OPINION

What’s the Difference?
Comparison of American and Japanese Medical Practice

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Abstract. Medical systems in the USA such as EBM., DRG., Informed Consent and Second Opinion have already been introduced into the Japanese medical system. However, some of these systems have met resistance from a part of the population due to the differences of social structures, morals and customs between the two countries. Briefly, I described the medical education and licensure, the private practice and “open hospital system” of the USA. The following 4 topics which drew great interest in Japan will be discussed.

1) Cerebral death and Bioethics: Cerebral death has been restrictively accepted as human death since the 1980’s only in terms of terminal cares in clinical medicine. The rather simplified current neurological criteria for death are approved in the USA. In order for an organ transplant to take place, a potential doner must be diagnosed as brain dead. However, Japanese society has not accepted the concept of cerebral death completely because of an accident in the 1960’s where an organ was improperly removed when the donor who was not in the state of brain death. Recently, more people in Japan are showing interest in Dignity and Euthanasia from the point of view of “Right to die”.

2) Malpractice and Litigation: “To err is human” was introduced by the Institute of Medicine for Risk Management. Accidental deaths of patients under medical care ranks No.8 in total number of deaths in the USA. There are 100,000 malpractice cases in the “Law-suit Society” of America, which is 100 times that of Japan. Furthermore, the legal fees and insurance premiums are extremely high in the US as opposed to very low in Japan.

3) Health Care Insurance: To reduce medical costs, the insurance companies introduced “Competitive Managed Care” which resulted in the formation of “Health Maintenance Organizations” (HMO). Furthermore, when you compare the two countries in respect to those who have health insurance, 44 million in the USA carry no health insurance, whereas in Japan, the government cover for everybody’s health insurance.

4) Disclosures in the USA: Medical bills and statements are sent to all patients. Maintenance records belong to the patient. The Medical Board discloses those physicians who are facing disciplinary action. (Keio J Med 56 (3) : 96-101, September 2007)

Key words: cerebral death, bioethics, malpractice, litigation, health care cost and insurance, disclosures

Introduction

On each subject, I will discuss about the major differences of medical care in the USA and Japan. The Japanese are not only learning and introducing new advanced medical sciences but are also being introduced to the American medical system, which in many ways is an improvement or can be detrimental such as, “informed consent”, “second opinion”, and “evidence-based medicine (EBM)”, etc. Japanese physicians should learn more about the American methods in the near future. If so, then what? Why did the W.H.O. rate the health care...
system in Japan #1 in the world? Why are many patients unhappy or not satisfied with the health care system in Japan? Particularly those people who live in the rural area and those who are seeking emergency or cancer care remain unsatisfied, for example, while the entire nation is fully insured by the federal government. It is true that malpractice insurance premiums are very low in Japan while malpractice suits are rising. The Japanese population in general, with or without needs of urgent medical care, receive health examinations such as MRI, CT scans, PET, and “Ningen Dock” a thorough set of medical tests, for prophylactic purposes, which are covered by health insurance or by one’s employers. The health insurance covers the costs of these tests and medications, but compensates little for physician’s medical skills. Why are full time hospital physicians working long hours but get paid much less than those in private practice? What is the reason for the Japanese government’s attempts to reduce medical costs, when the GDP rate for medical costs in Japan is the lowest among the top seven countries in the world? In the USA, ER physicians and diagnostic radiologists are available for 24 hour as well as for specialists on call for consultations.

What is the Difference: Comparison of the American and Japanese Medical Practice

Medical Education: Following the completion of four years of a university education, an American medical student will enter a four-year medical university. In Japan, after a high school education, a Japanese medical student enters a medical university for six years. An American medical student goes through eight years of schooling, which is two more years than a Japanese medical student. In Japan, after graduating from medical school, a physician is required to go through a two-year internship. Afterwards, most physicians who select their area of specialties get additional training and must take a Board examination. Some physicians go on to obtain a Master and Doctor of Medical Science Degree (Igaku Hakushi), which involves medical research along with clinical trainings. In the USA, during specialty trainings, resi-
Emergency Room Care: Emergency care (ER) is not well established except the university and larger public hospitals in Japan and the quality of care is different from one hospital to the next, as well as the qualification of the ER physician and care is particularly poor in rural areas. The cost of requesting for an ambulance is free in Japan. In the USA, ER physicians and diagnostic radiologists are available for 24 hour as well as for specialists on call for consultations.

Since it is impossible to discuss about the many aspects of US medicine within such a limited time, I have chosen to speak about 4 topics. I have been asked by my peers to talk about these topics, which are highly debated with great interest in Japan (Table 1).

1) Cerebral Death and Bioethics

As a neurologist, I have been involved in the diagnosis of brain death. California is the first state, allowing cerebral death to be accepted as human death by law. In the early 1980’s, several repeated Isoelectric EEG’s were required to confirm total brain death, however, in the past years, tests were not necessary if the clinical neurological criteria were fulfilled, namely, a deep coma, apnea and complete loss of brain stem reflexes. It is important to keep note that life supportive measures should be disconnected only when the family members agree. Cerebral death must be confirmed by two physicians of whom one have to be either a neurologist or neurosurgeon. Physicians working for organ transplant cannot be involved in diagnosing cerebral death. Each person has a different opinion and acceptance of human death. Particularly in the USA, this is a highly debated topic because of various religious, cultural and moral differences. In certain circumstances, the Bioethics Committee can assist those family members in making the final decision.

The proper diagnosis of cerebral death patient is essential for the organ donation and transplant process. In the USA, the concept of brain death is established independently as a clinical matter in terminal care, and is not part of the organ donor process. In Japan, the story is quite different. Japan had a bad incident many years ago (about 30 years or more), where a cardiac surgeon in Sapporo was forced to remove a heart from a donor who was not in brain death state. Since then, the entire Japanese society, even the medical society has not accepted the concept of “cerebral death” being equal to human death. Subsequently, the actual number of diagnosed cerebral deaths has been minimal, directly affecting the number of organ transplants performed in the country, despite the fact that many patients, including children, who are in need of transplant surgeries are in long waits for donations. As a result, critical patients are forced to receive the transplants in the USA.

Dignity and Euthanasia are the current major subjects in Bioethics in Japan as well as in the USA. Currently in the USA, routinely upon every hospitalization, all patients are questioned about the possession of “Living Will” and informed about the “right to die” in a human being (Durable Power of Attorney).

In Japan, on the 5th day of hospitalization, a patient with multiple myeloma, his respirator was disconnected and given a muscle relaxant by a physician and passed away. The physician was arrested and accused of murderer. In USA, more recently, the medical provider was accused following the infusion of medicine for Euthanasia during a hurricane attack in New Orleans.

2) Malpractice and Liability

The proverb “To err is human” was introduced by the [Institute of Medicine] for Risk Management, and this word became quite popular in the world.

In the past five years in the USA, risk management was used to suppress malpractice insurance premiums and avoid legal liability for damage, rather than to reduce the errors caused by medical care providers.
Rate of accident:  
2.9% (California Study)  4.7% (Harvard Study)  
Subsequent death:  6.6% - 13.6%  
Out of these deaths 30%, the medical provider is responsible.

Death caused by medical errors is the No. 8 leading cause in the USA. In Japan, during the past six years, risk management in medical practice has been a major national project. Medication errors is the leading cause of medical errors both in Japan and the USA. Reports from the media on medical liability claims has risen dramatically in Japan.

The USA is known for their litigation system as a “Lawsuit Society”. The trial system was necessary to unite the nation due to the multi-nationalities and different races, which brings various morals and cultures together into one society. Furthermore, relationships become complex and to settle the troubles and quarrels, the nation needed peaceful and equal means of settling these differences through a fair system. In the USA, filing a lawsuit is an easy process, because 1) costs are low, 2) many lawyers are available as it is significantly easier to be admitted to the bar and practice law in the USA as compared to Japan (rate of lawyers to the population is No. 1 in the world), 3) most cases are settled before going to the courts because verdicts in malpractice suits are often in the grey area, 4) processed as civil cases and 5) compensation for lawyers is high.

Malpractice insurance premium for a physician is very high in the US. For example, neurosurgeons and obstetricians may pay more than $100,000 a year for insurance. In Japan, the premiums are very low and consistent for all specialists ($500-600 a year), even for neurosurgeons. Also, the indemnity coverage is $1 million — $3 million in both Japan and the USA. More recently, mediator system was introduced to negotiate for the reduction of compensation following the physician’s apology.

To mitigate the risk of malpractice lawsuits, physicians refined their skills, improved how the practices were run, re-emphasized the importance of the physician-patient relationship and the proper maintenance of complete medical records. “Informed consent” is one of the byproducts of this initiative.

AMA (American Medical Association) published a booklet [Code of Medical Ethics] in which Fundamental Elements of the Patient Physician Relationship is emphasized in the first chapter.

As known, William Osler Society emphasized the importance of “the Art of Medicine” in curing the patient, along with the medical techniques. “Humanology” is also re-emphasized to develop the superb personality as being a physician as well.

3) Health Care cost and Insurance

Medical costs soared as a result of defense medicine, increase in malpractice insurance premiums, increase in the use of specialists, humanitarian support for illegal immigrants, and increase in the population of senior citizens, investment in advanced new equipment and the spread of AIDS. The insurance company reformed the health care systems to control the medical costs and introduced “Competitive Managed Care”. The business-oriented experts introduced another form of health care called a HMO (Health Maintenance Organization). And as the result of this system, physicians lost their autonomy and decrease to the patient service. More than half of the nation now belongs to HMO’s. The Kaiser Foundation is an example of a successful HMO. The quality of care in a HMO has been improving, with the hiring of full-time physicians (hospitalists) into the HMO. In the USA, an individual decides on whether he/she is covered by health insurance, and approximately 44 million people are without health insurance, including business men who make between $70,000 and $80,000 a year. In Japan, the federal health insurance covers the whole nation. Individual patients are responsible in co-paying 30% of the medical bill while the elderly is responsible to pay 10–30% of the medical costs.

Public federal insurance in the US and Japan is similar. Medicare is covered for elderly people over 65 years old and Medicaid is covered for people with low income.

Long Term Care Insurance: an individual is responsible in paying for this coverage in the USA. In Japan, federal and local governments provide for some coverage for these services. The premium is relatively high even for young workers.

4) Disclosure

(1) The Medical Bill and Statements: The state medical insurance agency and private insurance companies send the detail of the bill and the “Explanation of Benefits” to all patients. If there is a discrepancy in the information, the patient should report this to the state or insurance companies. In Japan, brief note is available, but, no details are described on the bill. The patient has to make a specific request for details of their cares from the physician or hospital and may be charged a fee for the request.

(2) Medical Record: The medical records belong to the patient. Disclosure of these records could improve and the service quality of the physician and practice and could mitigate the number of malpractice lawsuits and liability. In Japan, providing records to patients is slowly increasing and their records are maintained and available in computers in large hospitals, but the records are not readily available at private hospitals and practices. The patient is afraid that asking for a copy of their medical re-
cords will offend physicians and damage their relationship.

(3) Administrative Action from Medical Board of California: Every three months, the Medical Board of California publicizes the names of physicians who are facing disciplinary action for fraud, malpractice, tax evasion, drug abuse and alcoholism. Disciplinary action can include suspension of a license, taking educational courses and free community services. Approximately 4,000 physicians out of 700,000 physicians in the USA are facing disciplinary action and is disclosed, however the number of physicians facing disciplinary action in Japan only stand at about 40 out of 23,000 physicians.

5) Headline in the Los Angeles (LA) Times

The LA Times on the front pages in 2002 reported an accidental death following the cardiac surgery for a septal defect due to the failure of a pump. This report also discussed about the quality of medicine, inadequate clinical training, limited patient’s rights, and arrogant attitude of physicians in Japan. In this case, the parties involved forged the medical records and tried to cover up the incident, which led to the physicians being charged of murdere.

6) Statistical views in the USA and Japan (Table 2)

<table>
<thead>
<tr>
<th></th>
<th>America</th>
<th>Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Expectancy</td>
<td>78 y/o</td>
<td>82 y/o</td>
</tr>
<tr>
<td>Infant Death</td>
<td>7.2/1000</td>
<td>3.8/1000 lowest in the world</td>
</tr>
<tr>
<td>WHO</td>
<td></td>
<td>Japanese Health Care is No.1 in The World</td>
</tr>
<tr>
<td>Insurance</td>
<td>self</td>
<td>federal</td>
</tr>
<tr>
<td></td>
<td>44 million uninsured</td>
<td>all insured</td>
</tr>
<tr>
<td></td>
<td>Elderly 20% self</td>
<td>30% self</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Elderly 10–30% self</td>
</tr>
<tr>
<td>Medical Cost</td>
<td>expensive</td>
<td>less expensive</td>
</tr>
<tr>
<td></td>
<td>$2566 per person</td>
<td>$1113 per person</td>
</tr>
<tr>
<td></td>
<td>High Payment For the Medical Provider (Physician)</td>
<td>For Tests and Medicine</td>
</tr>
<tr>
<td>GDP RATE</td>
<td>14.4%</td>
<td>7% &lt; 8.8%, No. 20 in the world</td>
</tr>
<tr>
<td>Number of Hospital (total)</td>
<td>5000</td>
<td>9000</td>
</tr>
<tr>
<td>Number of Bed</td>
<td>1</td>
<td>2x of USA</td>
</tr>
<tr>
<td>Average Hospital Stay</td>
<td>1</td>
<td>33.5 days, 5x of USA</td>
</tr>
<tr>
<td>Pharmaceutical Cost/person</td>
<td>No.2</td>
<td>No.1 in the world</td>
</tr>
<tr>
<td>Number of MRI CT/person</td>
<td>No.2</td>
<td>No.1 in the world</td>
</tr>
<tr>
<td>Administrative Action</td>
<td>4000/700,000 M.D.s</td>
<td>40+/23,000 M.D.s</td>
</tr>
<tr>
<td>Malpractice Premium</td>
<td>very high</td>
<td>very low</td>
</tr>
<tr>
<td></td>
<td>e.g. Neurosurgeon $100,000 and more</td>
<td>$500 (all specialties)</td>
</tr>
<tr>
<td></td>
<td>Coverage 1 million / 3 million</td>
<td>1 million / 3 million</td>
</tr>
<tr>
<td>Medical License</td>
<td>Renew Every 3 years (California)</td>
<td>for Life (No renewal)</td>
</tr>
<tr>
<td></td>
<td>With 60 hours education and duties of seminars for analgesics and terminal care</td>
<td></td>
</tr>
<tr>
<td>Medical Specialty</td>
<td>Oncology Maintenance Of Certificate (M.O.A.)</td>
<td>Cancer Chemotherapy</td>
</tr>
</tbody>
</table>

Table 2 Statistical View in America and Japan

Comments

Some medical systems such as EBM, DRG, Informed Consent and Second Opinion have already made their ways from the USA to Japan. Social structures and morals are quite different between the two countries. Both systems have their advantages and disadvantages to both physicians and patients. We should be open in learning some of the American medical methods and consider introducing them into the Japanese medical system.
Meanwhile, we may have to face the facts and reconstruct the current system in the near future in Japan. For example as described in these materials, the physician’s license should be renewed with required professional education, patient records should be made available to patients, the litigation systems need to be changed and emphasis should be made in increasing the number of physicians in some specialties in need.

It is very important that these reforms should be conducted by physicians themselves in Japan.

I hope this presentation has provided useful information to those particularly in private practice.

This summarizes the presentation given at the Keio Medical Society on October 17, 2006.

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