應是不可忽視的一環。Neary 教授的經驗當可為台灣相關議題的討論帶入新的觀點。

(5) 加強台灣學界及非政府組織與國際學界之交流互動。邀請國際學者來台，除了增進台灣各界對國際人權研究之了解外，亦對國際學者了解台灣發展的狀況頗有助益。依我們的經驗，國際學者來台後，對台灣都持十分友善的態度，這對台灣國際空間的拓展是很有幫助的。

(6) 藉由引進迷你課程，加強東吳大學作為人權教育推動者的地位。而國際學界也可藉此了解台灣在人權教育推動上的努力。

(7) Neary 教授同意我們將其授課內容整理後，放在東吳大學人權教育網(http://www.scu.edu.tw/hrp)，供各界瀏覽。因此他的到訪雖然不長，但他的授課內容仍可持續供台灣各界使用。

三、執行情形

（1）開課情形-講授課程

講授課程名稱	時數/小時	參與人數									
		校內人數				校外人數				男女比例	合計
		教師	博士生	碩士生	大學生	教師	非政府組織	社會人士	學生		
The Rights of the child- a history	2	1	1	1	15	4	4	6	2	7：27	34
The Rights of the child in Japan	2	1	1	1	13	3	4	5	2	5：25	30
The Rights of the child in South Korea and Taiwan	2	1	1	1	10	3	3	6	1	3：23	26
Patients' Rights- the background	2	1	1	1	9	3	4	4	1	2：22	24
Patients' Rights in Japan	2	1	1	1	8	4	3	4	1	2：21	23
Patients' Rights in South Korea and Taiwan	2	1	1	1	10	4	3	2	2	2：22	24
總計	12	6	6	6	63	21	21	29	9		161

五、執行成果分析與檢討

（一）迷你課程工作規劃：

學程自成立以來及針對發展、貧窮、環保、和平、高等教育、疾病等人權議題逐步開授相關課程，同時積極規劃與其他系所結合開設跨領域課程。在此基礎上人權學程開始邀請國際重要學者來台短期講學，以增進學生的國際視野及了解國際人權研究趨勢。本次迷你課程的籌備工作大致如下：

1. 課程進行前籌備工作項目：與講者充分的溝通，包含授課時間、授課主題、授課大綱、參考資料等，有助於整個課程的順利進行。同時展開迷你課程宣傳，包括郵寄文宣並針對當次主題加強相關單位之宣傳。

2. 課程進行期間工作項目：事前得知參考資料和配合的口譯人員，增進教師與口譯人員的溝通與熟悉度使課程進行更為順暢。

3. 課程進行期間後工作項目：資料整理剪輯與建檔。

（二）計畫執行成果及後續效益分享：

人權學程目前積極整合張佛泉人權研究中心及人權學程研討會、座談會及教學課程之錄影／錄音資料，建立《東吳大學人權教育網》，以分享人權教育資源。因此在邀請國外學者講學前我們會先取得授課教師同意將課程錄音錄影，剪輯建檔之後會放置於此平台供學生及社會各界觀看。同時學程亦同步添購人權相關領域的書籍、期刊、非書資料等，收藏於東吳大學外雙溪校區圖書館七樓「人權教育圖書室」中，以促進相關領域之研究。

六、結論與建議

本計劃之目標在於透過國際重要學者的授課，提升台灣人權教育與研究之水準。Ian Neary 教授為亞洲人權研究之重要學者，這次來台的時間雖然不長，但卻為我們勾勒出台、日、韓三國兒童權利及病人權利研究之方向，對國內學者而言是個重要的參考。

Neary 教授的講課十分仔細且有耐心，因此學員們對他的講課印象頗佳。這對本計劃的口碑是十分有利的基礎，相信往後若再推動迷你課程當會更順利。

學員們的英語聽講能力仍是我們較擔心的一點。此次我們安排逐步口譯人員，於某種程度上稍微克服了這個問題。但長期而言，如何提昇學生們的英文能力仍是需要進一步思考的。

總體而言，台灣目前對人權教育的投資非常有限，這次獲得「97 年人文教育革新中綱計畫子計畫三人文領域人才培育國際交流計畫」的補助對本中心而言是很大的幫助。不過，既然本計畫以促進國際交流為目標，強烈建議貴單位考慮補助國際學者的機票費用，否則在國際交流的推動上，仍會有經費上的困難不易克服。

七、附錄

English 東吳大學 人文社會學院 回首

東吳大學
Soochow University

人權教育網 人權學程暨人權碩士學位學程
Human Rights Education, Soochow University

最新訊息

最新訊息 | 人權學程 | 人權碩士學位學程 | 相關連結

- 新書資訊
- 一般公告
- 活動公告

人權資料庫
張佛泉人權研究中心
人文教育革新中綱計畫

[活動公告] 訊息來源：人權學程 發佈日期：2008/04/11 最新訊息

東吳大學人權學程迷你課程

主講人／出席：Professor Ian Neary

活動舉辦地點：東吳大學外雙溪校區 第二教研大樓10樓【人文社會學院會議室 D1005】

東吳大學人權學程迷你課程

課程內容 ：

・兒童的權利（The Rights of the child- a history）

・日本兒童權利（The Rights of the child in Japan）

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・日本病人權利（Patients' Rights in Japan）

・南韓與台灣病人權利（Patients' Rights in South Korea and Taiwan）

本課程爲英語授課並搭配逐步口譯人員(Consecutive Interpreting)

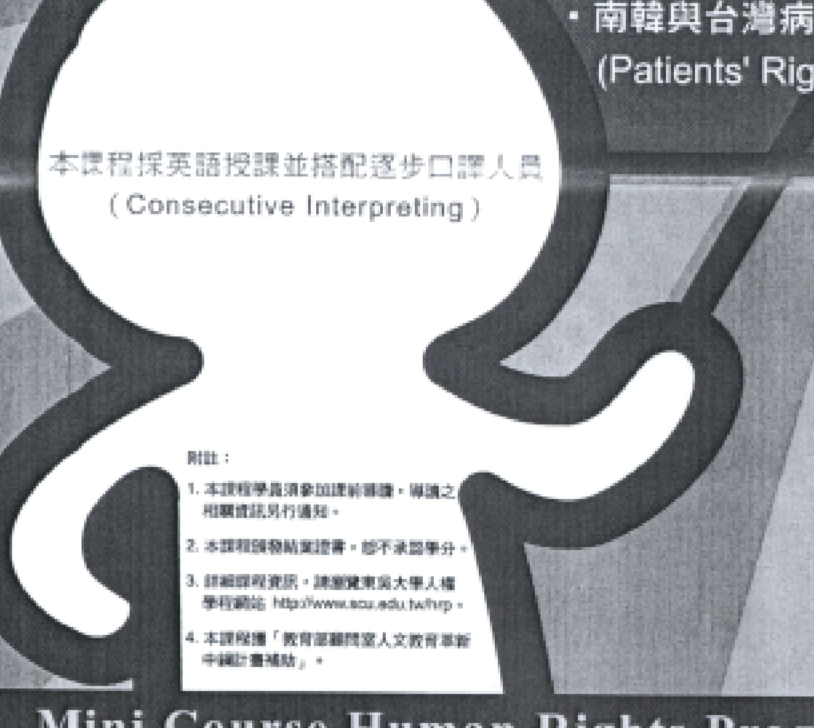
講者：**Professor Ian Neary**

東吳大學

人權學程迷你課程

課程內容

- 兒童的權利 (The Rights of the child -a history)
- 日本兒童權利 (The Rights of the child in Japan)
- 南韓與台灣兒童權利 (The Rights of the child in South Korea and Taiwan)
- 病人的權利 (Patients' Rights- the background)
- 日本病人權利 (Patients' Rights in Japan)
- 南韓與台灣病人權利 (Patients' Rights in South Korea and Taiwan)



本課程採英語授課並搭配逐步口譯人員
（Consecutive Interpreting）

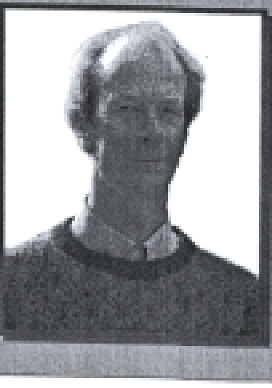
上課地點：東吳大學外雙溪校區 第二教研大樓10樓
【人文社會學院會議室 D1005】
課程時間：2008年4月7日～18日，每星期一、二、五
(星期一15:30～17:30、星期二10:00～12:00
、星期五10:00～12:00)
報名時間：即日起至2008年3月31日止
報名方式：請將報名表傳真或mail至聯絡人

附註：
1. 本課程學員須參加課前導讀，導讀之相關資訊另行通知。
2. 本課程頒發結業證書，但不承認學分。
3. 詳細課程資訊，請瀏覽東吳大學人權學程網站 http://www.scu.edu.tw/hrp。
4. 本課程獲「教育部顧問室人文教育革新中綱計畫補助」。

聯絡人：廖劭文小姐
電話：02-28819471 #6951/ 6952
傳真：02-28805650
Email：swliao@scu.edu.tw

Mini Course Human Rights Program, Soochow University

講者：Professor Ian Neary



Neary教授於1981年獲得英國Sussex大學的博士學位，長期研究亞洲國家的民主政治，專攻日本、韓國及台灣的政治文化與人權。歷任教於英國Huddersfield大學歷史與政治系（1979-1984）、英國紐卡索大學政治系（1984-1989）、英國Essex大學政治學系教授（1989-2004），目前為英國牛津大學教授，並擔任牛津大學Nissan日本研究院主任。

Neary教授主要的著作包括：

Political Protest and Social Control in Pre-war Japan: the origins of Buraku liberation (1989), Intervention and Technological Innovation: Government and the Pharmaceutical Industry in the UK and Japan (1995), In Search of Human Rights in Japan (1996), Leaders and Leadership in Japan (1996), Human Rights in Japan, South Korea and Taiwan (2002), The State and Politics in Japan (2002)，近來教授致力於研究日本部落解放同盟首任委員長松本治一郎 (Matsumoto Jiichiro)的傳記，並於2007年在Japan Forum發表了Matsumoto Jiichiro and the making of democracy in postwar Japan (2007)。

Mini Course

東吳大學人權學程迷你課程

課程內容　：

兒童的權利（The Rights of the child- a history）

- 日本兒童權利（The Rights of the child in Japan）
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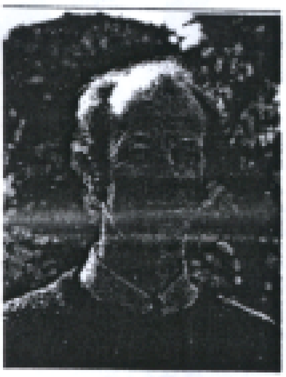
講者：Professor Ian Neary

Neary 教授於 1981 年獲得英國 Sussex 大學的博士學位，長期研究亞洲國家的民主政治，專攻日本、韓國及台灣的政治文化與人權。歷任教於英國 Huddersfield 大學歷史與政治系（1979-1984）、英國紐卡索大學政治系（1984-1989）、英國 Essex 大學政治學系教授（1989-2004），目前爲英國牛津大學教授，並擔任牛津大學 Nissan 日本研究院主任。Neary 教授主要的著作包括：*Political Protest and Social Control in Pre-war Japan: the origins of Buraku liberation* (1989), *Intervention and Technological Innovation: Government and the Pharmaceutical Industry in the UK and Japan (1995), In Search of Human Rights in Japan* (1996), *Leaders and Leadership in Japan* (1996), *Human Rights in Japan, South Korea and Taiwan* (2002), *The State and Politics in Japan* (2002)。近來教授致力於研究日本部落解放同盟首任委員長松本治一郎 (Matsumoto Jiichiro)的傳記，並於 2007 年在 Japan Forum 發表了 *Matsumoto Jiichiro and the making of democracy in postwar Japan* (2007)。



Professor Ian Neary

- **上課地點：東吳大學外雙溪校區 第二教研大樓 10 樓【人文社會學院會議室 D1005】**
- **課程時間：2008 年 4 月 7 日 ~18 日，每星期一、二、五。**
（星期一 15:30 ~ 17:30、星期二 10:00 ~ 12:00、星期五 10:00 ~ 12:00）

報名時間：即日起至 2008 年 3 月 31 日止

報名方式：請將報名表傳真或 mail 至聯絡人

聯絡人：廖劭文小姐　Email：swliao@scu.edu.tw

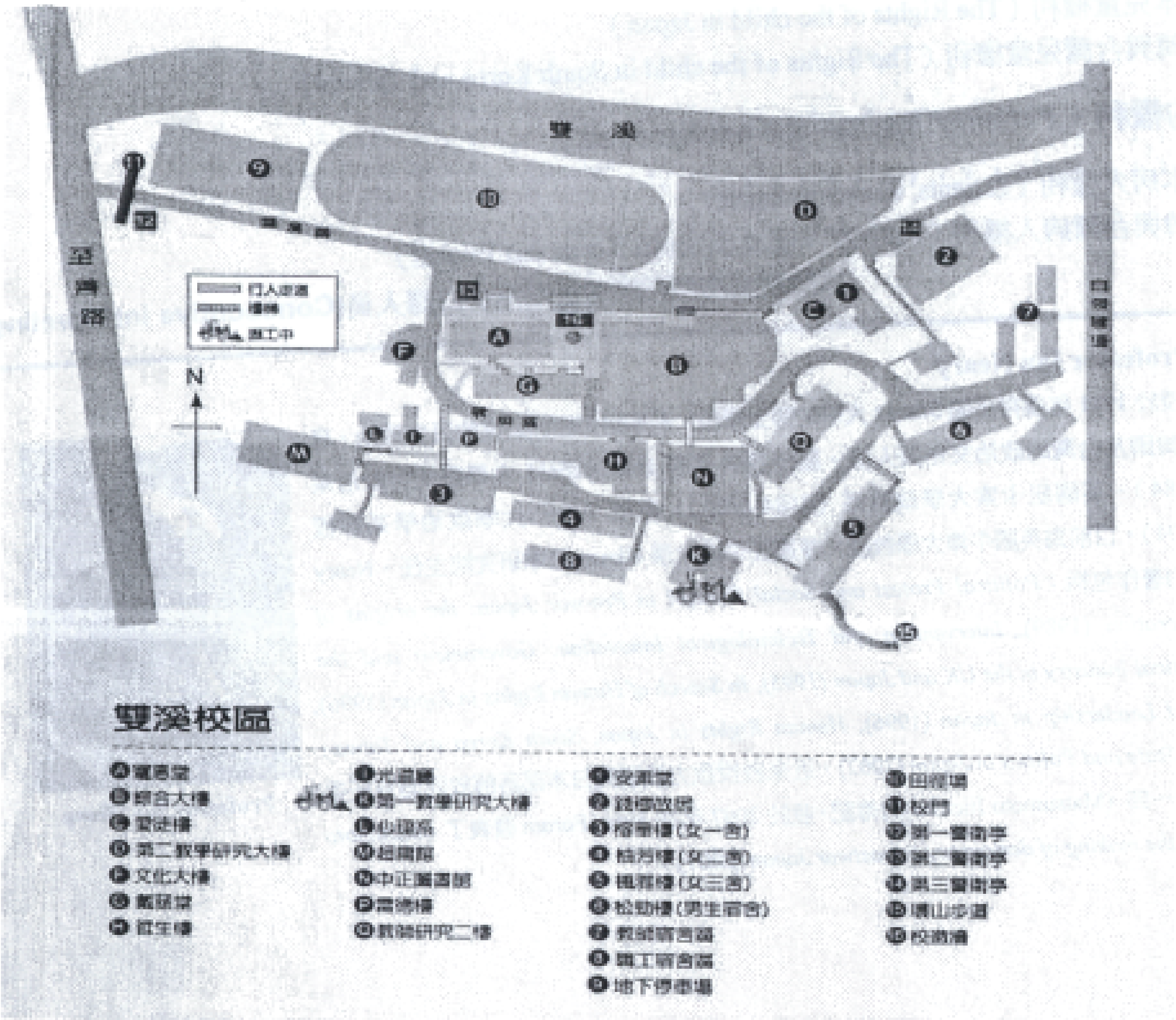
電話：02-28819471 #6951/ 6952　傳真：02-28805650

詳細課程資訊，請瀏覽東吳大學人權學程網站 http://www.scu.edu.tw/hrp

【人權學程迷你課程】報名表

姓名		職稱	
服務單位/就讀學校		傳真	
聯絡電話		Email	
聯絡地址			

【交通資訊與校園地圖】



公車

255、267、304、620、645、小 18、小 19（東吳大學站）213（外雙溪站）

捷運

捷運淡水線至士林站，往中正路出口，再轉搭公車 255、304、620、小 18、小 19 至東吳大學站下車

鐵路

至台北車站下車，轉乘捷運至士林站，往中正路出口，再轉搭公車 255、304、620、小 18、小 19 至東吳大學站下車

自行駕車

中山高速公路-->重慶北路交流道（往士林方向）-->重慶北路四段-->百齡橋-->中正路-->至善路-->外雙溪校區

北二高-->堤頂交流道-->往左至內湖路（內湖大直方向）-->自強隧道-->至善路-->外雙溪校區

topics and CV

Ian Neary <ian. **Wed, Mar 5, 2008 at 9:52 PM**
To: Mab Huang

Dear Professor Huang

Please find below a list of 6 lecture topics and an attachment of a brief CV.

If there is anything else you need please let me know.

Best wishes

Ian

1. The rights of the child – a history
2. The rights of the child in Japan
3. The rights of the child in South Korea and Taiwan
4. Patients' rights - the background
5. Patients' rights in Japan
6. Patients' rights in South Korea and Taiwan

Dr Ian NEARY

Higher Education

Sheffield University B A Politics 1973
Kyushu University 1973-75
Sussex University D Phil 1981

Employment

Lecturer,
Department of History and Politics
Huddersfield University 1979-1984,

Lecturer,
Department of Politics
Newcastle University 1984-9,

Professor,
Department of Government,
University of Essex 1989-2004

University Lecturer in Japanese Politics
Department of Politics and International Relations
Fellow St Antony's College
University of Oxford 2004-

Principal Publications

Political Protest and Social Control in Pre-war Japan: the origins of Buraku liberation, *Manchester U P* 1989.

Intervention and Technological Innovation: Government and the Pharmaceutical Industry in the UK and Japan (with J Howells)
Macmillan 1995.

In Search of Human Rights in Japan (edited with Roger Goodman) *Japan Library* 1996.

Leaders and Leadership in Japan (edited volume of papers from the EAJS conference in Copenhagen) *Japan Library* 1996.

'Burakumin in Contemporary Japan' in M Weiner (ed.)
Japan's Minorities, *Routledge,* 1997, pp 50-78.

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‘Matsumoto Jiichiro and the making of democracy in postwar Japan’
Japan Forum, Vol 19 No 2 July 2007.

March 6, 2008

Soochow University
Human Rights Program

This is to certify that Ms/Mr.

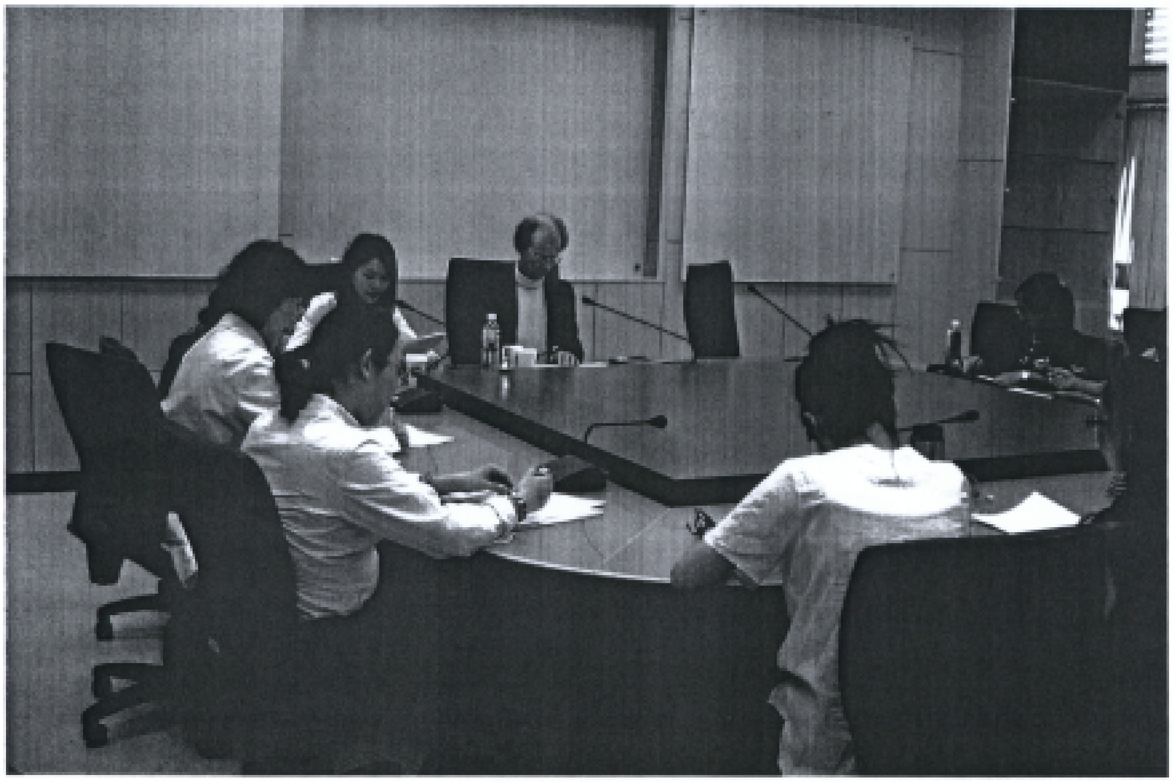
has successfully completed a mini course on the Rights of the Child and Patients' Rights offered by the Human Rights Program of Soochow University, Taipei and taught by Professor Ian Neary from April 7- April 18, 2008.

Professor Ian Neary

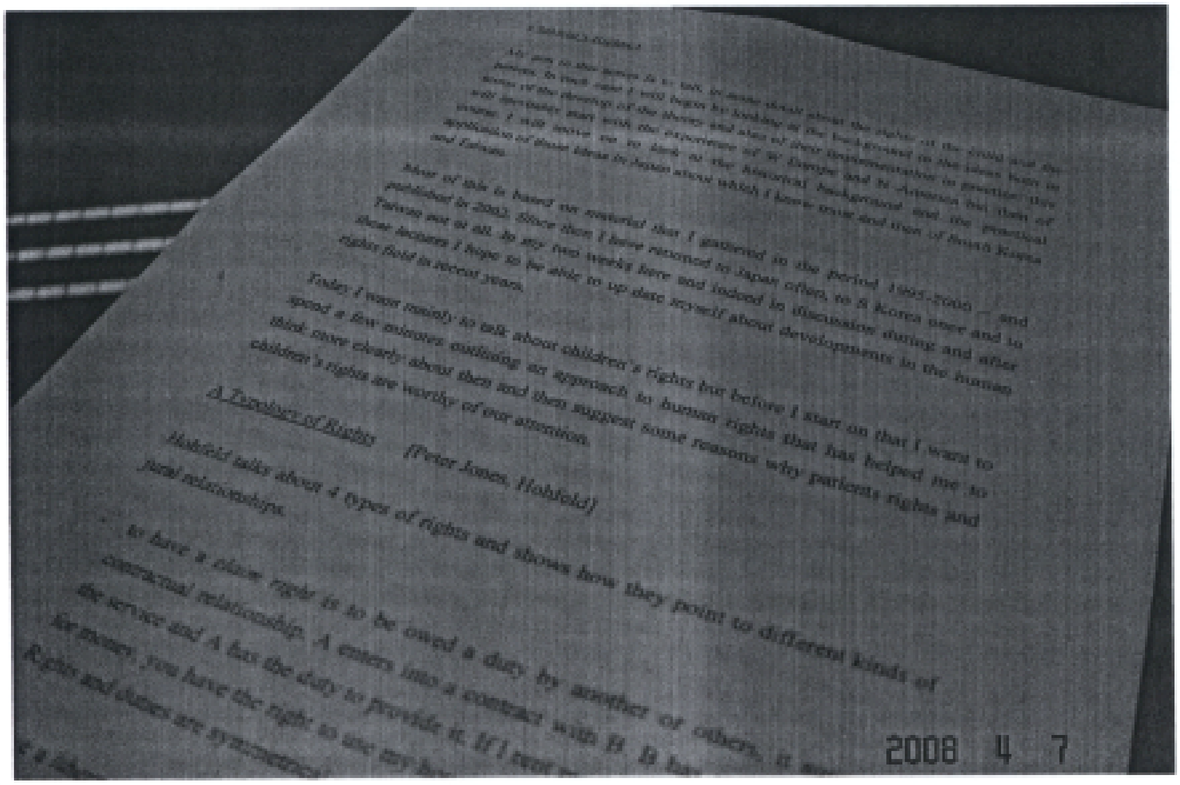
University Lecturer in Japanese Politics
Department of Politics and International Relations
The Director of the Nissan Institute of Japanese Studies
Fellow St Antony's College
University of Oxford

Professor Mab Huang

Director of Chang Fo-Chuan Center for the Study of Human Rights
Director of Human Rights Program
Soochow University



人權學程迷你課程



Most of this is based on material that I gathered in the period 1995-2000 -- and published in 2002. Since then I have returned to Japan often, to S Korea once and to Taiwan not at all. In my two weeks here and indeed in discussion during and after these lectures I hope to be able to up date myself about developments in the human rights field in recent years.

Today I want mainly to talk about children's rights but before I start on that I want to spend a few minutes outlining an approach to human rights that has helped me to think more clearly about them and then suggest some reasons why patients rights and children's rights are worthy of our attention.

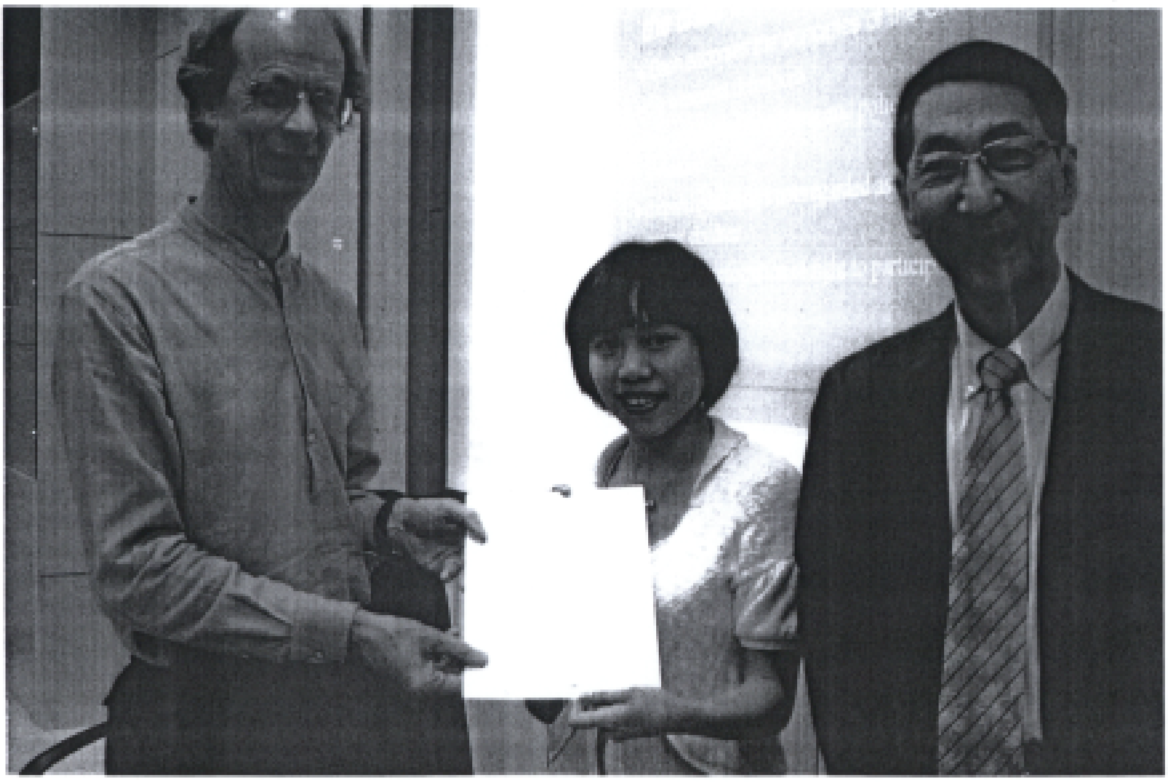
A Typology of Rights   [Peter Jones, Hohfeld]

Hohfeld talks about 4 types of rights and shows how they point to different kinds of jural relationships.

- to have a claim right is to be owed a duty by another or others, it
contractual relationship. A enters into a contract with B. B has
the service and A has the duty to provide it. If I rent
for money, you have the right to use my
Rights and duties are symmetrical

人權學程迷你課程

Professor Ian Neary 與學程黃默主任共同頒發結業證書



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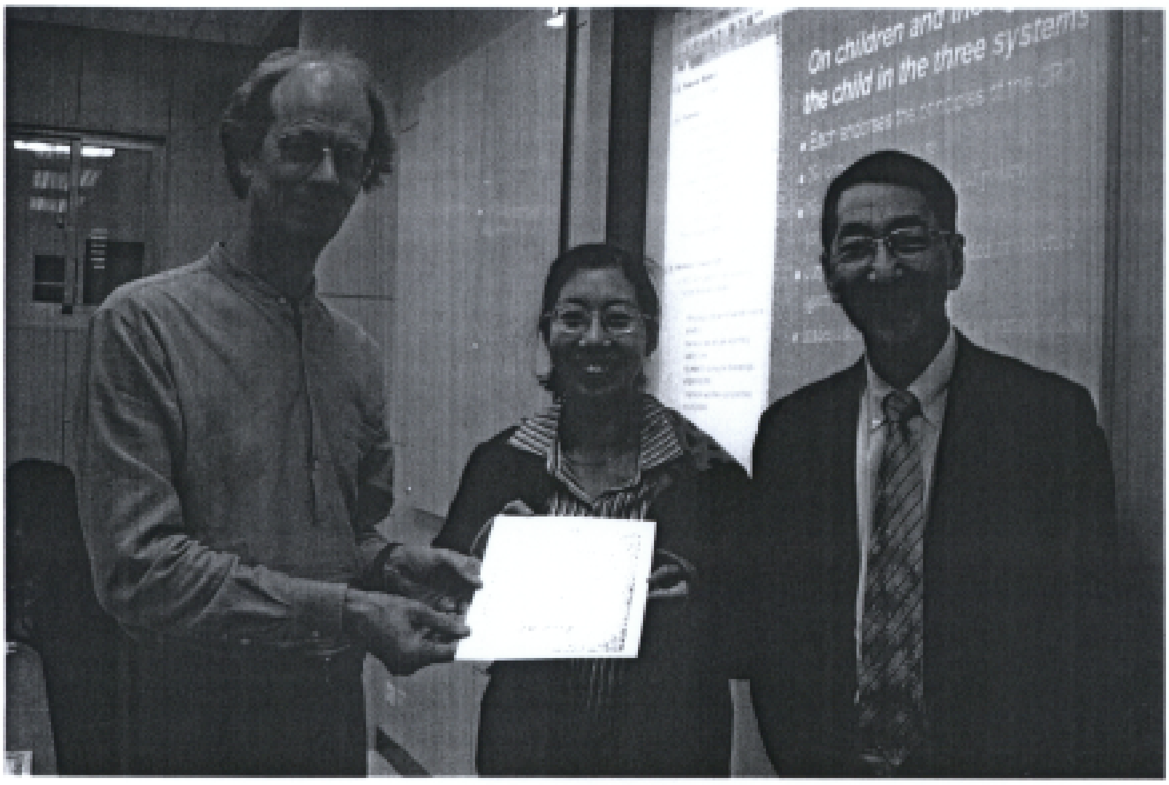

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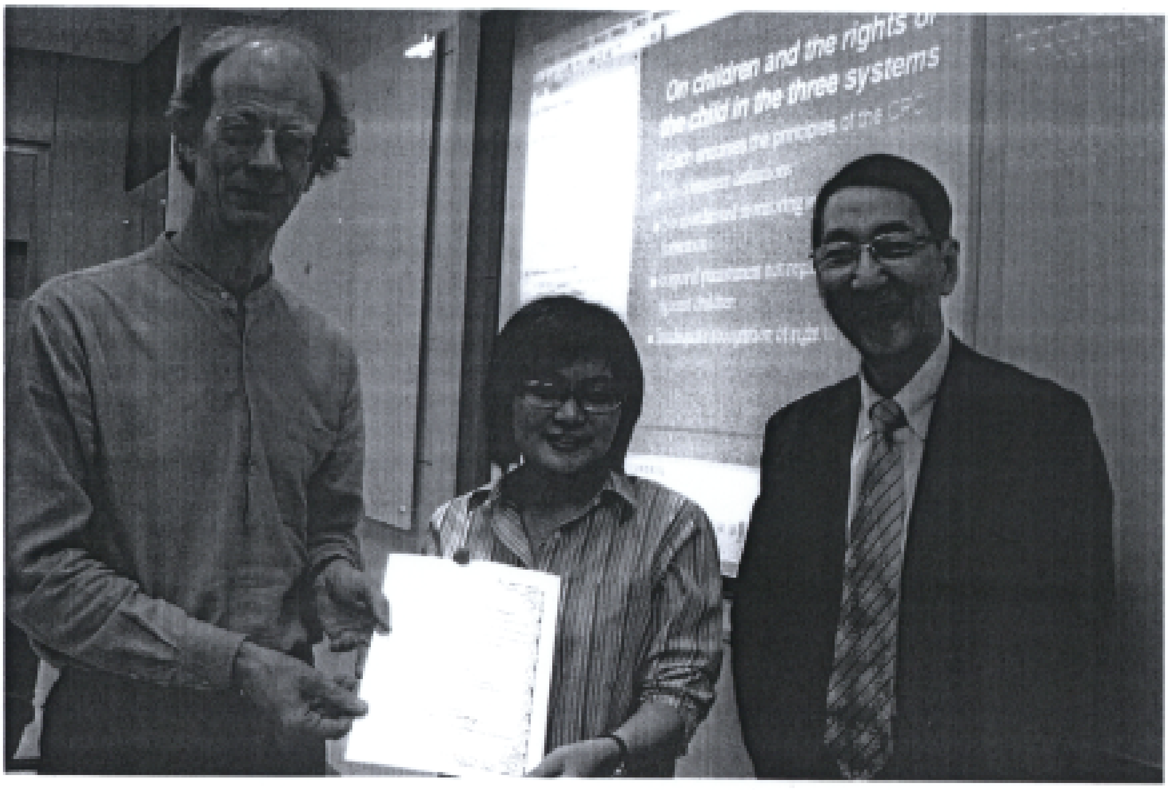

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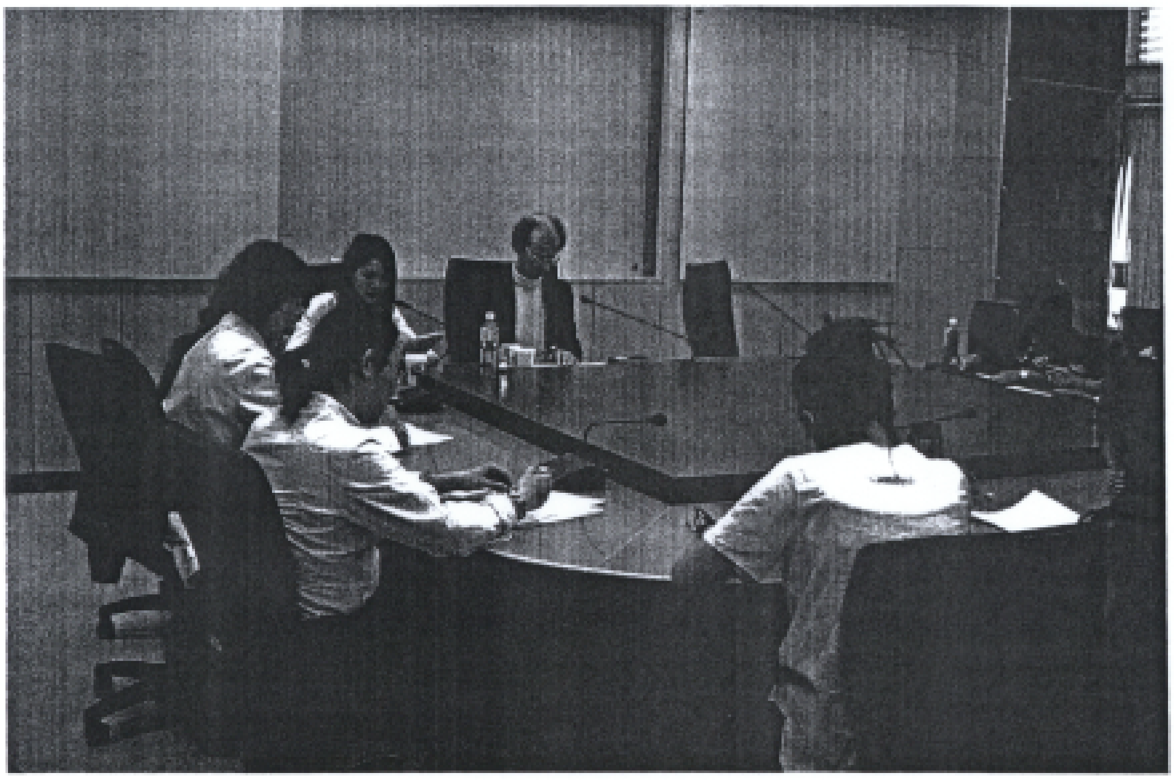

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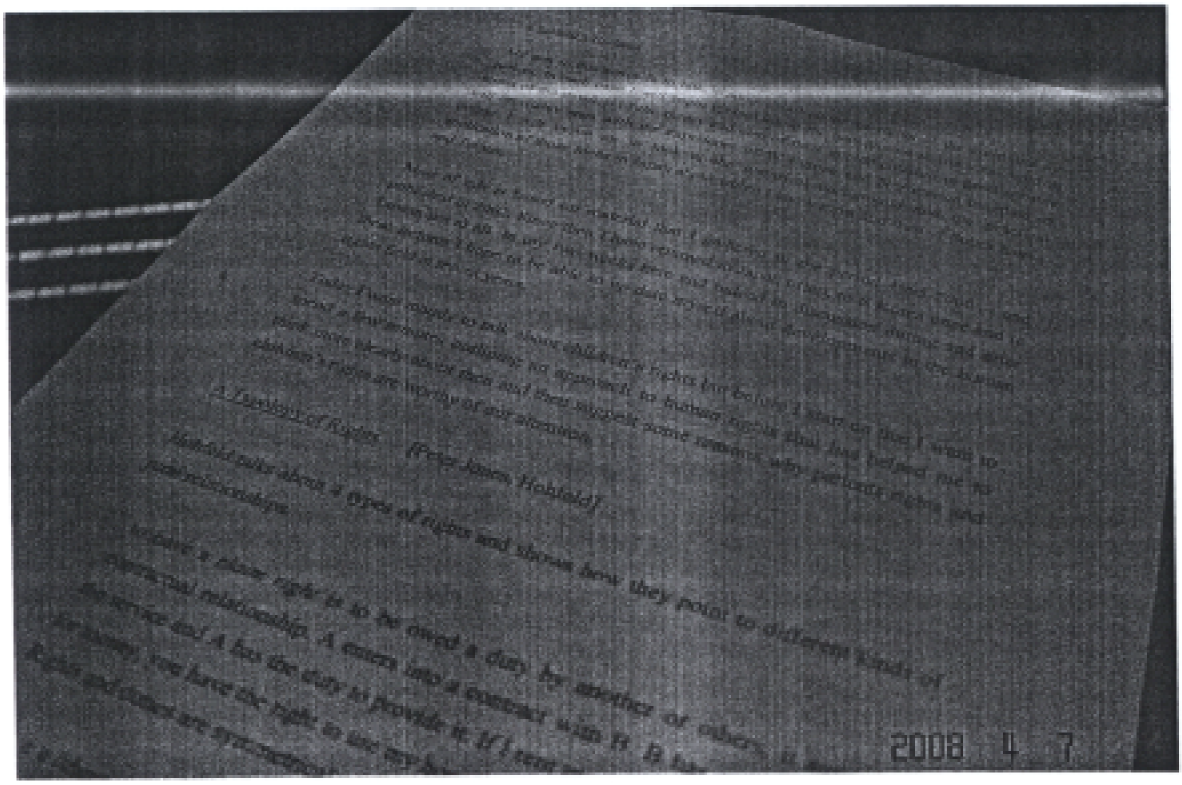

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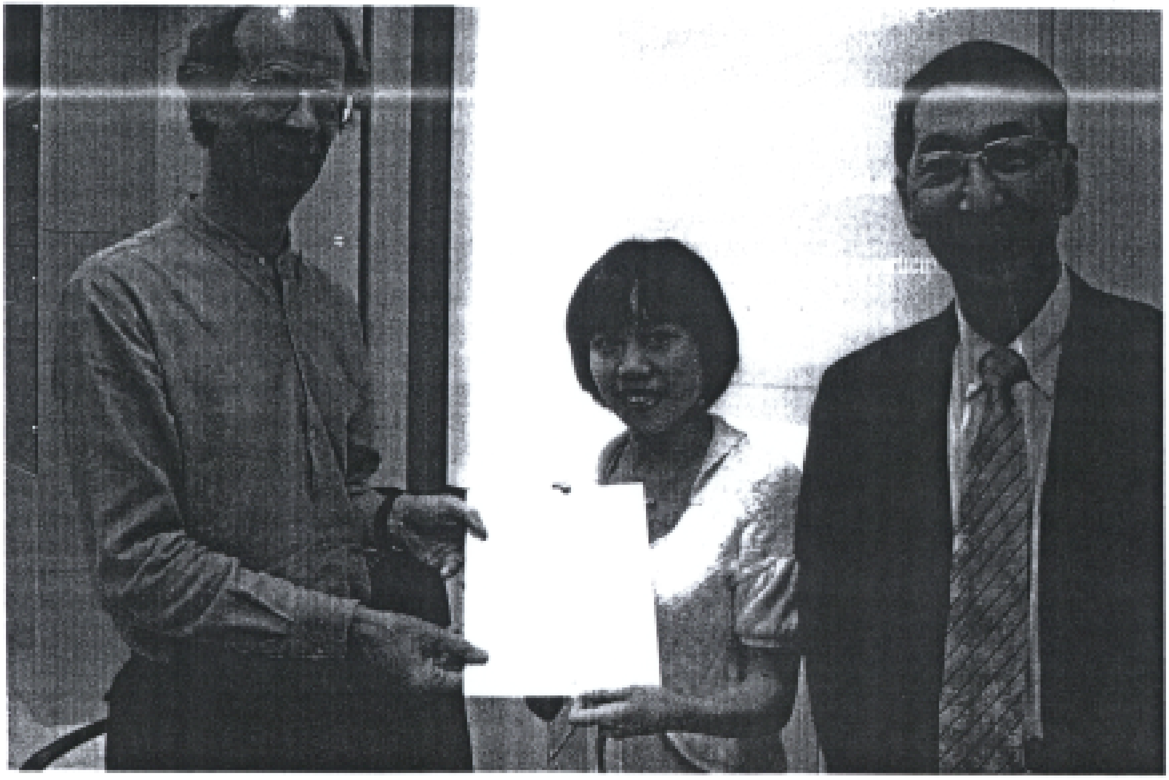

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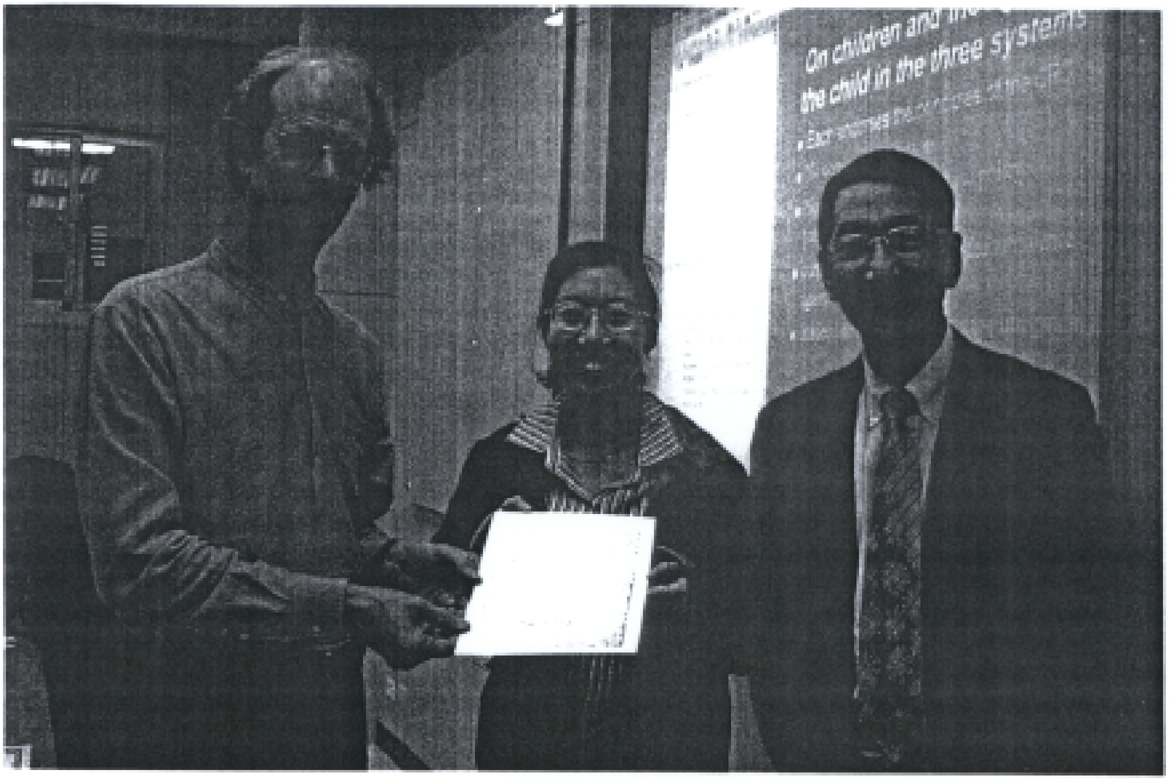

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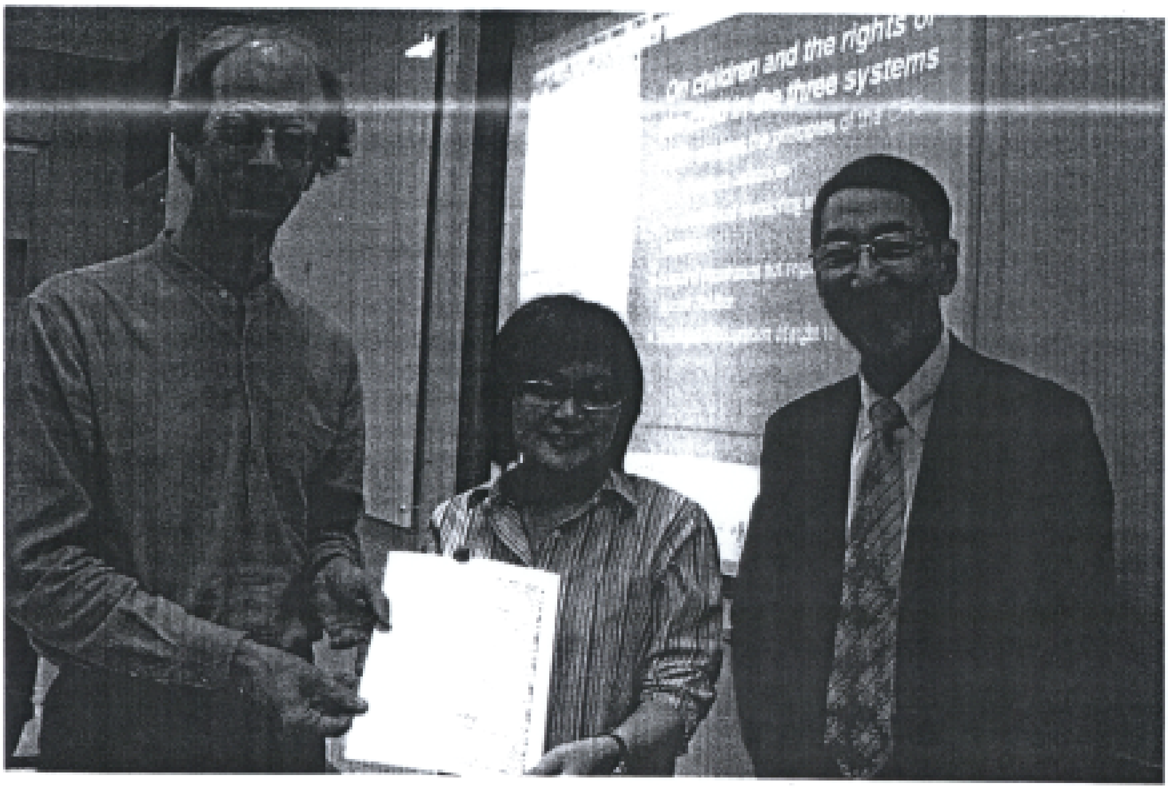


Professor Ian Neary 與學程黃默主任共同頒發結業證

臺灣大學人文社會高等研究院

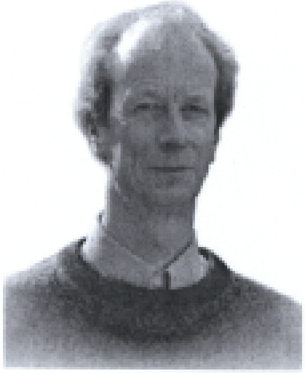
Institute for Advanced Studies in Humanities and Social Sciences
National Taiwan University

專題演講

主講人：

Dr. Ian Neary

英國牛津大學政治與國際關係學系教授



演講

主題：**Asian Perspectives on Human Rights**

主持人：葉德蘭教授 臺大外文系

時間：97年4月17日(四) 19：00-20：30

地點：東亞經典與文化研究計畫演講廳

合辦單位：東吳大學人權學程

本院網站：http://ntuihs.ntu.edu.tw
東吳人權學程網站：http://www.scu.edu.tw/hrp

聯絡人：(02)3366-3750 郭于楨小姐
(02)2881-9741#6952 廖劭文小姐

東吳大學

人權學程迷你課程

Mini Course
Human Rights Program
Soochow University

講　　者：Professor Theodoor Cornelis van Boven

講者簡介：Theodoor van Boven教授出生於1934年，為荷蘭馬斯垂克大學法學教授、萊登大學Cleveringa講座教授，長期專攻國際人權法、國際組織、國際法庭等議題。

Theodoor van Buven教授在聯合國工作多年，並於國際人權機構擔任要職。歷任荷蘭駐聯合國人權委員會代表(1970-1975)、聯合國「防止歧視及保障少數族委員會」委員(1975-1976, 1986-1991)、聯合國「重大侵權行為受害者權利之復原、賠償及重建之委員會」特別報告員(1990-1993)、聯合國「消除種族歧視委員會」委員(1992-1999)及聯合國人權委員會刑求特別報告員(2001-2004)。目前擔任國際法學家委員會副主席、國際人權服務組織諮詢委員等。

課程內容：

第一單元：基本概念
- 人權的普世性與相依性

第二單元：基本權利議題
- 防止與禁止刑求
- 消除族群與種族的歧視

第三單元：當前的人權議題
- 在尊重人權的基礎上打擊恐怖主義
- 對受害者的救濟與補償

第四單元：執行機制
- 人權條約監督機制
- 人權調查
- 國家人權委員會與公民社會組織的角色

課程時間與上課地點：

2007年4月23日至5月12日，

每星期一14:00~16:00、星期五10:00~12:00。

上課地點為圖書館會議室。

課程聯絡人：人權學程董岩竹小姐
電　　話：02-28819471# 6951
1、本課程學員需參加課前導讀，導讀之相關資訊另行通知。
2、本課程採免費授課，歡迎東吳大學師生參加，意者請於4月9日前向聯絡人報名。
3、[illegible]
4、詳細課程資訊，請參閱人權學程網站 http://www.scu.edu.tw/hrp

八、附件

Patinets Rights – an introduction

Patients' rights have not been the focus of attention by the UN and may not seem to be of such urgent concern as the suppression of the rights such as freedom of speech or the rights of minority groups. And yet rather than being a minority issue these are not simply a majority group issue they include issues that involve us all. In modern society there can be few if any people who do not have encounters, probably frequent encounters with medical systems. In this sense one might think that all of us can benefit from the improvement in the quality of these encounters. All of us want not only an improvement in the technical quality of the service be also that our moral autonomy is respected in the course of that encounter. This is important in itself but there is also evidence that it will reduce the incidence of both mistakes and malpractice. This is the relevance of the discussion of patient's rights. I will start today with a description of the context in which the notion of patients rights has evolved firstly in the western context and in the next two lectures in East Asia. The two areas that I will focus on will be the development of the idea of 'informed consent' and the implementation of rights ideas to the situation of psychiatric patients.

Development of Modern Medical Practice

Until as late as 1940 the doctor-patient relationship involved a major act of faith. The patient simply had to trust the doctor to do his best. In fact the range of illness that doctors could cure was relatively narrow; invasive techniques were few and the number of effective pharmaceutical products quite limited. However ten years later the character of medical science had changed. The development of antibiotics enabled doctors to cure previously incurable diseases such as tuberculosis. Psychotropic products were changing the nature of the treatment of the mentally ill. In many fields families of drugs were developed that offered cheap and effective cures for both somatic and psychiatric disorders. Surgical science developed too culminating in the techniques of organ transplants which started in the 1960s.

However there was a dark side to this progress. Firstly a shadow was cast over the post-war development of medicine by the discovery that in Germany doctors had carried out barbaric experiments on captive patients. Debate began about what rights patients had in medical experiments. What limits should be placed on the discretion of doctors either in experimental or ordinary clinical circumstances? Secondly, the new drugs and new surgical techniques all carried with them a certain degree of risk. Few drugs were 100% safe and effective for all patients. Most produced an adverse reaction in a minority. Surgery too entails risks. Was it still appropriate that a patient should rely entirely on the judgement of her doctor? If not, how far should a patient participate in decisions about treatment, in the assessment of risk? How far should others, the patient's family for example, become involved in the decisions about treatment? Thirdly, soon after the creation of the National Health Service in 1947 in the UK most countries of the capitalist world devised health care insurance systems that gave access to free or low cost medical treatment. In the socialist world too there was easy access to health care. Thus across the developed world health-care became a massive service industry and in this process the pre-1940 model of the doctor as the trusted mentor of the patient and her family became increasingly anachronistic. Medicine became industrialised. In these new circumstances was the patient any more than simply a consumer of services and, if so, what kind of consumer rights did she have?

Theorising about patients' rights has developed alongside, sometimes informing, changing medical practice. Patients rights is a particularly interesting area in that although an international discourse of patients’ rights has developed over the last 50 years it has done so with little direct linkage to the UN system.

In the next section we will briefly review one example of recent writing on patients' rights theory and then consider some aspects of the process that has led to the creation of international statements on informed consent and the rights of psychiatric patients.

A Theory of Patients' Rights

The increased complexity of decision-making in contemporary medicine has stimulated an extensive literature on rights in medical practice. Here I have time to review only two examples of this.

Sheila McLean has been a pioneer in the development of medical ethics in the UK and we will look at some aspects of her advocacy of the right of patients to be informed. She starts by describing the 'traditional' view of medicine in which the patient made only one decision, 'to place herself in a given doctor's care, thereby delegating all subsequent authority to the doctor...their expertise justified the doctor making decisions on the patient's behalf'. (McLean 1989 quoting Schultz: 4) However she argues that good medicine is more than technology. Thus a good medical act is one which respects the client's moral autonomy <u>and</u> is technically competent. As the technical capability of doctors increases, the need for communication becomes more important so that the patient must become an active participant in health care. Patients come to expect, she says, an acceptable level of health care and illness (or the suspicion of illness) does not justify any reduced standing as a human being. (McLean 1989: 21) One aspect of the respect for the moral autonomy of the patient is recognition of the need for adequate information disclosure which will enable the patient to accept or reject therapy or chose between therapies. This will require two types of information disclosure - of therapeutic alternatives and of their risks and benefits. She suggests, 'the potential invasiveness and its social and political potential make it an area ripe for rights discourse.' (McLean 1989: 25)

She does not underestimate the difficulties either in theory or practice. Can the doctor's duty to disclose, based on a patient's right to receive information, be tested independently of patient understanding? But, if a patient is unable to understand what is the point of disclosure? Would it make sense to place a duty on the doctor to ensure understanding? There are further problems in determining the 'rationality' of a patient's decision - is it rational for the patient to reject the advice of her medical advisor? This is, of course, a particularly difficult conundrum in the case of psychiatric patients. However separating the issue of respect for self-determination from the matter of a doctor's technical expertise, the requirement that a doctor should obtain consent is not peculiar to medicine but simply part of 'the standard of professional behaviour that it is reasonable to expect from any group possessing special skills and dealing with basic human rights'. (McLean 1989: 81)

Enhancing patients' rights she sees as enhancing medicine's capacity to facilitate autonomy, but the legally sanctioned behaviour of doctors often actively denies the autonomy of some adult patients. (McLean 1989: 162) This reluctance to recognise decision-making practices which respect the rights of patients derives in part from a perception of the beneficence of medicine and a failure to distinguish between the technical and moral aspects of treatment. Patients have an interest both in the technical competence of the medical act and their own autonomy. In summary her argument is:

- medicine is more than a technical event, the system should acknowledge and foster the rights of patients by showing them respect individually and collectively,

- the fundamental element of showing respect is the honest provision of information which enables a patient to make a self-determining decision,

- law should prioritise rights and de-emphasise the weight of professional opinion.

However she is sceptical about the ways that have been developed so far to do this. English law, unlike that in the USA, does not recognise the term 'informed consent' and the quality of information disclosure has usually been judged on the basis of the <u>duties</u> of doctors not the <u>rights</u> of patients. In England no claim against the medical profession's failure to disclose information can succeed unless the failure is so gross as to amount to assault. The argument based on contractual remedy, used in the USA, is of limited relevance in the UK given that the majority of health care provision comes within the NHS. At least in the UK, informed consent has not widened the liability of the medical profession. She concludes,

> The ease with which any jurisdiction is capable of vindicating patients' rights depends on its history and jurisprudence as it does on its willingness to make appropriate modification or enthusiasm for change.
> (McLean 1989: 169)

This suggests the need to look both at the medical and legal culture and assess the impact on them of the forces demanding change. It also suggests that it may add to our understanding of patients rights issues more generally to look at the situation in East Asia.

International Trends

- informed consent

Medical practice throughout its history has not been sympathetic to either patients' rights or informed consent. The first step in the development of these sets of ideas does not occur until after 1945.

In 1945/6 the trials of those accused of crimes against humanity in Nuremberg revealed the extent to which German doctors had experimented on prisoners. This led to the realisation that there was a need for guidelines to govern the relationship between doctors and patients and that, at least in clinical trials, it was important to get the consent of the patient that was based on information provided by the doctor. Of course, even before this time most legal systems had recognised that an element of consent was required to distinguish surgery from assault but few if any legal systems specified the amount of information that doctors should provide patients. The 'Nuremberg Code' was set down in 1948 and made clear that in research on human subjects consent is absolutely essential and that this must be voluntary, competent, informed and comprehending. These ideas were developed in the 1950s and in 1964 the World Medical Conference held in Helsinki adopted a set of principles which would distinguish ethical from unethical research. A distinction is made between therapeutic and non-therapeutic research: in the former case the research is 'combined with patient care' and need not entail informed consent 'if this is not consistent with patient psychology'. Purely scientific research with no therapeutic value for the subject requires the 'subject's freely given informed consent'.

These codes provided the starting point for the formulation of ideas about consent in medicine, 'Nuremberg was the first code prescribed for medicine externally by a court system and Helsinki the first code prescribed internally by a professional body in medicine.' These codes have been developed further by the World Medical Association that recognised the Rights of the Patient in Lisbon in 1981. Its statement was premised on the idea that ‘a physician should always act according to his/her conscience and always in the best interest of the patient’. It went on to assert the following rights:

a) The patient has a right to choose his physician freely.
b) The patient has the right to be cared for by a physician who is free to make clinical and ethical judgements without any outside interference.
c) The patient has the right to accept or to refuse treatment after receiving adequate information.
d) The patient has the right to expect that his physician will respect the confidential nature of all his medical and personal details.
e) The patient has the right to die in dignity.
f) The patient has the right to receive or to decline spiritual and moral comfort.

Over the years the WMC has further elaborated on these principles on the necessity for informed consent even from minors.

New treatments were devised for previously incurable diseases. Some were very effective, such as antibiotics but others were less so and had dangerous or unfortunate side effects as with radio or chemo-therapies. At the same time it became clear that some alternative therapies or changes in life-style were as effective as conventional medical intervention in alleviating such conditions as high blood pressure. Thus there were choices to be made between different sets of treatments and the possibility arose that the values and priorities which guided the doctor or medical professional would not be considered important by the patient. Under these circumstances the pattern of the patient depending entirely on the doctor's discretion was brought increasingly into question.

Perhaps in part because medical technology advanced most rapidly in the USA, it was there that the demands for patients' rights and informed consent were first articulated clearly. The term 'informed consent' was coined in case law in the USA in 1957 which became a watershed year when the era of the 'beneficence' model of medical disclosure and consent seeking began to be replaced by the 'autonomy' model. Whereas in the former model the doctor's primary obligation is to provide medical benefits and in his handling of information he should aim to maximise patients' medical outcomes, in the latter the primary and perhaps sole priority is given to the principle of respect for autonomy. However after reviewing the literature on informed consent before the 1970s, Faden concludes that doctors, even in the USA, were only dimly aware of informed consent as an 'issue'. Moreover much of the response to the explosion of interest in the issue in the 1970s was negative; doctors did not routinely inform patients when they had cancer and many thought the demands of informed consent impossible to fulfil.

At least until the 1960s US medical practice was doctor centred. However during that decade the developments in medical ethics intersected with the emergence of the civil rights and women's movement and also the rise of the consumers' movement. This led on the one hand to wider dissemination of the notions of the importance of human dignity and self-determination and, on the other, criticism of the consequences of the 'industrialisation of medicine'. This is the context for Peter Schuck's proposal for a re-conceptualisation of informed consent as 'a normative variable not an empirical constant'. In place of a unitary doctrine the content of informed consent would vary according to the condition - from a time limited disorder with little or no risk to conditions where prognosis is dire and death likely - and according to the nature of the relationship with the medical profession - an on-going relationship with the family doctor to the fleeting encounter with an anaesthesiologist. Not all patients want or need the same levels of information in each encounter. Though Schuck does not suggest this, the notion of informed consent as a normative variable would also suggest that it has a cultural plasticity too. The implementation of informed consent should, and probably must if it is to be effective, allow for changes in the way it is defined to attune it to the local medical culture.

The first and most influential statement that used the language of rights was the Patients' Charter devised by the American Hospitals Association in 1972 and distributed to 7000 hospitals in 1973 It had two aims: to reduce the incidence of malpractice claims by reducing the impersonality of patients' experience of the modern hospital and to meet the demands of consumer groups for more accountability among health care providers. Even so it was not until 1980 that the AMA code for the first time acknowledged a doctor's obligation to respect patients' rights and in the following year it recognised informed consent as '"a basic social policy" necessary to enable patients to make their own choices even if the physician disagrees'.

- the rights of psychiatric patients

Patients with mental disorders may be confined against their will in circumstances very similar to imprisonment. Just as all countries have complex structures to ensure only those who have committed crimes are confined to prison, so many countries have erected a judicial or quasi-judicial framework to oversee psychiatric care.

Until the 1970s these criteria were set by each country and there were no international standards. At that time concern grew about the misuse of psychiatric hospitals for the confinement of political critics but there was also a new suggestion that 'admission to hospital and treatment genuinely intended for therapeutic purposes may violate minimal standards to human dignity and autonomy...' In March 1977 the UN Commission on Human Rights declared its concern about 'the consequences that advances in the field of neurosurgery, biochemistry and psychiatry may hold for the protection of human personality and its physical and intellectual integrity.'

The Sub-Commission on the Prevention of Discrimination and Protection of Minorities was asked to study the question and they in turn in 1980 appointed a Special Rapporteur to prepare 'principles for the protection, in general, of persons suffering from mental disorder.' She produced a draft document which was developed by a working group and others over the next ten years before a final version was ready to be put before the UNGA. The UN expressed its concern that, 'Persons with mental illness are especially vulnerable and require special protection.' So, although the right 'to the highest attainable standard of physical and mental health' is guaranteed in ICESCR Article 12 and ICCPR Articles 9 and 10 deal with deprivation of liberty, the UNGA agreed by resolution in December 1991 to adopt the 'Principles for the protection of persons with mental illness and for the improvement of health care.' (Hereinafter 'Principles') These amount to the specification of how the international covenants apply to persons with mental disorders in much the same way as the CRC elaborates on the implications of children having rights. But, as well as the protection of persons with mental illness, another goal was to encourage the improvement of mental health care. The expectation was that although the Principles were not binding (in the way that a covenant would be) they might contribute towards the reform of national law and provide grounds upon which cases of abuse or violations of rights and freedoms could be denounced.

Gendreau comments on the emergence of two discourses in the course of the formulation of the principles: the first focuses on health as the principal value while the other pays more attention to equality and autonomy: the medical/beneficence and the legal/autonomy models. The emphasis of the first is on the 'right to treatment' which may justify forced intervention based solely on a medical decision. In the latter view psychiatric patients are not necessarily incompetent to exercise their right to consent to or refuse treatment and a refusal to accept treatment should not necessarily be regarded as evidence of mental illness. From this perspective the decision to administer treatment to an unwilling patient should not be made solely within the framework of medical objectives. Moreover those who support this latter position advocate that the law should protect individuals from the coercive power delegated to psychiatric experts especially when they are deprived of their liberty. This latter was a minority viewpoint and it was the medical/beneficence orientation which influenced the final document supported not only by the psychiatric experts in WHO and the World Psychiatric Association but also by the government of Japan, the only government to make explicit its opinion on the consent-to-treatment issue.

Gendreau is not optimistic about the likely impact of the Principles,

> All in all, the UN Principles do less to increase the protection of the psychiatric patients against a coercive medical power than they do to formulate a series of means to justify the use of this power. (Gendreau 1997: 277)

Codification of rights in this context may unwittingly have done more to sustain power relations than assist the patients in their struggle against them. However elsewhere in the same article she concedes that the recognition that mental health interventions raise human rights concerns even when motivated by therapeutic aims provides the basis to address human rights issues in mental health treatment.

Conclusion

In the process of the formation of the concept of informed consent and the international principles on the treatment of psychiatric patients we observed conflict between two sets of principles that might guide the conduct of medical treatment: the beneficence/medical model and the autonomy/legal model. It is only in the context of the latter model that it is possible to talk about 'patients rights'.
So we can talk of patients' rights in terms of,

> A combination of claims, liberties, powers and immunities that ensure the protection of the patient's dignity and moral autonomy.

This then covers not only the claim that a patient might have against a doctor (and the duty of doctor to patient) in the sense that there exists a contractual relation between them, but also clarifies such issues as access to medical records (empowerment), it includes protection from most kinds of unconsented treatment (immunity) and suggests that a patient does no wrong (has a right, is at liberty) to change doctor or to accept, reject or cease a recommended treatment. Put like this, the notion of patients' rights while remaining based on the legal autonomy model of treatment is defined in terms which go beyond the confines of a particular legal system.

In the lectures which follow on patients' rights in Japan, Korea and Taiwan we will explore whether there are any aspects of local medical culture which have promoted or detracted from the implementation of rights ideas in the medical context and whether there have been any specifically East Asian elaborations of the arguments which were originally devised based on western practice.

Patients' Rights 2 Japan

There is an idealised view of the doctor in pre-modern Japan as an individual who practised medicine out of a generalised feeling of benevolence towards his fellow men not charging any fee to his patients. Grateful patients might make suitable gifts to the doctor but, in theory at least, neither side would see it as a commercial transaction. Traces of this attitude remain and it is still common for patients to give their doctors more or less valuable presents as expressions of gratitude despite the efforts to suppress the practice. However Germany was not the only country to conduct inhuman medical experiments on human beings during the war. There is evidence of similar experimentation by Japanese some of whom were tried in the Far East war crime tribunals but these cases are much less well known than their German counterparts both internationally and within Japan. If these atrocities had been better known in Japan there would have been a more critical view taken of the medical profession and the Japanese people would perhaps have been better disposed to the Nuremberg principles

The notions of rights and duties may not have made much sense within the pre-1945 medical system but by the end of the 1950s, by which time most Japanese citizens had low cost access to medical treatment, the old model of the doctor patients relationship was a little real relevance to actual practice even if many doctors would cling to it for several more decades. From that time there have been a series of demands from patients advocacy groups, mostly led by lawyers, for the implementation within Japan of the patient's rights ideas that they have seen being developed both in such arenas as the World Medical Conference and practised within medical practice in the USA and Europe.

The medical profession has been able to resist demands for patients' rights mainly on the grounds that they are ideas based on a western individualistic approach to the contractual nature of the doctor patient relationship that did not exist in Japanese medical culture. Indeed such an approach to medicine would, it was argued, result in an increase in litigation relating to medical incidents which in turn would lead to a rise in 'defensive medicine' which even many Americans were realising was a high cost to pay for patients' rights. However despite the Japan Medical Association's attempts to resist the acceptance of the idea of patients' rights, the situation in the 1990s changed rapidly and partly responsible for this is a sea change in Japan's medical culture caused by groups campaigning for patients' rights since the late 1970s. We will look at the development of the idea of patients rights from the perspective of the introduction of ideas of informed consent and the rights of psychiatric patients but before looking at the reception given to these ideas, let us briefly consider the background to the formation of these groups.

Patients' Rights Advocacy Groups in Japan

Lawyers involved in medical malpractice suits found it difficult to defend the interests of their clients because of the very high burden of proof placed on the appellant who has to demonstrate firstly that the doctor made a mistake or error of judgement and, secondly, that this was the direct cause of the subsequent damage to the patient's well being. It was difficult to get access to a patient's case notes and there was sometimes a strong suspicion that records were changed by the doctor or hospital subsequent to the complaint. Study groups that were set up across the country were mainly composed of young lawyers plus patients and a small number of doctors. One immediate result of the creation of these groups was that more cases of alleged medical malpractice came to light suggesting that the dominant medical culture and problems of the burden of proof meant that a large number of incidents of medical malpractice have gone unreported.

The Japanese patients' rights groups have their origins in the 1970s at a time when there was widespread optimism about the potential that citizens' movements had for encouraging social change in Japan through the use of the courts. The 'Big Four' environmental cases had shown how the judicial system could be used to protect ordinary citizens against the power of big corporations and the state. Moreover these national level campaigns encouraged smaller groups to take action to affirm their environmental rights within their own communities. Such spontaneous activity by small groups across the country demonstrated that the idea of citizens claiming their environmental rights had become part of Japan's political culture. Rights were no longer 'remote alien and misunderstood entities of a foreign legal system'. Optimism about the reforming, perhaps even revolutionary, potential of the citizen's movement which was widespread in the late 1970s and 1980s proved unfounded. Bureaucratic obstruction and the slowness of the legal system often managed to exhaust the energies of citizens' groups before they achieved their goals.

Nevertheless the patients' rights groups, even if they have not achieved quick results, have succeeded in continuing to assert their case and have forced concessions from the JMA and the government. The individuals at the core of the most active patients' rights groups in Nagoya and Fukuoka are both lawyers, Kato Yoshio and Ikenaga Mitsuru respectively. Both have become specialists in medical malpractice cases and in part their campaigns aim to change the legal balance between the patient and the medical profession to make it easier for them to get redress and to speed up the process. Ikenaga describes how, as he took on more cases of malpractice, he began to realise that often the problem arose because of a lack of communication between the doctor and patient at an early stage in the treatment. Apart from making the legal process fairer to the patient, another aim is to reduce the incidence of malpractice altogether. Both Ikenaga and Kato criticise the medical profession for not regarding the patient as the 'principal' (*shujin*) in the relationship. Thus they are not permitted or able to question doctors, they are not even permitted to see their own records. Indeed such was their unfamiliarity with the idea of asserting rights within the medical relationship that many people who became involved in medical malpractice suits would try to avoid that fact becoming known to other members of the family, company or neighbours.

In October 1984 a draft Charter of Patients' Rights was produced based in part on those devised elsewhere, borrowing concepts from Par. 12 of the International Covenant on Economic, Social and Cultural Rights and Par. 13 of the Japanese Constitution.

By the end of the 1980s there were seven patients' rights groups spread across Japan and from 1987 demands emerged for a Patients' Rights Law which would give legal recognition to the principles outlined in the draft Charter. The medical profession produced a report in January 1990 which redefined informed consent in terms of 'Explanation and Agreement' which, as Ikenaga pointed out, was little more than a restatement of the law as it stood at that time. In 1991 an Association to Enact a Patients' Rights Law was formed among patients groups, lawyers, health care professionals and academics. At this time there was widespread interest in the issue. There had been discussion in the 123rd session of the Diet (September 1992) on the right to information and self-determination within medical care. While some members of the Diet feared that creating mutual obligations would damage a relationship based on trust thus damaging the quality of medical care, others stressed that anything which improves patient understanding of their own condition would reduce medical accidents. In 1992 the Third Administrative Reform council took up the issue of redress for victims of medical malpractice referring to patients' rights and in a judgement published in August the Tokyo District Court asserted the patient's right to a full explanation of treatment and prognosis. In May Yamashita Tokuo, Minister of Health and Welfare, declared in the Diet that the time was close when informed consent would be introduced into Japan as a legal obligation.

The JFBA Human Rights conference of November 1992 had as its theme 'Patients Rights - with special focus on informed consent'. There was detailed discussion of the meaning of the term, the attitudes of lawyers, patients and medical professionals plus a review of the situation in other, mainly western countries. The conference discussed the case for the rights of access to medical records, the implications of patients' rights and informed consent in the debate on organ transplants, disclosure of a diagnosis of cancer and the concept of a 'dignified death'.

Lawyers active in these groups have continued to involve themselves in medical malpractice suits. Thus the campaign for patients' rights is being argued at two or three levels: in the courts, within the political and administrative élites as they respond to these demands and among the public at large to the extent to which the media reports the campaigns of individuals and groups. By 1991 there were over 400 grass roots organisations addressing medical issues - patients support groups focused on specific diseases, diabetes, arthritis etc., victims groups, education and consciousness raising groups plus organisations seeking systemic reform - and many have been formed since then. There is now a large constituency of interest in ideas of change within the health care system and sympathetic to reforms that will shift the focus of medical provision from the doctor to the patient.

Although strictly speaking unrelated to these campaigns, the revelations in 1996-7 about the involvement of senior MHW officials in decisions that led to HIV infected blood products being given to haemophiliacs in Japan both discredited the bureaucracy and generated still further distrust of the medical profession. The patients' rights groups have succeeded in getting publicity for their ideas and there is an incremental acceptance of many of them.

Informed Consent

At the JFBA conference in 1992 three types of problem were identified as preventing the implementation of informed consent in Japan: doctors, patients, and the system. Doctors tend to expect patients to leave decisions to them and do not like to be asked questions. The JMA discussion of informed consent puts it into the context of the need to balance it against a doctor's discretion thus denying the idea of informed consent as a right. Doctors have a formalistic attitude to informed consent; many believe they already practice it, which reflects the inadequacy of medical education. Finally doctors may be unaware of recent research and therefore may not know of possible alternative courses of treatment. As for patients, many of them are prepared to accept the doctor's paternalistic approach and it may be that some of them may not be able to understand sufficiently well the choices before them (though this may depend on the quality of the explanation by the doctor). Finally, the system does not allow time for adequate explanation as it is not rewarded by the 'points system' that determines the fee paid for the medical service.

The JMA has put up considerable resistance to informed consent. Its bioethics committee report used the phrase *'Setsumei to Doi'* (explain and agree) rather than the usual *katakana*-isation of the term and concluded that informed consent principles have already become part of the trusting doctor patient relationship. However they reject what they regard as the wholesale introduction of US ideas, 'We must consider our history, cultural background, national character and national feelings in creating a concept of informed consent appropriate for Japan.' The report does not mention giving patients access to information about the costs of alternative treatments, including no treatment, and it specifies that cancer patients be informed of their diagnosis only if four quite precise criteria are met. Critics of the report argue that the report shows nostalgia for paternalism where a doctor knows what is best for the patient and tries to get her to agree to that treatment. This does not amount to an acceptance of equality in the doctor-patient relationship, still less to empowering the patient to practice self-determination by deciding between the options described to her by a doctor. Ikenaga is not convinced by the 'traditional medical culture' argument suggesting that there is no major difference between the US and Japan and that in either country an important medical decision should ideally be taken by doctor and patient acting together.

A report published in June 1995 by the MHW went a long way towards recognising the importance of informed consent in medical practice but stopped short of recommending that it be given legal codification. It suggests instead that an environment be created within which the patient wants more detailed explanation and the doctors want to explain more. Overall the introduction of informed consent is expected to improve the patient's Quality of Life by increasing the mutual respect of doctor and patient. It reports a growing consensus within the medical professions on the need for informed consent to strengthen the doctor-patient relationship and the growing weight of case law on the duty of doctors to provide more explanation. However there was no agreement among the committee on the need for progress toward codification. The majority view was that the forced imposition of an obligation to explain could damage the doctor-patient relationship. A 'Japanese' approach to the introduction of informed consent through positive promotion in education and by health care groups is contrasted to the 'American' approach which generates 'confrontational aspects of patients' assertion of rights and medical practitioners avoidance of liability' resulting in 'defensive medicine' which is widely accepted in Japan as being a 'bad thing'. It may be that this presentation of informed consent as compatible with the much promoted image of Japan as an harmonious society and its implementation in a way which will further enhance that harmony is a persuasive argument. However another way of looking at it would be to see this committee made up mainly of doctors as recommending that their scope for discretion is left largely unrestricted and that the medical professionals should be left to decide how best to implement informed consent with the support of the state and health promotion bodies.

Critics of the report point out that it avoided such controversial issues as a patient's right to be told of terminal illness and the need to reform the point/fee system to reward doctors who take the time to provide patients with fuller explanations. There were also some criticisms of the closed, secret way in which the committee conducted its business and that only three of the panel were women when most carers in Japan are female. Still, while some argued the report showed Japan was 'an undeveloped nation in medical ethics', others accepted, albeit reluctantly, that this report was first evidence of a positive attitude to informed consent based on the approach of 'how can we do it' - a considerable advance on the negative attitude taken by the JMA in its 1990 report.

In April 1986 MHW started to pay health care providers for providing hospital in-patients with written information about their treatment and medicine. MHW pointed out in the 1997 Welfare White Paper that health care is a service industry and one in which the provision of services may soon start to outstrip demand if the number of doctors continues to increase. However, one might conjecture that an increase in the number of doctors will lead to greater competition in the 'medical market place'. If so, doctors and hospitals may compete on the basis of the quality of their service, one aspect of which could well be their ability to create an environment in which doctors and patients would be able to discuss diagnosis and prognosis, the comparative risks and benefits of alternative treatments and the possible side-effects of drugs or surgery; the full implementation of informed consent.

Human Rights and Mental Health

Japan faced international criticism for its treatment of psychiatric patients in the 1980s in response to which quite radical reforms were introduced. There was a momentum behind this reform process which was maintained by the legal profession and other patients' rights advocacy groups which resulted in further changes being made in the 1990s and there are suggestions that the reform process is not yet complete. Our main interest will be in how these reforms have incorporated human rights considerations and the extent to which international discourse has guided indigenous policy making.

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There were three sets of measures that were designed to reduce abuse of the kind that had caused such international criticism of Japan. Firstly, the law introduced a rigorous and comprehensive set of requirements for obtaining the 'Designated Physician' status that is necessary for a doctor to be able to place a patient in a hospital against his will. Secondly, this set of requirements includes the obligation to undertake study sessions in medical law, including human rights, within five years of the law's introduction and every five years thereafter or lose designated status. Thirdly, hospitalisation is subject to review by a Psychiatric Review Board set up initially in every prefecture.

The 1988 act included provision for a review of the system every five years and the UN Principles approved in 1991 provided an external standard for reviewing the mental health care system. Reforms were introduced as a result of this review which were mainly aimed at improving the facilities to help patients to return to life in society. Plans were made to create a network of halfway houses and government promised more aid for services provided to the mentally ill outside hospitals and there was even an initiative to promote greater awareness of mental illness in society as a whole. The report on which these reforms were based accepted that problems arose when the guardians were themselves old or dependent on a low income and thus not in a position to look after their relative even when he or she was sufficiently well to be released from hospital.

Yet more reforms were introduced in 1996 with the enactment of the Law Concerning Mental Health and Welfare for the Mentally Disabled. On the one hand this strengthened government control of the hospitals where involuntary admissions occurred and on the other it sought to create a welfare policy that strengthened rehabilitation facilities. Changes were also made in the financing of care so that there was greater central government subsidy for involuntary patients. There was some criticism that the rehabilitation schemes were poorly funded and that problems surrounding senile dementia were not being seriously addressed but these eight years of reform represent a significant move in the direction of the normalisation of the treatment of mental illness and the establishment of the principle of 'from hospital to the local community'.

Conclusion

Pressure has been exerted on government and the medical profession by advocacy groups led mainly by lawyers to adopt a rights based approach to health care in Japan. One might cynically say that this was simply the pursuit of self-interest by a profession that has the most to gain if there is greater use of litigation to resolve medical disputes. However this is inadequate to explain the activities played by the legal profession in making the series of demands for a full recognition of 'informed consent' in Japan and in particular the support for the rights of patients in psychiatric care. It is rather related to the perhaps obvious preference among the legally trained to an approach to medical care which stresses the right to autonomy/respect for dignity over the right to treatment. Lawyers within the JFBA continue to play a radical role asserting the continued relevance of the role of rights as set out in the constitution.

They have been supported in their campaigns by the development of international standards. In Japan the medical profession chose largely to ignore the standards devised by the World Medical Council and the UN to guide national health care regimes, but the national and regional bar associations have urged they be taken seriously. Moreover as these international standards develop it is likely that the JFBA will continue to insist that practise in Japan keep pace. For example, there is currently discussion of the creation of an international system to inspect psychiatric institutions to check they operate within agreed guidelines set under the CAT provisions. One could imagine that being advocated by the JFBA and resisted by the MHW and JMA.

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There were three sets of measures that were designed to reduce abuse of the kind that had caused such international criticism of Japan. Firstly, the law introduced a rigorous and comprehensive set of requirements for obtaining the 'Designated Physician' status that is necessary for a doctor to be able to place a patient in a hospital against his will. Secondly, this set of requirements includes the obligation to undertake study sessions in medical law, including human rights, within five years of the law's introduction and every five years thereafter or lose designated status. Thirdly, hospitalisation is subject to review by a Psychiatric Review Board set up initially in every prefecture.

The 1988 act included provision for a review of the system every five years and the UN Principles approved in 1991 provided an external standard for reviewing the mental health care system. Reforms were introduced as a result of this review which were mainly aimed at improving the facilities to help patients to return to life in society. Plans were made to create a network of halfway houses and government promised more aid for services provided to the mentally ill outside hospitals and there was even an initiative to promote greater awareness of mental illness in society as a whole. The report on which these reforms were based accepted that problems arose when the guardians were themselves old or dependent on a low income and thus not in a position to look after their relative even when he or she was sufficiently well to be released from hospital.

Yet more reforms were introduced in 1996 with the enactment of the Law Concerning Mental Health and Welfare for the Mentally Disabled. On the one hand this strengthened government control of the hospitals where involuntary admissions occurred and on the other it sought to create a welfare policy that strengthened rehabilitation facilities. Changes were also made in the financing of care so that there was greater central government subsidy for involuntary patients. There was some criticism that the rehabilitation schemes were poorly funded and that problems surrounding senile dementia were not being seriously addressed but these eight years of reform represent a significant move in the direction of the normalisation of the treatment of mental illness and the establishment of the principle of 'from hospital to the local community'.

Conclusion

Pressure has been exerted on government and the medical profession by advocacy groups led mainly by lawyers to adopt a rights based approach to health care in Japan. One might cynically say that this was simply the pursuit of self-interest by a profession that has the most to gain if there is greater use of litigation to resolve medical disputes. However this is inadequate to explain the activities played by the legal profession in making the series of demands for a full recognition of 'informed consent' in Japan and in particular the support for the rights of patients in psychiatric care. It is rather related to the perhaps obvious preference among the legally trained to an approach to medical care which stresses the right to autonomy/respect for dignity over the right to treatment. Lawyers within the JFBA continue to play a radical role asserting the continued relevance of the role of rights as set out in the constitution.

They have been supported in their campaigns by the development of international standards. In Japan the medical profession chose largely to ignore the standards devised by the World Medical Council and the UN to guide national health care regimes, but the national and regional bar associations have urged they be taken seriously. Moreover as these international standards develop it is likely that the JFBA will continue to insist that practise in Japan keep pace. For example, there is currently discussion of the creation of an international system to inspect psychiatric institutions to check they operate within agreed guidelines set under the CAT provisions. One could imagine that being advocated by the JFBA and resisted by the MHW and JMA.

Patients' Rights 3 Korea and Taiwan

Introduction

Looking through what I have written about patient's rights in S Korea and Taiwan I am struck by the need for more research in the area. Most of my work is now 8-10 years old and I think that there must be more developments now that should be incorporated. I am aware of some developments – and I will mention them in passing – but it would require a new research project to update my account supplemented by reference to the work in Chinese and Korean that I feel sure must have been done about some of the topics I am going to comment on today. On the other hand not much, if anything, has been written on these topics in English and there have been no further attempts to provide any kind of comparative analysis. So what I am going to do is to sketch out the situation as I saw it in 2000 where possible adding to the account with additional sources that are more recent. I would welcome any comments especially about Taiwan either about the analysis or about how and where I can find further information to up date this account.

I will begin by looking at the situation in S Korea first of all summarising the situation in which ideas of informed consent and access to patients records have been discussed and then looking at the situation of the rights of patients with mental disorders,

South Korea

Background to the medical system

In 1976 Korea started a programme to provide health insurance which by 1989 had achieved universal coverage. A measure to integrate the insurance system was passed by the National Assembly in 1998 and was fully implemented by 2000. These reforms ensured the steady growth in the demand for health care and there was a rapid increase in the supply between 1970 and 1994: the number of patients per doctor fell dramatically from 2216:1 to just over 855:1.

During the 1990s there has been an increase in the number of medical malpractice cases which have found there way to the courts, up from 100 in 1990 to around 300 in 1998. This can probably be connected to the increasing 'industrialisation of medicine' and in response in 1994 a law on mediation in medical disputes set up a system of mediation councils both at the national level and to work in the regions and major cities. Twelve of these medical disputes committees were set up composed of people with a law qualification, each serving for three years and assisted by medical specialists and consumers. The system came into operation at the start of 1996. But it is the view of those involved in these cases that a better appreciation of patients' rights might well contribute to the reduction of the incidence of medical malpractice. Often the problem arises from the poor relationship between doctor and patient. Improve this and the number of cases will fall.

Such ideas had little support although there were some consumers groups who had advocated this approach in the 1980s in the face of strong resistance from the medical profession. In 1993 a bill of patients' rights was adopted by Yonsei Severance Hospital –the oldest and one of the most prestigious in Seoul.

> We profess that we will perform medical practice based on the principle of providing quality care to patients causing no disadvantages, respecting the maximum autonomy and practising social justice. Specifically the following rights will be respected:
>
> 1. Every patient has a right to be concerned and respected as a human being.
>
> 2. Every patient has a right to receive sincere treatment from medical staff.
>
> 3. Every patient has a right to know about the speciality of the medical staff in charge.
>
> 4. Every patient has a right to be informed about his or her disease, present conditions, plans for treatment and prognosis.
>
> 5. Every patient has a right to decide whether to try a new medical therapy or participate in the education on the disease concerned.

6. Every patient has a right to be informed of medical procedures such as treatment, diagnosis, operation, hospitalisation etc.

7. Every patient has a right to have his or her medical record inaccessible to any individual except medical staff in charge or legally authorised persons.

8. Every patient has a right to be secured of privacy regarding the treatment.

9. Every patient has a right to be secured of privacy regarding his or her body even when undressed for the purpose of treatment.

10. Every patient has a right to know about specification of the medical expenses.

However this is clearly a bill of rights written by doctors and was probably a pre-emptive move designed to prevent the creation of one by activists or lawyers. It addresses the right of patients to be informed about treatment, diagnosis etc. It talks about a right to privacy and the 'right to be concerned and respected as a human being'. And it gives the right to decide whether or not to participate in a new therapy. However it does not mention a right to refuse treatment. It does not discuss the right to a second opinion or a right to access to one's own medical record. In sum there is no mention of informed consent or commitment to its implementation.

Rights in Psychiatric care

Traditional attitudes to mental disorder and disability in Korea have resulted in psychiatric patients being isolated from society, and in general not being treated as full human beings. Even the statistics of how many patients there are in psychiatric institutions is made difficult to assess because of the vagueness of definition and the varieties of institutions. There is no doubt that there were large numbers of people, many thousands, who in the early 1990s were being held in very poor conditions. One psychiatrist commented that is some institutions patients 'led a concentration camp like life that is near to maltreatment', confined to large hospitals with little or no access to a full time psychiatrist.

Until 1995 there was no unified Mental Health Law in Korea. It is said that the attempts to reform the mental health system up to this time were resisted by the medical profession which feared that psychiatric hospitals might be used by the authoritarian government to silence it critics. It was only when these fears had receded in the early 1990s that it was possible to plan reform. The law came into effect in 1997 at which time a Mental Health Policy Division was created with the MHW.

A new system for admissions to mental hospitals was created: around 80% of admissions are 'admissions by relative' which requires the request of a relative and the agreement of one psychiatrist, ten per cent of admissions are 'voluntary' and the remaining 10% are 'emergency admissions'. The final category, 'compulsory admission', is hardly ever used as it requires the presence of two psychiatrists and an administrative officer, usually a policeman.

The act produced for the first time a set of clear definitions of nurses, psychologists and social workers and different kinds of institutions – clinics, long term hospitals, community rehabilitation centres. Moreover it set up a Mental Health Review Tribunal system which reviewed the circumstances of all those not admitted voluntarily and could hear appeals about illegal detention and poor conditions. It was suggested that these tribunals might become pro-active visiting hospitals to inspect conditions.

The number of beds in psychiatric hospitals increased in the 1990s to around 98 per 100,000 population (still much lower than in Japan, 290 per 100,000)

In 1998 an individual escaped from an 'unlicensed' closed institution, went to Seoul and persuaded a HR group to send some activists with him to the facility. They confronted the management and later investigations showed that they had used solitary confinement, compulsory medication and violent treatment in their handling of the patients. It later become clear that this was not an isolated incident and that there was evidence of similar levels of abuse at children's homes and in similar 'unlicensed' institutions. At the time it seemed possible that this might mark a starting point in the development of a policy for the improvement of treatment of the mentally disordered and other institutionalised people in the same way that a similar scandal had had in Japan in the 1980s. Several of the leading HR NGOs began to take up this issue.

There is a need for some careful research about what happened next. Ten years after the introduction of the new law and the operation of the tribunal system what evidence exists of changes in practice? Did the scandal of 1998 have the effect that I expected? What role are the NGOs now playing? Is there any evidence of improvement of the treatment of those in psychiatric hospitals or changes in the general attitudes of the population to mental illness?

Recent Developments

In the discussion of children's rights I mentioned the creation of a NAP – an action plan for human rights that was adopted in 2006. This does mention 'Disease Sufferers' as one category of people whose rights need to be taken seriously. However looking carefully at the text it becomes clear that this is only concerned with certain classes of patients: those with HIV/AIDS, Hansen's disease and Hepatitis B. It is silent about the broader issues of patients' rights such as informed consent and there is no mention of patients with mental disorders. It would be interesting to enquire of the NHRC why these two important areas were omitted.

In March 2007 the Korean medical profession engaged in a one-day strike in opposition to the government proposals to change the medical law in order to impose the obligation on doctors to provide more detailed information and explanations about treatment and symptoms. Representatives of the KMA argued that it 'will threaten the health of people and 'undermine the authority of medical health professionals'. The same news report contained comments from a lawyer, 'The patients' rights to decide for themselves must be guaranteed.'

It is clear that the topic of patient's rights has re-emerged in Korea. There is an important research project to be carried out here on the background to the government's proposals, the responses of the medical profession and the attitude of the legal profession and human rights groups.

Taiwan

At the risk of repetition let me emphasise that the research that these comments are based on is rather old, was based on a relatively small number of brief visits and on a small amount of English language material. I think at the time the account I gave was broadly accurate but also I think it is likely that things have changed. I would be very pleased to hear your comments on changes within the Taiwanese medical system and in particular changes in approaches to patients Rights.

Background.

As had happened in Japan and Korea, Taiwan adopted a health insurance system that depended in part on patient co-payment which by the end of the 1990s covered almost all the population. Supply of health care increased to match demand and the number of doctors increased to 1:837 by 1997. As happened elsewhere as the demand/supply of health care increased in quantity there was a trend for patients to prefer the larger hospitals to the smaller 'one-man' clinics. In other words the medical system has become 'industrialised' and patient/doctor relationships have become more contractual, more like that of the consumer/producer, even if this is about the provision of services rather than commodities.

In her pioneering study on informed consent in Taiwan, Yang Hsui-I wrote, 'For most Taiwanese physicians and lawyers ...it is an unheard notion and rarely invoked.' She wrote that in 1997. What I wonder has changed in the last ten years? Consent was the required for major procedures – but this was not the kind of consent that is premised on the right of the patient to have full knowledge prior to making an informed decision, neither does it entail the right to refuse treatment or to choose between different treatments. Unusually in our three state comparisons the Consumers Foundation played an important role in sustaining the idea of patients' rights from the 1980s as an extension of consumers rights. One of its 15 committees was concerned with medical care. It had very few powers though, and if its recommendation were ignored the only alternative a patient had was to use the courts a very expensive and risky venture. Does this committee still play a key role in dealing with complaints?

From 1962 until 1986 the responsibility for dealing with cases of alleged medical malpractice lay almost entirely with a Medical Disputes Reviewing Committee (MDRC) which was composed of between 7-11 doctors and funded by the Taiwan Physicians Association. Almost every case that was taken to the courts was referred to this committee for an 'expert opinion' which was later accepted by the court. Prior to this, courts had made decisions based on the judges' assessment of the often-conflicting testimony. The medical profession disliked this as the resulting court decisions were unpredictable.

Growing public dissatisfaction with the MDRC led to the inclusion in the 1986 Medical Care Act of proposals to create Medical Review Boards (MRB) in both central government and local health authorities which have a broad remit to review medical technology, experiments on humans, the promotion of medical ethics, the approval of plans to build large hospitals and 'matters concerning the examinations entrusted by juridical and prosecuting organisations'. (Par.73.4) So, as before, when a court encounters a case of possible medical malpractice, the judge will refer the case to the central MRB for an 'expert opinion'. This board is still dominated by the medical profession of various specialisms, ten of them, but there are five others, at that time two professors (law and sociology), a judicial official, a legislator and a social worker.

Changes such as this and others improved the quality of patients' records but there is no evidence that patients have easy access to them. Let alone a right to access them. Has this changed?

Mental Health Care

Traditional attitudes to mental illness are similar to those held in Japan and Korea and, if anything, more strongly held. When I was here in 1995 people talked to me about the scandalous continued existence of Long Hwa Tan, an institute for those with psychiatric disorders. It was impossible to imagine the existence of such an institution in Japan at that time and as we have seen there was growing public criticism of the similar institutions that existed in S Korea especially from the HR NGOs. Its continued existence suggested to me the deep-rooted nature of Taiwanese attitudes to psychiatric illness. Does it still exist?

The Law on Mental Health was passed in 1990 and set standards for the provision of psychiatric care and the criteria for hospitalisation. It includes a chapter on the Rights of Ill Persons which begins

> The personal dignity and legal rights and interests of ill persons shall be respected and protected and they shall not be subjected to discrimination, cruel treatment or unlawful uses.
>
> Par. 36

There are further guarantees to personal privacy, to the right to freely communicate with the outside world and to meet visitors.

However there seems to be no independent appeals system or inspection regime which is independent of the medical profession. However weak, these systems have been put in place in Japan and Korea and provide some degree of check on the potential abuse of power by doctors. There are, or were, peer review systems that oversee the conduct of medicine but there is nothing in these systems that is able to protect or extend the immunities, liberties or powers of patients.

At the time I was writing in 2000 there was very little evidence that the state system or medical profession was sympathetic to the idea of patients rights becoming a routine part of medical practice. Moreover there was nothing to suggest that there was any patient centred NGO community that was trying to insist that patients' rights be taken seriously. I wonder if this has changed?

Conclusions on patients' rights from the three systems

One of the key characteristics of the welfare systems of East Asia is that they have tended to subordinate welfare to the broader priorities of economic growth and efficiency. It would be unrealistic to expect that this conservative political logic would be open to ideas of rights practice. However authoritarian ideas have been in retreat in all 3 states since the 1980s and at the same time the medical care systems have grown in size and sophistication. It would not be surprising or impossible that there could develop ideas that the patient within these systems has a right to dignity enhancing care.

The technical competence of health professionals in these three countries lags little, if at all, behind that of anywhere in the developed world. Indeed most leading specialists have trained and sometimes practised in the west, usually the USA. However there has almost been a conspiracy of silence among these doctors about patients' rights issues once they have returned home. There may be a sociological explanation here: that the structure of medicine in these countries is a highly hierarchical system. If a doctor felt inclined to give his support to such ideas as patients' rights, he or she would be easily dissuaded from carrying them out by senior elements within the hospital on whom the young doctor would rely both for assistance on a day to day basis and for promotion later in their career. One suspects that this is what is being referred to by doctors when they talk about 'traditional attitudes' preventing the introduction of patient oriented practice.

In these systems where there are demands for the practical application of patients' rights, whether informed consent or access to ones own record, the case is rarely made on any concern for the patients' moral autonomy' of the kind that MacLean talks about. Rather the emphasis has been on the way it might improve the technical quality of the health care, helped cut costs or reduce the likelihood of medical accidents. Moreover, especially in this latter case, it is usual that most of those who have chosen to speak or write about rights are not doctors but lawyers.

International standards have played an important role in Japan – perhaps not surprising since it has been the most open of the three systems to both international inspection (the ICJ) and to the recommendations of UN committees. Patients' rights have not been an area that the UN has taken a direct interest in so the potential for the influence of reports etc. is obviously less. Even the 1991 principles for the protection of persons with mental illness do not appear to have had much impact on the region.

Indeed in Japan there has been a small but focussed group of activists interested in PR issues led mainly by lawyers that does seem to have had an impact, and has forced the medical profession to accept some limitations on their ability to dominate the medical policy process. Some of the more effective PR advocacy groups e.g. the 'Patients Rights Ombudsmen' include both lawyers and senior doctors among their central committees. In Korea, and to an even greater extent in Taiwan, the patients rights groups that exist have pitted lawyers against doctors. Thus far not much progress seems to have been made. Doctors retain both the legal power and medical authority and are eager and able to resist any attempt to alter their relationship with their patients. The strikes that took place a year ago show how far the medical profession in Korea was prepared to go to resist the imposition of policy that would reduce their autonomy. How, I wonder would the Taiwanese medical profession react to similar proposals?

On children and the rights of the child

Each of the three states on the one hand endorses the principles of the CRC, even if Taiwan is not legally bound by it, while at the same time there are a number of problems which either have not been resolved or not even been addressed.

One is the issue of gathering and presenting data about children. In none of our states are there consistent definitions about children which extend even across the ministries in the same state. One of the alternative reports produced in Japan noted that there are six different words used to refer to children in government documents which makes the production of meaningful data difficult. While on the one hand local linguistic patterns need to be recognised it would not be too difficult for each state to adopt the UN guidelines as a minimum definition for the purposes of presenting data.

Secondly, and related to this, is the issue of coordinating monitoring and policy formation towards children across government. Some countries have established an office for children headed by a Children's Champion, A children's ombudsperson whose role is to enquire of policy makers about the child related element of policy proposals and to advocate the inclusion of a children's dimension to policies. An alternative might be to create a coordinating committee within, for example, the presidential or PM Office. There is little evidence of this anywhere in East Asia.

Perhaps the S Korean state has made a move in this direction by establishing part of the NHRC with a specific remit to consider children's issues although this may only be able to monitor having too little authority within the governmental structure to be able to coordinate. All three of our states need to go further making structural changes before they will convince critics that they really have engaged with the child rights agenda.

A third issue is corporal punishment. There needs to be a clear recognition that this is violence against children. It is morally wrong in itself but also any recognition of its acceptability by school or state legitimates its use within the family where it can cause both physical and psychological damage. Moreover it is part of a pattern of thought that regards children as belonging to parents to the extent that when they consider their lives no longer worth living they kill their children too. There can be no better example of the need to think seriously about the need to look after the best interest of the child.

On a different level there is a need to look at difficulties in appreciating the three core principles of the CRC because of the way that they clash with the patriarchal values that have supported authoritarian decision-making within the family and the state. Respect for the elderly, respect for the father, respect for the state have all been given priority over giving primary concern to the special interests of children, and most problematic of all are the interests of the girl-child. The East Asian developmental state was built on the foundations of this respect structure. Many parts of the political system have been democratised but family patterns seem to resist this process. It may require the democratic state structure to take measures to encourage at the very least some loosening of this top down system.

The problem is that this is often interpreted as demonstrating how the CRC is intent on somehow 'destroying' the family and yet as article 5 makes clear on the contrary it encourages the state to respect the family, however locally defined, to provide for the child what s/he needs consistent with his/her 'evolving capacities'. This does nevertheless put great emphasis on the need to recognise the constantly changing nature of children. This seems to be difficult for the governments in our three states to comprehend.

Finally, and related to the above two points, the implementation of children's rights in each of these systems has encountered difficulties with the right to participation. State structures have shown a distinct lack of imagination about how this can be done whether the context be the school or the legal system.

Over the past 25 years the states in Japan, South Korea and Taiwan have come a long way in subscribing to the international human rights agenda. However in each of these three states we have found that there have been problems that have arisen when people have demanded that they be incorporated in aspects of everyday life. Formal recognition of rights ideas is not enough. The human rights agenda has the potential to make significant changes – I think improvements – to all our lives but this requires us to think about their impact on every day activity. At this level there may well emerge local variation and although we must always be alert to ensure that this is not subverting the original aim this should surely be welcomed.

Children's Rights 2 Japan

Notions of children and childhood have evolved in the course of Japanese history in response to changes in the social environment. I mentioned last time the idea of childhood being a social construct 'constituted in particular socially located forms of discourse'. I want to begin with a brief overview of how the discourse of childhood has changed in Japan since the early modern period up to the present day. Then I want to describe the actors involved in discussions about children's rights in Japan before, in the 3rd and final section describing Japan's involvement with the CRC regime.

The Evolution of Childhood in Japan

Children of the village

Before the C19th Japan was an overwhelmingly agrarian society and though there was a clear division based on social class, and class affected how childhood was defined and children treated, most children were children of a village.

Peasant custom regarded children under the age of 7 as liminal – belonging more to the world of God than of men. They were not regarded as fully human, how they were treated was up to the family, social sanctions did not apply, they could act freely. Many children had their hair done in a topknot so the gods could pluck them from this world more easily. From the age of seven however they had to start learning to work and from the age of fifteen, when they were regarded as mature and economically able to support a household, they were accepted as adults. [At the other end of the scale, men over the age of 60 were no longer regarded as full members of society and the older they got the more venerable they became until by the age of 80 they were almost gods.]

As Japan entered the early modern period - say from the mid sixteenth century - some changes can be observed. Although there was some variation across the country, children under thirteen were generally treated differently from adults during the Tokugawa period. Some suggest that this view of children emerged with the breakdown of the extended family management of agriculture and the development of an independent peasantry based on smaller (almost nuclear?) families. However these families were closely linked to the village community both as a productive unit and the basic structure of social control. There was a broad community interest in the welfare and up bringing of the village children and, with the development of an early commodity economy involving the use of contracts, basic literacy and numeracy became important. Temple based schools (*terakoya*) were set up in many villages to teach the peasant children. Each daimiate had its castle town, its administrative headquarters, which would often also be the location of an academy for the sons of the former warrior class who manned the bureaucracies of the Tokugawa regime. These towns had links with the major cities of Edo, Kyoto and Osaka and a commercial publishing industry developed to serve this urban population both with textbooks and child raising texts, often written by Confucian scholars.

Between 1720 - 1850 the Japanese population remained stable mainly due to the control of family size by abortion and *mabiki* (neo-natal infanticide). Some local lords sought to prevent this, sometimes for religious reasons but more often because of a desire to increase the size of the local population to maximise or increase production. This was the origin of some of the 'child protection' policies of the C19th.

Relations with parents were complex. Many village children relied on 'parenting' from those other than the natal parents as well as belonging to peer group organisations for 'children' (age 7-11) and 'adolescents' (age 11-15). However what this suggests is that children were not the members of 'private' families which were the basic units of society but that they were instead, or as well, members of the 'public' unit, children of the village, and it was not difficult to move from regarding children as belonging to the village to belonging to the state.

'Children of the State'

A major concern of the rulers of Japan in the 1870s was to create a sense of national identity. Samurai were loyal to their lord, peasants identified with their village – very few felt loyalty to the abstract entity 'Japan', or even were aware of it. Two policies were aimed at addressing this: the decision to create a conscript army and the introduction of compulsory primary education, initially for 4 years from the age of 7.

Both aimed to break down class and regional loyalties and, particularly through the school system, by history and moral education to create feelings of national pride.

The legal structure was also completely revised informed by a mixture of European (mainly German) ideas of the state and Confucian notions of obedience to parents and family solidarity. There was a great deal of variety in family customs at this time. When a committee reviewed the situation in the 1880s it found that 90% of the commoners were following patterns of kinship relations and forms of marriage that did not conform with Confucian standards of the upper class. Rules were therefore imposed to unify Japanese practices – in the name of Japanese tradition.

At the same time the legal system was reformed and a formal distinction was made between the treatment of adults and children within the legal system. In 1900 a reformatory system was set up and 47 should have been set up over the next few years to act as alternatives to prison for juvenile offenders. In fact growth was slow and even in 1907 only 7 had been set up. In 1908 the age of criminal responsibility was set at 14. So the state began to define children and childhood through the education and legal systems.

But it was not only the state that was changing ideas about the position of children in Japan. Ueki Emori (1857-92) an influential member of the *Jiyu Minken Undo* (People's Rights Movement) argued that the individual, not the family, should be regarded as the basic element of society and that children should be regarded as individuals in their own right. He criticised the contemporary system, which exaggerated the rights of parents, and paid too little attention to the rights of children, he said 'children exist for themselves, not for their parents'. The short-lived Social Democratic Party of 1901 included in its manifesto the child's right to education paid from public funds.

The first book with the title 'Children's Rights' (*Jido no Kenri*) was published in 1911. The author, Tamura Naomi states that at a time when many western countries are accepting the idea of women's rights and Japan has adopted laws against cruelty to animals, there should be no difficulty in asserting the rights of children. He criticises the Japanese state for focussing on creating good citizens from children rather than protecting their rights. This does not mean that they are the same as adults though. To dress children in adults clothing would not be to treat them with respect. He thought that a radical focus on children's rights would transform; or contribute to the transformation of society. Interestingly he was influenced by the work of Ellen Key whose book had been partially translated in 1906 and finally published in full in 1916. Ideas of children's rights developed alongside the women's movement while on the other hand the state strengthened its control of education/children's lives through its control of textbooks and schools, placing increasing stress on nationalism. However for a time the idea that children have rights continued to develop, for example,

Nishiyama Tetsuji published a book in 1918 entitled 'Educational Issues and Children's Rights' (*Kyoiku Mondai Kodomo no Kenri*) in which he criticises the uniformity of Japanese education, its curriculum, textbooks and even school architecture. He suggested that children have three main rights: the right to be born well, the right to be brought up well and the right to an education.

Shimonaka Yasaburo in a book on education reform published in 1920 talks of the child's right to play and argues the case for full equality of opportunity in education and educational autonomy from the state through the election of local education committees.

The socialist *Kagawa Toyohiko* made a speech three months before the League of Nations produced its 'Geneva Declaration' in which he talks of children having 'the right to eat, the right to play, the right to sleep, the right to be scolded, the right to request parents to stop arguing and the right to demand they stop drinking'.

This was the height of the period called Taisho democracy. From 1925 onwards Japan became more involved in the war in China and internally all forms of dissent, whether liberal or socialist, became difficult and finally impossible and with this all rights talk disappears. For a time the liberals and socialists had clung to an Appollonian vision of children – 'never forget your pure childish hearts' but quickly the demands of the state urged them to forget that, and focus on becoming servants of the state and by the end of the 1930s soldiers of the state.

However what I want to emphasise is the existence of this pre-war discussion of rights, even children's' rights.

'Children of the Company'

Reform of the Japanese education system was a key priority of the US occupation – it was regarded as one of the main sources of pre-war nationalism. The structure was changed and the focus moved from education for the service of the state to child centred learning. This transition was not too difficult as many teachers were familiar with these ideas from their training in the 1920s (and most of those who were not resigned from schools).

Equally urgent was to decide what to do with the large number of orphaned children, over 100,000 of whom had lost both parents. Local governments were given responsibility for them under the Child Welfare Law of 1947 and in 1948 a Children's Bureau was set up in the MHW.

A Central Child Welfare Council (*Chuo Jido Fukushi Shingikai*) was set up in 1948 and among other things it produced a Children's' Charter which was proclaimed in 5 May 1951 based on three principles:

The child shall be respected as a human being.
The child shall be esteemed as a member of society.
The child shall be raised in a good environment.

It goes on to promise adequate food, education and protection from exploitation. However this is no more than a set of promises that neither the child nor his representative can enforce if they are not delivered. At best it is about 'immunities with no room for claims or powers.

During the 1950s two things happened: as the economy grew once more policy towards children moved from 'protection' to 'welfare' and indeed more comprehensive policies began to be introduced. . Meanwhile however the Min of Education began to re-assert its power over the school system both through its control over teachers and over the textbooks/ curriculum. Meanwhile business too was exerting influence through the LDP to change the content of education to serve its needs as a manpower training policy – another manifestation of the development of ‘companyism’ that came to characterize much of Japan’s social and legal system in the 1950s. If the pre-war education system functioned to produce first citizens and later soldiers, the post-war system was molded to serve the needs of industry. Education to pass exams became the accumulation of more and more useless facts. Schooling took over not only the day but also dominated family life consuming increasing amounts of both time and money. As the sociologist RP Dore put it, it became ‘an enormously elaborate, very expensive intelligence testing system with some educational spin-off rather than the other way round.’

This was resisted. Within the schools and classrooms the JTU tried to hold back the controlling tendencies of the state /Ministry of Education. Some small groups criticised the stress on exam passing and increasing nationalism. But there was little use of the language of rights and the critical voices had difficulty being heard in the context of the drive towards economic reconstruction and growth at all costs.

Into the C21st

Several dimensions of children’s lives changed in the social context of the 1990s and after. Firstly, if most of the post-war policy had been aimed at economic growth – catching up with the west – that had been achieved by the late 1980s. The collapse of the economy in the early 1990s and the failure to recover in the later 1990s suggested that perhaps to move forward Japan needed a new kind of education system that allowed or fostered greater creativity. Note this is still not about education for the sake of the child. It still focuses on economic objectives it is simply that it is thought that fostering individuality will generate more creativity that is what the Japanese economic system needs today.

Secondly the birth rate changed fairly drastically. Whereas in 1952 70% of people had 3 or more siblings, by 1971 the average number of births per women had gone down to 2.1 more or less a replacement rate, but this had dropped to 1.3 by the end of the century. Japan’s overall population is now falling and the proportion of children in society is shrinking fast. Policies had been devised to try to make Japan and its employment practices more family friendly but it may be that the key issue is not how many children are being born to married women – but the relatively large proportion of women who are not marrying – and not having babies. This issue may be more difficult to address.

Thirdly the smaller number of children has consequences across the education system as competition for places in universities is reduced and there is much less need for children to work hard at school. People are concerned about the collapse of the school system.

Fourthly as the recession of the 1990s continued unemployment and under-employment increased, and the recruitment of young adults by the major companies dropped. This created a new social problem of 'Neets and freeters' – individuals who seemed to be choosing not to enter 'normal' career patterns.

All these four changes have impacted on the way children have been defined at the state of the C21st. The education system is perceived to be in crisis and children are being blamed.

The Rights of the Child in Japan

Discussion of the rights of the child has involved two main groups; lawyers and teachers.

Lawyers have played a key role in most of the HR NGOs in Japan since the 1950s and the children's rights movement is no exception. The Tokyo Bar association and other bar associations around the country became interested in children's' rights in 1975 when the government proposed revision of the Juvenile Crime Law – their opposition seems to have prevented more radical reforms. Since 1980 there has been a CR committee both within the national federation and in many of the larger local associations. The 1985 conference was focused on Children's Rights, especially corporal punishment in schools, strict school rules and confidential report cards. There has been a bi-monthly newsletter produced since 1994.

Since the late 1980s there have been campaigns against the practice of insisting on boys having their hair cropped on entry to junior high school that used to be common in rural areas. This was first challenged in a local court in 1985, unsuccessfully. But in 1991 the Tokyo court gave an opinion that to decide ones own hair style was guaranteed by the constitution and the campaign was revived.

In the 1990s lawyers have campaigned on demanding that all juveniles arrested or accused of a crime should be accompanied by an 'attendant' usually a lawyer - something which at the start of the campaign hardly ever happened – only in 1% of cases.

Teachers often at the local level have resisted the demands of lawyers that they see as undermining their authority within schools but at the national level their union, the JTU, was engaged in a struggle from the 1950s onwards against the attempts of the MoE to assert its control over the education process. In 1985 it supported the creation of the *Kodomo no Jinkenren* (Federation for the Protection of Children's Rights) with the support of a number of progressive groups and unions. At first its main mission was to encourage the government to support and then ratify the CRC. When this had been done it has monitored its implementation and demanded that it be made more effective. It has also played a key role in the drafting of alternative reports in 1997 and 2003, of which more in a moment. Its offices are within the JTU HQ in Tokyo and the JTU remains its main source of support.

In addition there are a large number of groups large and small which maintain an interest in children's rights issues most of which are members of the Children's Rights Network. The CRN holds an annual conference and an annual event on child rights topics.

CRC ratification and implementation

The Japanese government signed the CRC in September 1991 but it was another 3 years before ratification – mainly due to political confusion following the Gulf war and disruptions within domestic politics. Finally in May 1994 ratification took place.

Not everyone welcomed the convention. Some saw it as another western imposition that would weaken the family system and threaten the school system. Many perceived it to be coming from America, ironic in view of the fact that the USA has refused to ratify it. It was thought to be another step towards an American-style litigation society. Conservatives claimed that it might have some relevance in countries like the US or Europe where the traditional family had collapsed or in less developed countries where welfare systems were weak but they thought it could have no positive advantages for Japan.

Although superficially positive this was the view of the Japanese government too. Some specialists were appointed to positions of 'Children's Ombudsmen' at the local government level but they have few powers and are under the control of the local MoJ office. The only positive impact has been where there have been active NGOs that have joined with the local ombudspersons to create an active network.

The Reports to the United Nations *the initial report*

The CRC stipulates that countries which ratify the CRC shall submit to the Committee on the Rights of the Child, 'reports on the measures they have adopted which give effect to the rights recognised herein and on the progress on the enjoyment of those rights: a) within two years of the entry into force of those Convention...b) thereafter every five years.' The Japanese government submitted its initial report in May 1997 and the committee considered it in May 1998 and produced its final considerations on 5 June 1998.

The production of the government report provided the occasion for child rights advocacy groups to produce and submit an alternative report for the Committee's consideration. In the Japanese case there were no less than three lengthy reports produced; one by the JFBA, one (mainly) by the *Jinkenren* and one by a coalition of groups with an interest in children's rights (*Kodomo no Kenri Joyaku: Shimin/NGO Hokokusho o Tsukurukai*).

The basic approach of the government to the CRC is expressed most clearly in Par. 12 where it states:

> Ratification of the Convention ...did not require any amendments to Japanese legislation nor any new enactments of law since most of these matters have

> been stipulated by the ICESRC and ICCPR...and are guaranteed under the existing legal framework of Japan, including the Constitution.
> (Initial Report 1996: 5)

The report follows each reference to articles of the CRC with an indication of how this point is dealt with in Japan either in the constitution or in law. Compared, for example, to the UK Initial report (1994), it is a very formal document, more concerned to show the existence of legal provision than to explain any, 'factors and difficulties ...affecting the degree of fulfilment of the obligations... ' (CRC, Par.44.2)

The JFBA's counter-report, 'A Report on the Implementation in Japan of the Convention on the Rights of the Child' was released in June and published in Japanese as a book in August 1997. It is very critical of the government's report:

> ...the report is no more than a specification of the appropriate laws and regulations, lacking an approach of concrete examination on whether the rights of children are sufficiently guaranteed.
>
> ...the government has not made any specific efforts to consolidate policies in a comprehensive manner.
>
> ...the CRC aims to realise children's participation and expression of views...Nevertheless the child as the subject of these efforts is completely left out and ignored in the government's report.
>
> ..no consideration is made at all to the point that since children are not experienced nor informed about exercising their rights, it is necessary to establish an appropriate environment in order for them to actually enjoy and exercise these freedoms and rights.
>
> The Government Report does not reflect correctly the present situation, difficulties and tasks of Japan.
> (JFBA 1997: 1-2)

As one might expect the JFBA report focuses on legal issues while the other two focus more on educational issues. They too are scathing in their criticism arguing that the government interprets the CRC in terms of 'one way protection and control of the child by adults and society without considering the independent desires of the child.' (Tsukurukai 1997: 7) All three of these reports point out that the key concept, ‘the best interests of the child’ is not explicitly stated anywhere in Japanese law

the second report

In response to the government’s 2003 report the NGO criticisms were very similar. They comment that still the ‘best interest’ principle ‘has not been incorporated into any pieces of legislation’ in spite of the recommendation of the CRC in the previous round of reporting. Indeed some laws they argue have actually gone contrary to the best interests of the Child, for example the reduction of the age of criminal responsibility from 16 to 14. There remains no comprehensive policy on children and government has taken hardly any of the recommendations of the committee issued in 1998 seriously.

I will return to the CRC in a moment but I want to briefly mention one further area, child abduction cases. As there are more international marriages so there is an increasing number of children caught in disputes over custody after divorce. Problems can become particularly acute when one parent forcibly takes the child with him to another country. An international treaty on this exists, the Hague Convention on the Civil Aspects of International Child Abduction. It seeks to return the child who has been ‘wrongfully removed or retained’ to his or her habitual residence. Once returned, the access dispute between the two parents should be resolved in the country of ‘habitual residence’. Japan has not ratified the convention. The reason is said to be that the domestic legal system is weak in this area. ‘Parental kidnapping’ is not against the law and the Japanese legal system either cannot or will not enforce the custody decisions of foreign courts. Critics suggest that Japan refuses to ratify because would be forced to return more children than it would gain and secondly because it would contravene Japanese notions of sovereignty to be forced to give up a citizen to another country. Japan does not recognise dual nationality. International pressure on Japan to abide by the treaty is being applied by the USA and Canada but I doubt if we will see much change in policy in the near future.

However it is noticeable that although most European countries and many in America, north and south, have ratified this Hague convention, hardly any Asian country has. Why is not clear but it is not an issue confined to Japan. Is this an area here the Asian values argument would tell us something?

Concluding Words

What I have been able to indicate today is that, firstly, there have been evolving definitions of childhood in Japan over the last few centuries which are quite well documented, secondly, that although by no means widespread even before 1945 there was discussion in Japan of ideas of children's rights such that these ideas were not completely new to Japan in the post-war period or before the ratification of the CRC, and thirdly, that there were and are at least two groups, teachers and lawyers, who have taken a serious interest in children's rights since the 1980s and who continue to champion these ideas in the Japanese cultural context often in the face of government indifference.

Children's Rights 3 South Korea and Taiwan

In what I have said so far I have described the way in which in the second half of the C20th there was a change in how children and childhood were defined and that this process intersected with the emergence of a rights discourse. This resulted in a change from regarding children as being objects of protection – defining rules regulations and procedures simply in terms of how adults can care for them – to regarding them as a particular class of human being with the potential for autonomy whose liberties and immunities require protection but who also can be empowered and whose claims can and should be strengthened. Indeed only by taking the rights perspective as opposed to the interests view can children's dignity be genuinely protected and promoted. However this was not just a change in intellectual fashion. This change in view had consequences for the international HR regime and influenced the drafting of the CRC which was adopted by the UNGA in 1989 and was rapidly ratified by practically all the countries of the world apart from Somalia the USA and Taiwan.

What I want to talk about today is the development of the child rights discourse in South Korea and Taiwan and the impact that the CRC has had on these two states. To do so I will start with some comments on the democratisation process in the RoK and the evolution of the HR movement. Then I will look in a little more detail at the 2 reports to the CRC made by the Korean government and the alternative, supplementary reports made by the civil society groups.

Then with a little more trepidation I will briefly discuss my view of the background to the development of child rights ideas in Taiwan.

Finally I will make some comparative remarks and address the questions of whether the CRC makes any difference and if so what.

South Korea

The context – the first suggestion that the authoritarian regime in south Korea may be more fragile than it appeared was in 1979 when President Park Chun-he was assassinated – however this proved to be a false dawn as his place was taken by Chun

Doo Hwan, another army general. He acted ruthlessly against his critics and the supporters of democratic reform but installed a regime that proved to be in many ways more liberal that its predecessor. The events that proved to be the leverage point for change turned out to be the Olympic games and the election for the post of President that was scheduled for 1988.

As early as 1985 a joint council of religious and political groups had been created to protest about the routine use of torture by the police on political prisoners. This led to the creation of a number of other coalitions to coordinate the activity of social movement organisations that were opposed to authoritarian rule. The outcome of this was the formation in early 1987 of the National Coalition for a Democratic Constitution and for this group the key issue was the method used to elect the president. Should the existing system be used – which was indirect, operated though an electoral college and permitted the manipulation of the result by the army/incumbent OR should it be a simple direct election?

During the Spring of 1987 the NCDC though its 22 branches organised a campaign across the country demanding consitutional reform. On 13 April president Chun announced that all public and formal discussion of constitutional reform would be forbidden until after the Olympic games and the mass media would be subject to strict control. It was thought that Chun might stand again or support a close army associate to continue military rule and that manipulation of the system would ensure that result.

However the demands for constitutional reform did not cease – the demonstrations continued and indeed won more support when the police admitted having killed a student demonstrator in the course of torture. Massive demonstrations took place on 10 June in 22 cities and towns. The government had to choose between military intervention and making concessions. On 29 June PM Roh Tae-woo, by then designated the army's presidential candidate, announced his acceptance of the direct election of the President, the restoration of human rights, the freedom of the press and local autonomy. Elections were held on 16 Dec 1987 which elected Roh as president and his term proved to be a transition from military rule to democracy. The 2 candidates who stood against him, Kim Young Sam and Kim Dae Jung, succeeded him to the post of president. Thus a process of political succession had been created that allowed democratic political and social life to develop out of the shadows of military authoritarianism.

So by the 1990s we have a S Korean government that is interested in taking part in the various international regimes, is starting to become genuinely interested in HR promotion. In 1990 it ratified both the major international covenants on civil and political rights and economic, social and cultural rights. Meanwhile we have a social movement that, having achieved its primary target of structural democratisation, is facing the need to re-invent itself. This is the context for both the development of the government's child rights policies and those of the various parts of the social movement.

Background ideas about children and childhood

To my knowledge nothing has been written in English or Korean (?) that traces the status and role played by children in Korea history – although several exist about the situation in Japan. It is therefore very difficult to sketch out the pre-modern, 'traditional' attitudes to children. One suspects that they differed greatly according to class especially between peasants and the *yangban* rulers with the latter no doubt strongly influenced by neo-Confucian notions of hierarchy.

According to the neo-Confucian orthodoxy children were regarded as basically good but nevertheless needed to be educated so that they might mature and better serve the hierarchical order. Adulthood was defined as age 20 for men and 15 for women. Childhood was regarded as a period of preparation for becoming human so it was not possible to speak of treating children in any way as equals.

However in the C19th this orthodoxy was challenged. The Tonghak (Eastern Learning) movement emerged in the 1850s (rather similar to the Taiping). Their ideas based on a mixture of Christian and eastern religious ideas that inspired anti-government and anti-foreigner activity. It was the inspiration for a peasant rebellion in the 1890s that gave the Japanese an excuse to intervene in Korean domestic affairs. The Tonghak movement later developed into the Ch'ondogyo religious movement. What is of interest to us is their views about children which challenged the neo-Confucian orthodoxy. Rather close to the Appollonian view they argued that children, particularly babies, carried within them both the spirit of reason and nature of heaven and therefore not only should children be treated as equal but they have qualities from which adults can learn. Education is important and essential but it should treat children with respect. Teachers should not shout still less physically punish children. Whereas neo-Confucians regarded children simply as future adults, Tonghak/Chondogyo regarded them as worthy of respect in themselves- possibly a view that came out of the peasant roots of Korea rather than that of the ruling class. (?) The important point is that there is evidence of a plurality of thinking about children prior to the arrival of Christianity, liberalism, socialism and the Japanese.

Colonial Period

The modern Korean social movement traces its roots to the March 1 movement 1919 which saw demands for independence from Japan spread rapidly across the country, many youth groups were involved in this movement and suffered police repression.

Those writing about the development of that movement in the 1920s tend to be divided between those who emphasise the nationalist groups and those who stress the socialist movement.

For the nationalists the key date is 1923 when groups of all kinds were created including youth groups – one of which designated 1 May as Children's Day and on 1 May 1923 proclaimed the rights of Korean children:

- That children be regarded as human beings with full dignity and free from traditional repression
- That children under 14 should not have to work
- Facilities for play should be provided by society.

The influence of the Ch'ondogyo movement is clear in this account.

The socialist historians emphasise instead the meeting of the Socialist Youth League in 1926 which adopted motions that:

- Opposed the trade in young people (presumably girls and young women)

- Opposed marriage under 20
- Opposed the employment of children in dangerous jobs.

The colonial regime became less tolerant of dissent in the 1930s and most movements were closed down but I think it is interesting and significant that at a time when the League of Nations and activist in Japan were turning their attention to child rights issues there were also echoes of this in Korea.

After Liberation

However until the 1990s the image of children's rights was faint. In the late 1950s a group of writers persuaded the welfare ministry to adopt a Charter for Children which was adopted in 1957. Very similar to that adopted in Japan earlier in 1951 and by the UN in 1959, its basic approach is suggested in article 1: children should be born under healthy circumstances and nurtured in a warm and loving home'. They should 'receive an education in good facilities' (Article 3); ' value their great national cultural tradition' (Article 4); be protected from all harmful social conditions and dangers (Article 8). It does not use the language of rights but along with the UN declaration it may have guided the development of child welfare laws. In 1975, May 5 was designed as 'Children's Day', a national holiday.

During this period the main advocate of children's issues including rights in Korea was UNICEF the channel through which foreign aid flowed into Korea for the support of children related projects. This was particularly important in the 1950s and 60s. However by the late 1980s it was changing from the role of being a channel for aid coming into Korea to raising awareness about child poverty in the rest of the world.

UNICEF was an early advocate of the CRC in Korea. In 1990 it organised a group of 40 lawyers to review Korean law in the light of CRC standards. The following year RoK did ratify the CRC although probably less out of any interest in children rights themselves than concern for its international image. Ratification did not lead to any new initiatives and for a while it did not attract much interest in these issues either from activists or academics. This was after all the period immediately after the democratic transition process and there was uncertainly whether the changes would be permanent and the social movements had not yet re-oriented themselves. More attention has been paid to the issue recently as the issue has become embedded in the democratic agenda.

Next let us turn to discuss the Reports made by Korea under its obligations following ratification of the CRC.

Convention on the Rights of the Child *Initial report*

This was due in 1993; it was not submitted until November 1994 and finally considered by the CRC in 1996

The report seems to have been the creation of one academic which was submitted pretty much unchanged by the MoFA. It is a fairly dry document which provides some statistics about the demographic situation and gives a basic description of the provision of child welfare and child protection policies. However towards the end even this document comments, 'The RoK did not take concrete steps to publicise the provisions and principles of the Convention,' and, 'it is hard to say that children's rights presented in the Convention are fully exercised in the RoK'.

Twenty one NGOs with an interest in aspects of children's rights – teachers, lawyers, human rights groups and those representing the disabled - formed a 'Korean NGOs Coalition for the Rights of the Child' in February 1995 in order to produce an 'alternative' report for the UN committee. Various parts of the report were allocated to experts from the different groups and the final 17-page document was put together in July ready for submission. The report makes four general criticisms of government policy:

- that it has not made sufficient effort to disseminate the CRC,

- that it has no intention to re-examine the patriarchal ideology that defines a child as the property of his/her parents, which seriously hinders Korean society from implementing the CRC,

- that it does not recognise that a central body is necessary to co-ordinate the various government agencies working for the implementation of the CRC,

- that it does not acknowledge the NGO's independent role in implementing the CRC nor create channels to collaborate with the NGOs.

This was followed by detailed comments on the lack of respect paid to children's opinions in courts and schools, excessive control of children by school rules, inadequate spending on child welfare and education and poor protection for children within the juvenile justice system.

In its response the committee recommend that Korea reform the legal system's treatment of children in line with the Beijing rules and Riyadh Guidelines. It suggests more measure be introduced to prevent child abuse, changes to the adoption law and the abolition of corporal punishment in schools.

The second report was due on 1998 but not submitted until May 2000. This time it was accompanied by a 'Supplementary Report' compiled by 12 NGOs dated June 2002. The Committee produced its concluding comments in March 2003.

The main features of the government report are that it is longer – 58 pages – again it lists some basic statistics, discusses the meagre efforts made to publicist the CRC and the rather small changes made in the legal and administrative system to take on board child rights ideas. It argues that the 'best interests' principle has been adopted by the government in the child welfare legislation and that there is respect paid to the opinions of children in court proceedings. It notes the amendment of the nationality law to allow for acquisition of Korean nationality through both mother and father. It then reviews adoption procedures, health and safety issues, the treatment of children with disabilities, the education system and the treatment of children within the criminal justice system.

The Supplementary report argues mainly that there simply is not enough information given in the government report and in particular that there is insufficient publicity given both to children's rights and the CRC. It makes the general criticism that international HR standards set out in the CRC are not easily or routinely included into Korean judicial practices and that there is no body that can coordinate child policies.

The 'best interest' principle is poorly known and most administrative practices especially in schools pay it no attention being based instead on notion of 'children are subject to adults'. Children are not permitted to influence decisions in schools. School regulations see children as objects of control' in a way similar to the National Security Law. School rule are described as being too severe and excessively detailed. `They need to be amended taking into account considerations of 'children's human dignity'.

Corporal punishment is a serious issue as it continues as a result of government policy despite the recommendation of the committee in the previous round of reporting. The amount spent on child welfare and the school system is criticised as too low while the amount of time children spend at school is described as excessive – at 1254 hours per year it is the longest in the OECD, compared to the OECD average of 935.

The committee regretted that its recommendations of 1996 were 'insufficiently addressed' and it is concerned about the lack of monitoring of child rights issues. . It repeats it concern about the lack of publicity given to the CRC and the lack of consistent attention to the fundamental principles of the CRC in the development and implementation of laws and regulations concerning children. It asks for guarantees for greater freedom of expression and participation in decision making processes that affect the. Altogether it is much more detailed set of comments than in the previous round.

Finally it suggests that the 3rd and 4th reports be submitted together at the end of 2008. Over the next 12 months then we may expect to see activity in Korea and a new set of reports available in March 2009.

NHRC and NAP

In 2001 a National Human Rights Committee was set up in Seoul and although it has not been without problems it has developed a robust reputation. In 2006 it adopted a

National Action Plan for the Promotion and Protection of HR. It aims to create a national framework for the protection and promotion of HR and set up a system that will enable redress for those who suffer HR violations. The plan addresses the areas of: the disabled, irregular workers, migrant workers/refugees, women, aged persons, disease sufferers, soldiers, those living welfare facilities, sexual minorities, refugees from N Korea, and children. Pages 57-64 of the NAP go into some detail about the precise areas of child related policies that will be monitored: children in care, the rights to health and social welfare, the right to education and the right to participation.

This may provide the coordination/promotion of polices that the NGO sector and the CR Committee has complained is lacking. It will be interesting to see how the government reports about it and what the NGO sector and committee have to say about it in the next round of reporting.

Children's Rights in Taiwan

Writing in 2000 I concluded that 'Children's rights until the late 1990s had so low a profile in Taiwan as to be scarcely visible at all.' At the time it was even hard to get hold of a copy of a translation of the CRC in Chinese. If I say relatively little about Taiwan compared to what I have said about Korea and Japan it is not out of any lack of interest – on the contrary I hope to use at least part of my time here finding out more about the developments in the area of child rights and the history of children in Taiwan. Beginning perhaps with questions and discussions later today. I am also reluctant to say too much about this topic as at least some of you know more about it than I do.

I shall proceed based on the understanding that I do not need to say anything about the democratisation process in Taiwan that provided the background to my comments for the development of rights ideas in Korea. I would then like simply to summarise my overall picture of child rights in Taiwan which I is based on the situation as I saw it in 2000. Many of my comments will conclude with questions to which I hope to find answers while I am here and I would appreciate your comments.

- children generally do not figure in the histories of China. There is nothing like the studies that exist in Japanese about the development of ideas of childhood and in particular there is nothing about the history of children in Taiwan. Is there any evidence that work on women's history is generating perspectives on children?
- Of the three countries under discussion the rights discourse was last to emerge in Taiwan and it is therefore not surprising that the child rights sub-set of ideas has not developed yet, or had not by 2000.
- Not being a member of the UN, the RoC on Taiwan has not been forced to address the issue of how to report on child rights. There has been no need for government ministries to coordinate reports of policies. At the same time there has been no incentive for child rights groups and or HR groups to cooperate to respond to a government report or to provide their own perspective on these issues.
- At least up to 2000 I could find no evidence that the concept of 'childhood' was regarded as problematic in Taiwan. Formal definitions of the child have followed the pattern set in Korea and Japan: law treats people as adults from age 20, there are different ages to marry (16 girls, 18 boys). The school systems are similarly structured 6:6:3. A similar high priority is given to education but equally schools tend to be more focused on training than education more broadly defined, and the structures and regulations have been more about asserting control that encouraging participation.

The RoC was a signatory to the 1959 Dec of the Rights of the Child but this did not seem to have any impact on domestic policy. Some suggest that it might have influenced the first draft of the Child Welfare Law in 1960 but one cannot be sure.
When, 30 years later, the 1993 Child Welfare Law was reformed it contained in article 4 'when child related mattes are dealt with by government at all levels in governmental as well as non-governmental institutions or organisations the first consideration should be the best interests of the child.' So although Taiwan has been excluded from the international HR system it does seem to have been a desire to incorporate this key principle into some aspects of domestic policy practice.

And around this time, more or less simultaneous with Japan and Korea – Taiwan 'discovered" child abuse – an occasion when agents of the state may need to intervene into a family situation in support of the best interests of the child.

I know that the TAHR in 1998 began to lobby the government to have it take the CRC seriously, and in 1999 a Children's Bureau was set up in the Ministry of the Interior, not only to consider issues of child welfare but also to advocate and coordinate children's rights. Almost ten years later it would be interesting to know how far that agenda has been developed. Have there been any reports written in either Chinese or English that are in any way equivalent to the reports produced by other states for the CRC?

An NGO alliance was discussing in 2000 the possibility of having the government recognise the CRC and incorporate children's rights practices into schools. Has any of this happened?

Some tentative concluding comments

- *on a new and changing notion of childhood.*

The notion of original sin is almost absent from East Asian tradition and most ideas about childhood tend to be closer to the Appollonian model. This does not mean there is no room for physical punishment – indeed there is evidence of it continuing in all three states – but rather it is justified in a rather different way based on ideas of poorly developed reason. While it is hard to clarify pre-modern ideas of childhood in Korea and Taiwan it is clear that the experience of childhood in those rural agrarian societies was very different from life in a nuclear family living in a high-rise block in a crowded urban development. I characterised the contemporary Japanese child as the 'child of the company' but if we think about housing, children in all three states are 'children of the apartment block'.

Despite this, one is surprised at the invisibility of children within the major cities. Planning rarely has taken account of children's needs. There are few parks, playgrounds or open spaces where children can play relatively unsupervised, very little provision of free or cheap leisure facilities where children can go without their parents. This may be due to a lack of demand as children are often too busy with school or *juku* to have time to play. More likely it reflects a lack of attention to children's needs during the period of industrialisation and urbanisation when growth was the over-riding priority.

Growing affluence and smaller family size have meant that children are perceived both as consumers of commodities and almost as commodities themselves. A commodity culture for kids has developed over the last 20-30 years that goes a long way beyond the simple manufacture of toys – first publications for children, then popular culture that includes dedicated TV channels and more recently video games. This I suggest results in children being treated differently to even 30 let alone 100 years ago. Meanwhile children themselves are treated at some level as a commodity – an item to be acquired at a certain point in life once others have been secured – apartment, automobile, then child? I am unsure what impact this has on the advancement of rights ideas. Now most children are 'wanted' it may be that there is less need for the protection of their interests and some aspects of child welfare –such as the need for nutrition - are not systematic problems. On the other hand the process also places children in relatively isolated nuclear families with fewer possibilities for friends and family to intervene so that it may be more important to have structures that can take a child's side against the parents, as has to happen in some cases of child abuse.

- *the relationship with the state*

Each of our three states has made education policy central to both the training of an effective workforce and the discipline of the nation. Europeans often comment on the military like discipline of Japanese schools and something similar can be observed in Korea and Taiwan. It was a topic for comment in the S Korean NGO Supplementary Report of 2003. Teachers were and often still are regarded as servants of the state (not the parents) although in Japan in the 1950s and in Korean and Taiwan since the 1980s there have been some in the teaching profession who have supported progressive causes and urged the promotion of children's rights. Still this provides the background to the discipline structure of schools and explains why it has been hard to get recognition for children participating in decision-making. Democratisation has taken place within the society wide political structures and it is only rather later and more slowly that 'democratic deepening' has begun in schools and similar child related organisations.

- *on the impact of the CRC*

One obvious criticism of the CRC and the related bureaucracy is that when we look at the conclusions of the committee following the submission of the second reports by both Japan and Korea, the committee notes that its previous recommendation have been largely ignored. Both the UN committee and local NGOs comment that there has been very little publicity given to the conventions or the reports. Few people know about the Convention and governments evade its suggestions and ignore the reports the system produces. . A useless system then?

No one doubts that the system might be made more effective but the UN committee exists at a critical point given the impossibility of the UN to actually intervene in any way that might be perceived at violating sovereignty. But perhaps the contrast between the RoK and RoC is instructive. If, under different circumstances, the RoC had ratified the CRC in the early 1990s and had been obliged to submit reports, would the situation of children in Taiwan be different today? I think the answer must be, Yes. How much different is hard to say but at the very least we would know more about the situation of children in Taiwan today, and the possibility for them to exercise rights. It is likely that the various children's organizations would be better coordinated having had to produce supplementary reports. And they may have been able to lobby government more effectively thanks to the existence of an external standard to which the state had pledged itself. Both education and social welfare policy would have developed differently in small but significant ways. I may be wrong and I would be interested to hear if you think I am.

To summarise: at the start of the C21st childhood has changed and is changing. We cannot rely on accepted traditional views of children, even when we think we know what they were (and often we do not).

The relationship between the child and the state is changing as governments democratise which suggests that the child's role within its organisation structures – schools, welfare organisations etc. will change/could change too.

The CRC in particular and children's rights in general can guide our thinking in how these changes could and should work out.

[and when I make these final remarks I am thinking not only of E Asia but also of advanced industrial democracies in general]