I suppose I should introduce myself before I begin my reflection on my 13 years of teaching medicine in Japan.

I am a general internist with 45 years of experience in healthcare, beginning as a nursing assistant in a large psychiatric hospital and nursing homes in the 1960’s. I became very interested in hospitals and, after much work, managed to be accepted to and finish medical school and residency, and complete a masters in public health. Since then I have practiced family medicine, primary care internal medicine, addiction medicine, geriatrics, emergency medicine, preventive medicine and healthcare administration, and for most of my career, hospital medicine. I have also been a student and teacher of communication in healthcare.

I first went to Japan in 1962 with my family as a 13 year old, en route to the Philippines where I lived and went to high school. I fell in love with Japan as we travelled to Tokyo, Kyoto, Kamakura, Nikko, and Fuji-San. I returned in 1965 as a 1st year college student at International Christian University in Tokyo. Unfortunately I was not a very good student and did not learn Japanese well. I travelled in Japan later in the 1970’s especially in Kyushu.

In 2001, after 20 years in medical practice, I responded to a notice in an American medical journal looking for visiting faculty at Chubu Hospital in Okinawa. I visited and taught there in 1–2 week periods for several years. Through Drs. Yasuhiro Tokuda and Dr. Seishirou Miyagi, I established relationships with the staff at Fukuoka Miniren, and Dr. Tokuda’s network of colleagues in Mito, Ibaraki-Ken. I met Dr. Toshinori Ozeki from Aichi Miniren in Nagoya in 2006 and since then have been visiting a variety of hospitals in and around Nagoya. Altogether I have visited and taught in about 20 hospitals in Japan, and continue to do so.

My reflections are influenced by my long relationship with Japan, my own experiences in healthcare, and by the many wonderful healthcare professionals I have met and worked with in Japan. Of course, my observations reflect my own experiences in healthcare in the US, my travel elsewhere in the world (including medical teaching in South Korea, Singapore and Europe), my political, social and economic values, and my self as a person.

**Inter specialty collegiality and pay**

In the US over the past 40 years medical practice has become increasingly specialized. Young physicians tend to avoid specialties such as family medicine, general internal medicine, pediatrics, general surgery, and psychiatry in favor of more specialized and higher
paying specialties. My observation in Japan is that apparently there is less difference in pay between the specialties. It is also my impression that there is less competition and more cooperation among the specialties. Having said that, primary care, whether family medicine or general internal medicine has a very long way to go in Japan (and the US).

**Teamwork**
This is very hard for me to assess because of my poor Japanese comprehension. In the US there is a growing interest in and commitment to inter professional (interdisciplinary) communication and collaboration. Although I imagine the same opportunity for improvement exists in Japan as well, my experience is that people of different disciplines tend to work well as a team. I have participated in far more interdisciplinary conferences in Japan than in the US, in both rural and urban hospitals and nursing homes.

**Hard work**
All healthcare professionals work hard. Over the years in the US, however, formalized work limits for residents, and coverage agreements and vacation benefits for practicing physicians have developed. It is pretty obvious to me that, in general, Japanese physicians work longer days, see more patients (both in-patient and out-patient), and have fewer days off. Perhaps not surprisingly, staff members in a small town Kyushu hospital enjoy more family and recreational time than in urban Ibaraki prefecture or Kokura Kitakyushu.

**Healthcare access**
Without a doubt Japanese people have better access to medical, eye and dental care. Both US and Japan have a serious problem with access to mental health care and all care in rural and remote areas. The recent changes in US healthcare system will improve things for many people, but access in Japan is still much more available to all citizens. Difficulties continue in both Japan and the US for homeless people and many immigrants. I remember being told proudly by the staff of one hospital that “We are the only hospital that cares for Koreans.”

**Outcomes and life span**
For many years US healthcare has been advertised as excellent and utilizing very high technology. However, if one looks at international data on perinatal mortality, teen pregnancy, over-all lifespan, and deaths due to such preventable factors as obesity, diabetes, illegal drugs, and trauma (especially motor vehicle accidents and violent trauma), American healthcare lags far behind Japan and the rest of the “developed” world. Having said that, it appears that deaths from tobacco and obesity-related illnesses are increasing in Japan as they are almost everywhere in the world.

**Some differences**

**Medical education and assessment of competence:**
Of course the systems are different, with most US medical schools on a 4 year schedule after 4 years of university, and Japanese students entering a 6 year program after secondary school. The major differences I can see are much later introductions to clinical skills a training and direct patient care in Japan. Most US schools introduce students to the interview and physical examination in the first weeks (or days) of medical school. This has the advantage of building clinical skills very early. Third and fourth year students on many rotations actually write conduct and record complete histories and physical examinations, including detailed differential diagnosis, assessment and treatment plans, and, under supervision, actually write notes and orders in the medical record. By the time students begin post-graduate training they are very familiar with core clinical skills and the general work patterns of the hospital. In addition, it is my impression that differential diagnosis and clinical reasoning are most consistently emphasized at all levels of training in the US.

As far as assessment is concerned, although this seems to be changing in Japan, American medical education has far (!) more examinations at all levels, including post graduate and for practicing physicians. What the actual clinical impact on quality of care of these differences is I have no idea. The area of clinical outcomes and its relationship to medical curricula and assessment is complex and controversial.
Importance of the history and examination and healthcare communication in Japanese medicine

My impression is that there is less importance attached to the history and physical in Japanese medicine, at least in the resident training hospitals I have visited. When I trained over 30 years ago (and still in UK, Australia, New Zealand, and India), the history and especially physical examination received much more emphasis. I am afraid that the US is going backwards in this area, and I am unsure of the trend in Japan. The reasons for the change in the US are complex but appear to me to involve time pressure and the increasing role of diagnostic imaging along with America’s generally profit-oriented medical system. A corollary to this observation is that for many reasons, direct communication between clinicians, patients and families concerning the diagnosis, prognosis, and detailed treatment options, risks and benefits does not appear to be consistently taught or modeled well by faculty. Much of this I am reasonably sure has strong cultural origins. As in the US, many patients are hesitant to ask questions or express concerns and expect the physician to make the right decision for them. However, it seems clear to me, and to many physicians from diverse cultures, that patients and families do have important concerns and ideas which may influence their medical care and long term compliance. Medical education at both the UME and GME levels, and physicians in general everywhere would do well to actively include patients and family in honest dialogue about their illnesses and treatment on an ongoing basis. This is true for both Japan and the US.

Out-patient practice

One very clear difference in Japanese and US medicine is the difference in the number of patients seen daily in out-patient practice. Most US family medicine and general internal medicine physicians see no more than 30 patients in a day. This is far less, I understand, than in Japan. This is a very complex topic which involves differences in physician and clinic reimbursement, pharmacy regulations and prescribing customs. The custom of monthly visits for the sole purpose of refilling prescriptions for stable patients is neither medically necessary nor an efficient use of scarce time and personnel resources. It does represent a major opportunity for Japanese medical professionals to improve efficiency, clinical outcomes, and both staff and professional satisfaction.

Less violence, trauma, drugs

This is obvious. American medicine and public health is heavily influenced by violence of all kinds, guns, motor vehicle accidents, drug use and alcohol abuse. Amphetamine, on the other hand, and alcohol are problematic in Japan, as is domestic violence. Candid discussion on multiple social levels is necessary to deal with these devastating problems.

Less public wifi in hospitals

This is a minor, although interesting, difference. Most US hospitals have free public wi-fi internet for patients and families. This is very nice for entertainment of course. But many patients are also able to work while in the hospital and to research their health concerns.

Advanced nurse practitioners and physicians assistants

Both are far more prevalent in the US than in Japan. Although this change, which I have witnessed and participated in personally over more than 30 years, has been challenging and controversial, the benefits to society, patients and the healthcare system in the US have been great. Many of the problems of physician overwork and access to primary (family or general practice) care faced by Japan could be greatly improved in a short period of time by supporting advanced nurse practitioners and other professionals. Experimental NP training programs I have seen in Ibaraki prefecture but I am told physician concerns about “competition” (which we also heard in US) have unfortunately slowed progress.

Some similarities

Shortages of primary care and mental health:

I have already mentioned this, but it is so important for both countries. The lack of services and access has serious results for many people and for the societies in general. This problem cannot be overstated.
**Geriatric struggles:**
This is an international crisis. The population is aging rapidly. Medical practice and general healthcare services are different for aging people. There is little formal training and systems approach to the care of the aging person in most countries.

**Disconnect between hospitals, primary care and extended care facilities:**
Not surprisingly, physicians and nurses have great difficulty communicating with their colleagues in different settings: primary care, the hospital, specialty practices, and extended care facilities (nursing homes). This results in many avoidable errors, misunderstandings, unnecessary hospitalizations and medical procedures. Having worked in remote rural settings and tertiary care urban settings in the US, I am certain that this is a problem of major international scope.

**Rural urban discrepancies of access to and quality of care:**
Another international problem, services are far superior in cities than small towns and rural areas. This is not a criticism of the hardworking and dedicated healthcare professionals who serve rural people, but the result of complex limits imposed by budget and social-political priorities. There are no easy solutions.

**Time and skills for teaching:**
Another international phenomenon, most undergraduate and graduate teaching programs (and perhaps most education in general) provide insufficient support to the teachers, in terms of protected time, skills development, and usually inadequate compensation. Consequently, medical education at all levels suffers. Teachers should not be required to teach “on their own time”, to sacrifice patient care, their families and private lives, or their students. Time for teaching must be incorporated in institutional budgets. Skills development is also critical. Medical education does not include teaching skills. At the same time, we are expected to effectively teach students and residents. The old saying: “see one, do one, teach one” is inadequate. Furthermore, most residency programs I have seen, in both US and Japan, fail to have clearly curricula with specific learning objectives. This leaves both teachers and learners without a specific approach to what is a highly technical profession. You would never train an airline pilot this way.

**Practice variation:**
I have noticed a number of differences in various technical aspect of medical care. I have no idea what the variation is within Japan, but I do know that within the US there are large regional and hospital specific differences in such things as Caesarean section rates, immunization and mammography rates, length of hospital stay patterns, surgical vs medical management strategies, and the like.
Some differences I have observed between some of the hospitals I visited in Japan and similar practices in the US include differences in anti-coagulation targets for patients with atrial fibrillation (higher in US), prescribing patterns of benzodiazepines (high in US; seemingly higher in Japan) and opiates (lower use in Japan), and immunization utilization (more widely used in the US. I am certain that such variation is international and inevitable. I have also noticed the growth of clinical practice guidelines in Japan, a generally positive means of addressing the need for consistent, evidence-based practice.

**Primary care:**
In both countries primary care struggles. Both societies value medical specialties more highly and this is reflected in pay, respect, power, working conditions, and institutional support. Simply put, however, most specialists are not trained to provide primary care. This results in frequently superficial or incomplete care, fragmentation by excessive referrals to more specialists, and increased costs, often without any evidence of superior outcomes. As the many consulting specialists each prescribe their own medicines, usually without knowing what other medicines the patient is already taking, poly-pharmacy increases dramatically with all of the problems of adverse drug interactions and side effects, non-adherence, and uncontrolled costs. Government must support the development of primary care with improved teaching at the UME and GME levels, improved pay and working conditions, and providing
additional support through the training of and collaboration with advanced nurse and pharmacy practitioners.

Some very positive changes I have seen over time:

1. Fewer PEG tubes and prolonged ventilator use:
   In my 12 years in Japan I am clearly seeing fewer patients with dementia and severe stroke with PEGs and fewer patients on prolonged ventilators.

2. More Advanced Health Care Directives:
   While this topic was rarely raised with patients and families when I first came to Japan, it is far more common now in both rural and urban hospitals. There remains a great opportunity for early, sensitive conversations with patients and families about the nature of the illnesses from which they suffer, the natural history of disease, and the details of treatment benefits and risks.

3. More women physicians!!!

4. Specialized nurses:
   Common in the US for 30+ years+, the training and employment of nurse practitioners, midwives, non-psychiatrist mental health counselors, nurse anesthetists, and physicians assistants are slowly beginning in Japan. This will make a very big and positive difference to Japanese healthcare, especially in rural areas.

Conclusion:
These are limited and personal observations from a guest physician from another country, who does not speak Japanese well and who has never practiced medicine in Japan. I hope that readers will accept my apology for the inevitable inaccuracies.
At the same time, I sincerely hope that Japan will not adopt the American insurance approach to healthcare. Japan benefits greatly from its universal health care system, and less focus on profit in everyday medical practice.

My impression is that several aspects of traditional Japanese culture greatly contribute to the health of Japanese population and excellence of Japanese healthcare: traditional Japanese diet, transportation based on walking, bicycles, and public transportation, and the spirit of cooperation that seems to characterize Japanese medicine.
It has been an honor and a pleasure to visit Japan and attempt to contribute to Japanese healthcare and medical education.