Reliance Principle in Japanese Medical Criminal Law

Lou Jie

Ⅰ. INTRODUCTION

This article states the prerequisites of the reliance principle in medical cases and the position of the reliance principle in the theoretical system of crime. Teamwork has become common in the health care system. Cooperation has promoted working efficiency, assuring patients of more precise and timely aid. On the other side, therapeutic activity is regarded as risky to conduct, which more or less contains negative possibilities. When a medical accident occurs during teamwork, how to determine legal liability becomes a controversial problem. For the best interests of patients, should medical team members share identical legal risks for the result of joint conduct? Or some of the team members can invoke the theory —— the reliance principle to exempt themselves from criminal liability? For example, a surgical nurse incorrectly connected the surgical equipment, causing a patient's serious injury. Does the surgeon, as the team leader, have to supervise the nurse and to prevent the harmful result? If the surgeon fails to do so, should he/she take criminal liability? The reliance principle indicates that when the actor has adequate reliance on the victim or the third party to take appropriate actions, then the actor is not responsible for the harmful result caused by the victims or the third party's improper conduct. In that case, if the surgeon could prove his/her adequate reliance on the nurse to connect the equipment correctly, the surgeon can release supervisory duty. Otherwise otherwise, his/ her omission could constitute a crime of negligence (Penal Code of Japan, Article 211, Causing Death or Injury through Negligence in the Pursuit of Social Activities). Therefore, the principle of reliance is to negate the establishment of criminal

negligence. We can also see that the reliance principle relates to both the patient's interests and the medical practitioner's interests.

In Japan, three conditions as prerequisites of the reliance principle were widely accepted: (1) Division of labor among medical staff should be clear, and the medical equipment is qualified for specific treatment;[(1)] (2) Medical practitioners have received professional education and experienced;[(2)] (3) The reliance among medical team members is not just shown for formality but must be substantive.[(3)] Among these three prerequisites, a different attitude to the first one —— clear division of labor and the third one —— substantive trust could be assumed. Whether a medical team has reached a clear division of labor is decided by courts from case to case in Japan. Such approaches, however, fail to honor national medical guidelines, international guidelines, and unwritten conventions, since the requirements of division of labor have already been stipulated by those guidelines and conventions. What is more, courts discretion could expand the range of criminal negligence,

---

（1） Professor M. Oya and Y. Hagiwara elaborated on the three preconditions of the reliance principle in their studies, including (1) clear division of labor and qualified equipment, (2) competent medical staff, (3) substantive trust. At first, studies of the preconditions for the reliance principle were limited to traffic cases. Doctor W. Yokosawa switched the background to medical cases, studying the preconditions of the reliance principle in medical cases, and the conclusion is that the prerequisites of the reliance principle are identical in traffic cases and medical cases are identical. 大谷實「危険の分配と信頼の原則」藤木英雄編著『過失犯―新旧過失論争―』（学陽書房 , 1975）124 頁以下、萩原由美恵「チーム医療と信頼の原則 （２・完）」上智法学論集 49 巻２号（2005）66 頁以下、横沢亘「医療行為における信頼の原則の要件の検討」法学研究論集 42 巻（2015）59 頁以下。

（2） 大谷實・前掲注（1）124 頁以下、萩原由美恵・前掲注（1）66 頁以下、横沢亘・前掲注（1）59 頁以下。

（3） 大谷實・前掲注（1）124 頁以下、萩原由美恵・前掲注（1）66 頁以下、横沢亘・前掲注（1）59 頁以下、（日） 甲斐克則 :《责任原理与过失犯论》, 谢佳君译 , 中国政法大学出版社 2016 年版 , 第 95 页 .

increasing the probability of medical practitioners bearing criminal liability. Substantive trust requires medical team members to accumulate perception of reliance during daily collaboration. The problem is that the way medical staff cooperates has changed recently. Under the current medical system, it is barely possible for team members to accumulate reliance and achieve substantive trust in a reasonable time. Except for the above two points, no supervisory duty was introduced as another prerequisite. Whether the reliance principle is still available when the actor has supervisory duty has been debated in Japan. One theory states that supervisory duty objects to the reliance principle. The opposing party considers reliance arising from the daily collaboration between the supervisor and supervisee, and based on such reliance, the supervisee can engage a specific range of work individually and undertake legal liability independently. One major drawback of the latter opinion is that it frees superiors from obligation at the cost of increasing the risk patients have to bear. On the contrary, the supervisory duty should not be regarded as a precondition for reliance principle. Also, to defend both patient's interests and medical worker's interests, further restriction will be explored that under what circumstance superior medical staff must bear the duty of supervision. In the last section, to improve the theoretical system of crime, from the perspective of theories of anti-value conduct and anti-value consequences, theories on the position of the reliance principle were demonstrated. Overall, this study discusses the principle of reliance in Japan, seeking to clear theories about the reliance principle and promote the application of the reliance principle in judicial practice to limit the scope of criminal negligence.

Ⅱ. HISTORY OF THE RELIANCE PRINCIPLE

The reliance principle has improved the efficiency of social activities by dividing the risk and distributing it to respective participants. This principle derives from a precedent of a traffic case in Germany in 1938.[(4)] It indicates that an actor who is

carrying out certain activities could rely on other participants to obey the rules. If other participants break the rule and result in a negative result, the actor is not responsible. For example, at the intersection, Driver Y has the right of way (the right to drive across or into a road before another vehicle). Due to the reliance principle, Y could assume that other drivers will honor the rule. Even anyone knows that traffic activities, are risky —— at any uncertain moment, someone may violate traffic rules and cause traffic accidents. That is, if a car disobeys the rule, causing Y's car to smash into it, Y is not criminally liable.

In the first place, the reliance principle was adopted in traffic cases only in Germany. However, some researchers suggested that to limit the scope of criminal negligence; this principle ought to be available in other areas where a division of labor and cooperation is needed. The Supreme Federal Court of Germany affirmed this viewpoint in a medical case, where it stated: in principle, surgeons can rely on their coworkers.[(5)] Through this case, we still had no clue how far the reliance principle can expand to other areas of life, nevertheless, the validity of the reliance principle to medical cases had been confirmed. The reliance principle was introduced into Japan by Professor H. Nishihara in the 1960s. Following the German judicial opinion, prevaiting Japanese theory also upholds that the reliance principle can be adopted in medical cases. Misconnection of the electric knife (hereinafter referred to as *Hokkaido case*)（札幌高裁昭和 51 年 3 月 18 日高刑集 29 巻 1 号 78 頁）was the first case and so far, the only case where the reliance principle was approved by the

（4）（德）克劳斯·罗克辛 :《德国刑法学总论》, 王世洲译 , 法律出版社 2005 年版 , 第 74 页 ; 孙运梁 ,《刑法中信赖原则基本问题研究 —— 新过失论语境下过失犯的限缩》,《刑事法评论》2011 年 第 28 卷 , http://www.360doc.com/content/19/0321/11/50972023_823101648.shtml, 2019 年 5 月 15 日访问。

（5）（德）克劳斯·罗克辛 :《德国刑法学总论》, 王世洲译 , 法律出版社 2005 年版 , 第 74 页。

court.(6) This case indicated that doctors could trust nurses to perform a basic operation appropriately . If the nurse failed to do so and thus causing the patients' injury or death, the nurse took the liability of criminal negligence independently.

Ⅲ. CLEAR DIVISION OF LABOR AND SUBSTANTIVE TRUST

The reliance principle limits the scope of criminal negligence. This effect may raise another question that the reliance principle contradicts the legal interest of article 211, the Penal Code of Japan (people's lives and physical well-being). The possibility of abuse of the reliance principle cannot be ruled out.(7) Such risk still can be eliminated or at least decreased by setting proper standards for the reliance principle. In Japan, different opinions are addressed, while the following three are generally accepted: (1) Clear division of labor among medical staff and qualified medical equipment for specific treatment; (2) Professional and veteran medical practitioners; (3) Substantive trust among medical team members. As shown, three standards intended to protect patients' interests, however, the downside that needs to be pointed out is that clear division of labor and substantive trust do not keep abreast of the development of the medical system. With such standards, the possibility of medical practitioners constituting negligence crime is unconscionably increased.

A. Clear Division of Labor

（6） Hokkaido University Hospital performed heart surgery for a toddler in1974. Due to that surgical nurse Y connected the electric knife onto the incorrect electrode, the patient's right leg was burnt by high temperature and had to be amputated below the knee. In this case, the court affirmed nurse Y's criminal responsibility for negligence. On the other hand, the other accused — the surgeon was acquitted based on the principle of reliance. 井田良「チーム医療と信頼の原則 —— 北大電気メス事件」甲斐克則･手嶋豊編『医事法判例百選〔第 2 版〕』（有斐閣、2014）152 頁。

（7） 大谷實・前掲注 (1) 124 頁以下。

Clear division of labor requires professionals to perform expertise respectively during teamwork. To achieve it, hospitals need to build up an integrated and organizational system, in which each medical professional exactly knows their duties. The criteria for a clear division of labor are judged by courts (judiciary exercise discretion) in Japan. For instance, in the case of mixing up patients at City University Hospital (hereinafter referred to as *"Yokohama case"*)（最決平成 19 年 3 月 26 日刑集 61 巻 2 号 131 頁）,[8] the court found assignments in the team were not clear, and it became one of the reasons the reliance principle was denied.[9] The clear segment of tasks is indispensable to reduce the risk of surgery. However, the courts' discretion on the standards of the clear division of labor is questionable. It might have been more persuasive if courts would take into account medical guidelines and unwritten

（8） Two male patients received wrong surgeries at Yokohama City University Hospital in 1999. Doctors performed lung surgery on the heart patient X (74 years old) and heart surgery on the lung patient Y (84 years old). In this case, two nurses, two anesthetists, and two surgeons were convicted of the crime of Causing Death or Injury through Negligence in the Pursuit of Social Activities (the Penal Code, Article 211). Facts of the case: ward nurse A brought two patients from their wards to surgical nurse B. Neither nurse A nor B confirmed the names of the two patients, and then nurse B led two patients to the wrong surgery rooms. Despite two patients' differences in ages (10-year age gap), facial features and different physical status from the preoperative examination reports, the doctors failed to correctly identify them, and they operated on the wrong patients.

（9） The court remarked that in medical practice, confirming the identity of the targeted patient is a prerequisite to justify the medical intervention. To medical personnel, it is a rudimentary and fundamental care duty（注意義務）. The hospital can be desired establishing an organizational system — separate tasks were assigned to doctors and nurses, and the allocation of tasks was well known by all of the medical staff. The identity of the patient ought to be thoroughly confirmed. Based on the fact that this case did not meet the above conditions, doctors could not rely on their colleagues. Instead, each of them must confirm the patients' identity carefully by themselves. Analysis of this case can be found at 北川佳世子「横浜市大患者取り違え事件」甲斐克則・手嶋豊編『医事法判例百選〔第 2 版〕』（有斐閣、2014）156 頁以下。

conventions where duties of medical practitioners have been prescribed. For instance, Practice Guidelines for Surgical Medicine（*手術医療の実践ガイドライン*）presented that to prevent misidentification on patients, at least the anesthesia and nurse shall confirm the patient's name and the operative site before induction.[(10)] The surgeon who was responsible for the surgery should also check the patient's identity.[(11)] Besides national guidelines, considering that Japan is a member of the World Health Organization (WHO), regulations made by WHO also apply to Japan. These international regulations are consistent with the domestic ones, for example, WHO Guidelines for Safe Surgery also provided for measures to ensure the patient's identity before surgery —— before induction of anesthesia, the checklist coordinator verbally checks the patient's identity, the surgical procedure, and the surgical site.[(12)] Referring to these regulations, in the case like *Yokohama case,* the anesthesia, nurse, and surgeon were all imposed on the duty of confirming the patient's identity. Therefore the facts can show that division of labor was existing despite professionals' failure of thoroughly fulfilling it.

Except for the written regulations, many duties are unwritten conventions, especially those steps that are usually not critical to the treatment. For example, it is common knowledge for surgical staff to know that during surgery, one assistant surgeon or one surgeon must hold retractors. Such routine operations are fundamental knowledge and required to be mastered by each medical staff. Hence, like the Guidelines, a medical practitioner's violation does not deny the existence of rules. This result is inconsistent

---

（10）　菊地龍明・山田芳嗣「チーム医療の視点から見た業務の流れ」日本手術医学会誌 34 (suppl)（2013）51 頁。

（11）　菊地龍明・山田芳嗣・前掲注（10）51 頁。

（12）　World Health Organization, *WHO Guidelines for Safe Surgery — Safe Surgery Saves Lives* (WHO Press: Geneva, 2009) 101.

with the courts' practice that decides the standards of the clear division of labor by total discretion. This paper suggests judiciary respecting medical norms, including written and unwritten rules, using them as a reference to judge whether a particular medical worker has performed designated duties. Turning now to the exceptions. In exceptional circumstances, courts discretion on the standards of the clear division of labor is still needed. Sometimes the treatment can be especially complicated, requiring far more procedures than other similar operations or it involves a new method or advanced technology which has hardly been performed before. Rules are usually provided for comprehensive treatment to prevent common risks. As to the treatment with the high-risk and complex operation, the team leader is obliged to carefully assign duties to the team members in advance to control the risk down to a reasonable range. Otherwise, there will be no basis for reliance if they perform exceptional treatment without insufficient preparation.

B. Substantive Trust

Substantive trust is to share the contents of the adequacy of reliance（*信頼の相当性*）, requiring that valid reliance cannot be based only on formality, the medical team must accumulate mutual trust on a daily basis, in other words, substantive trust（*実質的信頼関係*）is necessary.[(13)] Otherwise, the reliance principle should be ruled out. The drawback of this opinion is that team members are usually not fixed in today's medical practice. The surgery team built for a specific surgery is made up of temporary members.[(14)] Therefore, the connotations of the substantive trust need to be replaced. The equivalent effects that substantive trust generates — preventing medical accidents resulted from the loose connection among team members can be

（13） 横沢亘・前掲注（1）65 頁、（日）甲斐克則 :《责任原理与过失犯论》, 谢佳君译 , 中国政法大学出版社 2016 年版 , 第 95 页。

（14） 菊地龍明・山田芳嗣・前掲注（10）49 頁。

completed by practical medical rules, for instance, the work undertaken by Professor Y. Yamada and Associate Professor T. Kikuchi presents: “one surgeon or surgical practice administrator serves as a coordinator and directs team member’s cooperation.” [(15)] Others like what is mentioned in the WHO Safe Surgery Checklist and WHO Guidelines for Safe Surgery —— during surgery, medical practitioners should run the checklist;[(16)] before the team implements the next operation procedure, the checklist coordinator ought to confirm that the previous process has been finished.[(17)] These findings suggest that substantive trust can be interpreted through the medical norms, to specify the adequacy of reliance（*信頼の相当性*）. Only when health care providers violate specific medical rules, can the judiciary deny the realization of substantive trust.

Ⅳ. DUTY OF SUPERVISION

Whether the duty of supervision negates the reliance principle is still controversial. Some researchers state that duty of supervision does not conflict with the reliance principle, namely the reliance principle is still adaptable when the actor is charged with supervisory duty.[(18)] They suggest that the perception of reliance is established during the cooperation of the supervisor and supervisee, and based on this reliance,

---

（15） 菊地龍明・山田芳嗣・前掲注（10）49 頁。

（16） Checklist here refers to the WHO Safe Surgery Checklist. It categorizes a surgery into 3 phases and provided a list of items that must be completed in each phase for the surgeon, anesthetist, and nurse.

（17） Furthermore, after the surgery team gets familiar with the checklist, team members can simplify the confirming procedure. See the World Health Organization (n 12).

（18） 米田泰邦「刑事過失の限定法理と可罰的監督義務違反（上）」判例タイムズ 346 号（1977）40 頁 ; 西原春夫「監督責任の限界設定と信頼の原則（上）」法曹時報 3 巻 2 号（1978）5 頁以下、（日）甲斐克则 :《责任原理与过失犯论》, 谢佳君译 , 中国政法大学出版社 2016 年版 , 第 95 页 .

the supervisor can allow the supervisee independently carried out certain work.[19] On the contrary, some researchers insist that supervisory duty objects to the reliance principle.[20] This paper supports the idea that the reliance principle and supervisory duty cannot coexist. Since using the reliance principle to disengage superiors from supervisory duty can dilute the actor's obligation. Supervisees such as medical students and interns are usually those who lack qualifications or clinical experience. If we allow the perception of reliance to free superiors from supervisory duty, the risk that superiors should bear will be unreasonably transferred to patients. For patients' interests, no supervisory duty would better be one prerequisite for the reliance principle.

A. Significances of Restricting the Duty of Supervision

The above section has focused on patients' interests; this section will discuss the exceptions for supervisory duty —— the scope of a duty of supervision. When people are deciding who the supervisor is, we usually refer to the positional titles, for example, senior doctors are considered superior to attending doctors, hence senior doctors are deemed as supervisors of attending doctors, or doctors are superior to nurses. Thus people generally think doctors are supervisors of nurses. However, under this criterion, three disadvantages show up. First, due to excessive supervisory duty, superior medical workers will face excessive accusations; secondly, patient's interests can also be impaired; thirdly, the efficiency of medical activities is likely to reduce. Take the case of a surgical team as an example, a surgeon is usually the leader of a surgical team. If we thereby define the surgeon as the supervisor in the sense of

---

（19） 西原春夫・前掲注（18）40 頁、米田泰邦・前掲注（18）5 頁以下、甲斐克則 , 同上注 , 95 页 .

（20） 土本武司『過失犯の研究』（成文堂、1986）138 頁以下、大塚裕史「監督過失における予見可能性論」早稲田大学大学院法研論集第 48 巻（1988）82 頁。

criminal law, the surgeon can be accused of any misconduct caused by team members. To avoid being accused, during the surgery, the surgeon has to continually pay attention to the work performed by the anesthesiologist, nurses, assistants and other participants, which makes the surgeon subject to continuous interference. Surgery is a difficult task requiring high concentration; distraction will most likely increase the risk of the surgery, infringing the patient's interests. Additionally, wide-ranged supervision duty will reduce the efficiency of medical work, turning the division of labor into futileness. For these reasons, we need to limit the scope of supervision obligation.

B. Modes of Medical Cooperation and the Duty of Supervision

Medical cooperation comprises two types: horizontal synergy and vertical synergy.[(21)] Horizontal synergy indicates no superior-subordinate relationship between staff, namely the two person's positions are at the same level, such as anesthetists and surgeons.[(22)] Based on the principle of self-responsibility（*自己答責性*）, medical specialists are responsible for the consequence of their own decisions and conducts. Generally, medical personnel do not have a supervisory duty in horizontal synergy and can access to the reliance principle. Vertical synergy mainly refers to the cooperation between doctors and other health care providers (such as nurses, surgical assistants, interns, and medical students). Doctor's working authority is more extensive than other health care providers,[(23)] but as certified specialists, other health care providers work independently of doctors, that is to say, other health care providers can individualistically practice within their scope of expertise. This

(21)　山中敬一「医療過誤と刑事組織過失（２・完)」關西大學法學論集第 62 卷（2013）1 -97 頁。

(22)　王皇玉 : "德國醫療刑法論述概說" , 载《月旦法學雜誌》2009 年第 170 期 , 141-144 页 .

(23)　山中敬一・前掲注（21）1 -97 頁。

standpoint was also implied in the judgment of the *Hokkaido case*, the court claimed that it was the nurse's exclusive responsibility to check whether the surgical instrument had been correctly connected since such a job was not a challenge for a qualified medical worker, especially a veteran like her.(24) However, another unresolved question is whether doctors have supervisory duty on interns and medical students. So far, there is no criminal case record in Japan. According to the judgment of *Intern Case* in Germany, the possibility of working independently for interns and medical students was confirmed. In 1961, the Federal Court of Justice of Germany tried a case, where two medical students worked as interns in a state hospital were accused of physical assault for independently treating patients.(25) The court commented that when it comes to simple medical practices, medical students can provide help as qualified as licensed staff and qualification becomes irrelevant.(26) According to the courts reasoning, not all practices require instructions from doctors, interns and medical students can be self-reliant in basic work like dealing with minor abrasions, bruises or bandages.(27) Nevertheless, the rationale is ambiguous, and whether the reliance principle is the justification of the intern's task autonomy is doubtful. This paper argues that it is not reliance principle but authorization（*授権*）as the theoretical basis behind the *Intern Case*. The scope of authorizable work is limited to low-risk work, and the distinguishment of high risk and low risk applies to objective assessment.(28) These two elements of authorization are consistent with the courts description of the work performed by the accused persons — any rational

（24） 井田良・前掲注（6）152 頁以下。

（25） 神山敏雄「西ドイツの医療過誤に関する刑事判例」中山研一・泉正夫編 ,『医療事故の刑事判例』（成文堂、1983）338-343 頁 ;（德）克劳斯 罗克辛 :《德国最高法院判例刑法总论》, 何庆仁、蔡桂生译 , 中国人民大学出版社 2012 版 , 第 74 页 .

（26） 神山敏雄・前掲注（25）338-343 頁、（德）克劳斯 罗克辛 , 同上注。

（27） （德）克劳斯 罗克辛 :《德国最高法院判例刑法总论》, 何庆仁、蔡桂生译 , 中国人民大学出版社 2012 版 , 第 74 页 .

patient knows and can estimate that the treatments which are safe, mild and routine …; the key is, in fact, the easiness (lightness) of the case …— which became one reason that interns, task autonomy was affirmed. Thus, this paper's views on the duty of supervision and reliance principle do not contradict the German precedent. It can be assumed that supervisor duty negates the reliance principle. Also, doctor's supervisory duty cannot be exempted. The reliance principle is maladapted between doctors and interns and medical students. Thus far, this section has demonstrated that horizontal synergy excludes supervisory duty. In the model of vertical synergy, doctors have no duty to supervise the auxiliary professors who have the working ability, while to interns and medical students, doctors must undertake the supervisory duty.

Ⅴ. EXCEPTIONS TO THE APPLICATION OF THE RELIANCE PRINCIPLE

As discussed above, it seems that the scope of supervisory duty is relatively narrow. This result may cause another concern that overly relaxing supervisory duty can impair patients interests. Then we will move on to discuss the exceptions for the application of the reliance principle to prevent it from being abused. When the coworkers' conduct obviously violates medical rules, the actor must correct it and is not allowed to use the reliance principle avoiding such duty. One point to be emphasized here is that the coworkers' violation should be obvious. Otherwise, the reliance principle tends to be easily repudiated by the refutation that coworkers' negligence is possibly being realized by the actor. Such refutation will immoderately expand medical worker's duty of care.

(28) Objective examination disregards the actor's characteristics and substitutes it with the appreciation of a reasonable person. In other words, the objective side examines what an ordinary prudent observer in the actor's position would have performed.

Besides, reliance is not a justification if the actor knows that the coworker lacks the experience to perform a treatment, in which circumstance other participants are liable to carry out core tasks together with the inexperienced colleague. *Saitama Case*（最決平成 17 年 11 月 15 日刑集 59 巻 9 号 1558 頁）(a patient died because doctors prescribed an excessive dose of the anticancer drug) is a typical case that embodied this viewpoint.[(29)] According to the Supreme Court of Japan, Y (instructor physician) and X (chief physician) could not leave Z (attending doctor) who is also the inferior doctor, designing the treatment plan alone. Y and X should have taken part in the treatment in the first place. To be specific, Y and X were obligated to investigate clinical cases, medical literature, and pharmaceutical descriptions to determine whether the treatment plan developed by Z is appropriate.[(30)] Studying the implementation of this treatment plan, possible side effects and the ways to eliminate or reduce the risks of this treatment were also duties of Y and X.[(31)] Besides, once the patient developed severe side effects, superior doctors (X and Y) had the duty of care to take prompt measures to prevent severe consequences (death or severe injury).[(32)] It

---

（29） A 16-year old patient suffered from rare cancer, and three doctors took charge of this case (no medical workers in their department had clinical experience with this disease). The attending doctor Z (Z is the inferior doctor among the three) undertook the task of designing the treatment plan for the patients. Finally, Z found a therapy for the patient's cancer in literature. However, Z misread the prescription (misread 2mg/week for 2 mg/day). Z submitted the treatment plan to his supervisor (instructor physician Y). Y proposed the wrong plan to his superior (chief physician X) without checking the attached documents which contained original literature. The chief physician X disobeyed the care duty, either. Z neither verified the dosage of the anticancer drug nor the side effect the drug could arouse, and he approved to Y and Z, permitting them performing the wrong treatment plan on the patient. Eventually, the patient died due to the overdose of anticancer drugs. 日山恵美「埼玉医大抗がん剤過剰投与事件」甲斐克則・手嶋豊編『医事法判例百選〔第２版〕』（有斐閣、2014）219 頁。

（30） 甲斐克則『*医療事故と刑法*』（成文堂 2016）210-212 頁。

（31） 甲斐克則・前掲注（30）210-212 頁。

is worth noting that the *Saitama Case* does not contradict the *Hokkaido case*. The nurse in the *Hokkaido case* was a veteran in her duty —— preparing equipment for surgeries. Thus the accused doctor had sufficient reason to trust her. Also, provided that the irregular tools or methods were used during treatment, the reliance principle cannot be allowed. Since illegitimacy creates additional risks, to prevent harmful consequences led by those risks, medical staff have to assume the responsibility of mutual supervision.

Ⅵ. THE POSITION OF THE RELIANCE PRINCIPLE

The present study raises three kinds of theories about the position of the reliance principle in the mechanism of crime（*犯罪論の体系*）：１) the reliance principle negates foreseeability (the harmful result must be reasonably foreseeable（*予見可能性*）；２) it negates the duty of foreseeability（*予見義務*）；３) it negates the duty of avoidance（*回避義務*）. Based on anti-value consequences（*結果無価値*）, the reliance principle is regarded as a principle of denying foreseeability,[(33)] while from anti-value conduct（*行為無価値*）, the reliance principle is located in the principle of disproving duty of care.[(34)] Also, Professor H. Nishihara considers the reliance principle is negating foreseeability from the theory of anti-value conduct.[(35)] In more detail, Professor H. Nishihara distinguishes foreseeability of criminal law from the foreseeability of facts and he claims that the reliance principle denies the foreseeability of criminal law.[(36)]

---

(32)　甲斐克則・前掲注 (30) 210-212 頁。

(33)　平野龍一『刑法総論Ⅰ』（有斐閣、1972）197-198 頁。

(34)　藤木英雄『過失犯の理論』（有信堂、1969）171 頁。

(35)　西原春夫『交通事故と信頼の原則』（成文堂、1969）20-205 頁。

(36)　西原春夫・前掲注 (35) 20-205 頁。

Before introducing theories of the position of the reliance principle, it is crucial to explain the status quo of anti-value conduct and anti-value consequences, since they are the principles of those theories. Japanese criminal jurisprudence has been influenced by German. Therefore the issue of substantive illegality（*違法性の実質*）is discussed around two theories —— anti-value consequences and anti-value conduct. In sum, anti-value consequences believe that the essence of illegality is that the legal interests protected by criminal law are infringed, that is, the consequences of the conduct. On the other hand, anti-value conduct identifies illegality as a negative evaluation of the act itself. So far both theories have their supporters, and scholars on both sides continue improving their theoretical system. The understanding of illegality in Japan is not immutable. From the late 1940s to the mid-1960s, anti-value conduct stayed predominant.[37] After the 1960s, a situation of confrontation occurred, and recently anti-value conduct is reviving.[38] Moreover, the opposition between these two theories is easing as well. Anti-value conduct advocated the exclusion of moralism, which is consistent with anti-value consequences.[39] In conclusion, Japanese anti-value conduct has the characteristics of eclecticism which attaches importance not only to acts but also results.[40] It adopts dualistic anti-value conduct decided by both anti-value consequences and anti-value conduct.[41]

A. From Anti-value Conduct

Anti-value conduct regards negligent behavior as a violation of an objective duty of

---

（37）（日）山口厚："日本刑法学中的行为无价值论与结果无价值论"，金光旭译，载《中外法学》2008 年第 4 期，第 590-595 页。

（38） 同上注。

（39） 同上注。

（40） 同上注。

（41） 同上注。

care（*客観的注意義務違反*）in the layer of constitutive elements（*構成要件*）and illegality（*違法性*）, and the reliance principle negates the violation of a duty of care.[42] On the premise of anti-value conduct, the actor's behavior conforms to the law, and the actor can believe that other parties will carry out lawful behavior, thus the actor's behavior has social adequacy (equivalence)（*社会的相当性*）. In Japan, however, the reliance principle may apply even if the actor violates traffic rules. Under anti-value conduct, regarding the position of the reliance principle in crime theory system, three theories were proposed: 1) The reliance principle negates the duty to avoid consequences;[43] 2) The reliance principle negates the duty to foresee consequences;[44] 3) The third one distinguishes the foreseeability required by the duty of care in criminal law from foreseeability of fact, and the reliance principle only negates the foreseeability in criminal law.[45] No matter from which point of view among these three, criminal negligence is negated at the stage of constitutive elements and illegality. Viewpoints are identical in legal effects, but function in the integration of theory.[46]

B. From Anti-Value Consequences

In the opinion of anti-value consequences, the reliance principle is regarded as the principle of disproving foreseeability.[47] Professor R. Hirano asserted that the

---

（42）　神山敏雄「過失」大塚仁・河上和雄・中山善房・古田佑紀編『大コンメンタール刑法（第三版）第 3 巻』（青林書院、2015）349 頁。

（43）　藤木英雄･前掲注（34）171 頁、高橋則夫『刑法総論（第 4 版）』（成文堂、2018）22 頁。

（44）　金沢文雄『刑法の判例』（有斐閣、1967）76 頁。

（45）　西原春夫・前掲注（35）20-205 頁

（46）　神山敏雄・前掲注（42）349 頁

（47）　平野龍一・前掲注（33）197-198 頁、Professor R. Hirano revised the old theory of negligence and regarded negligent behavior as substantially dangerous behavior against legal interests.

connotation of the reliance principle refers to the fact that the probability of the victim's improper behavior is quite low, hence it cannot be said that the actor's conduct is in substantial danger of infringing on legal interests, thus the criminal negligence is not established. In other words, the reliance principle applies to the situation where the actor's conduct is not substantially dangerous. Then how to define substantially dangerous behavior? This theory holds that it desponds on objective foreseeability（*客観的予見可能性*）. Other supporters of this theory include Professor M. Oya and Professor M. Mitsui.[48] Besides, from anti-value consequences, those who understand the reliance principle as foreseeability include Professor K. Naito, Professor K. Nakayama, Professor T. Matsumiya and Professor T. Kamiyama.[49] This paper argues that the principle of reliance negates foreseeability. Otherwise, if we assume the reliance principle denies the duty of care, it is difficult to explain the rationality of not performing the duty to foresee the result and avoid the result, since the harm is foreseeable and there is no justifiable cause for illegality（*違法性阻却事由*）. Therefore, it is more appropriate to locate the reliance principle in the position of foreseeability.

Ⅶ. CONCLUSION

This paper set out to discuss the application of the reliance principle and its position in the theoretical system of crime. The predominant opinion on preconditions of the reliance principle includes a clear division of labor and substantive trust, about which

（48） 大谷實・前掲注（1）119 頁、三井誠「予見可能性」藤木英雄編『過失犯――新旧過失論争』（学陽書房、1975）176-177 頁。

（49） 内藤謙『刑法講義総論（下 1 ）』（有斐閣、1991）1447 頁 ; 中山研一『概説刑法 1 』（成文堂、2000）169-170 頁、松宮孝明『刑事過失論の研究』（成文堂、2005）96 頁、神山敏雄「信頼の原則の限界に関する――考察」西原春夫先生古希祝賀論文集（第二巻）（成文堂、1998）45 頁。

we have reservations. The current medical norms are sufficient to estimate the completion of a clear division of labor and the substantive reliance. Medical guidelines and unwritten conventions have prescribed duties for medical positions, thus, the judicial practice might have been more convincing if the judiciary honor the current rules, admitting the existence of a clear division of labor. The requirement that accumulating mutual trust on a daily basis can be switched since medical team members assembled for a specific medical case is usually not fixed. Instead, the substantive trust can be translated into compliance with the medical norms. Only when health care providers disobey specific medical instructions, can the judiciary reject the achievement of substantive trust. Additionally, we discussed supervisory duty, suggesting that supervisory duty negates the reliance principle. Specifically, in vertical synergy, superiors have no duty to supervise auxiliary professors who have the working ability, while to interns and medical students, doctors must assume supervisory duty. Additionally, to prevent the abuse of the reliance principle, reliance is not a justification when the co-worker's violation is obvious, or the co-worker is inexperienced, or irregular tools or methods are used during treatment. The position of the reliance principle in the theoretical system of crime functions in the integration of theory. For the sake of the rationality of the duty of foreseeability and avoidance, this study locates the reliance principle at foreseeability. An issue that is not addressed in this paper is negligent complicity（過失共働 / 広義の過失競合）[(50)]. Reliance principle is formulated based on the theory of danger allowance（*許された危険*）and danger distribution（*危険分配*）to solve the apportionment of criminal liability. Thus, it should be interpreted in the context of negligent complicity, and considerably more work will be done to examine negligent complicity in the author's next article.

（50） Negligent complicity refers to the conduct of plural actors satisfying the constitutive elements of one crime. It also can be referred to the concurrent negligence in a broad sense, which includes the co-principle of criminal negligence. While in a narrow sense, the conduct of plural actors respectively satisfies the constitutive elements of a negligent crime. The translation of concurrent negligence and co-principle refer to 大塚裕史「過失犯の共同正犯の成立範囲――明石市 花火大会歩道橋副署長事件を契機として――」神戸法学雑誌 62 巻１・２ 号（2012）14 頁以下 ; the concept of concurrent negligence refers to 北川佳世子「複数人の過失処罰をめぐる問題点 ―― 横浜市大患者取り違え事件を素材に ――」高橋則夫ほか編『曽根威彦先生・田口守一先生古稀祝賀論文集 [上巻]』（成文堂 , 2014）621 頁。