THE UNREAD RECORD

English ineptitude among Japanese doctors is a metric of cronyism in a feudal-like medical system.

Mark Lee Ford

All current evidence of essential consequence in oncology is published only in English.

A negligible amount of that primary English-language record is translated into Japanese. Domestic studies conducted and published in Japanese are a sliver of the total body of the worldwide record, eclipsed by those in Mandarin, German, and other languages. Regardless, whereas the record in other languages is dispensable, the English one is not. Yet most Japanese doctors cannot string two coherent sentences together in English properly. Laborious for them; excruciating for their international and Japanese listeners alike.

Seventy-five percent of Japanese doctors say they lack confidence in their English ability; only 10 percent claimed confidence.[1] A 2025 survey found that over 90% felt that better English skills would have made their participation in international conferences more meaningful.[2] A 2014 survey revealed 68 percent lack confidence in communicating findings and fielding questions in English as the strongest factor discouraging them from more frequent presentations at international conferences.[3]

The record is left unread.

A system with incentives that certifies, pays, and promotes English-illiterate doctors without demanding that they understand or discuss the primary record has made that record officially optional and clinically irrelevant in Japan. Doctors tend to rely on Japanese sources only.

These enormous deficits in language ability are the direct, countable result of those incentives. Japanese doctors in the main cannot use the primary record to the fullest extent demanded of a competent doctor because fluency in English brings no revenue, no appointment, no cancer hospital designation, and no returns for politicians or life science companies. No bucks. But plenty of aggravation with English.

The unread record, therefore, is a measurable symptom of a closed incentive structure.

Surgeons throttle medical oncology in Japan

Medical oncology is the poster child for what arises under these incentives.

The field of medical oncology barely exists in Japan compared to the United States. It developed very late and is small and underpowered compared with Western counterparts. Surgeons and organ-specific specialists dominate cancer care in Japan, including much of the systemic drug therapy.

A valiant underdog, Japanese Society of Medical Oncology (JSMO) began in 1993 as a study group and somewhat languished in that form for over a decade until it was formally instituted as an independent medical academic society in 2004. Formal certification of "cancer drug therapy specialists" (i.e., medical oncologists) was squeezed out of the Ministry of Health, Labor, and Welfare (MHLW) even later, in 2006, a shocking forty-four years after medical oncology officially opened its doors as a board-certified practice in the United States.

Today, twenty years later, there are only 1,859[4] certified medical oncologists for a country of 125 million people and one million new cancer diagnoses per year, far lower per capita than in the US or much of Europe. Many prefectures have only a handful. JSMO notes that only 29 percent of certified medical oncologists work at cancer specialty or prefectural designated hospitals.[5]

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[1] Survey conducted 10–17 July 2023 among Nikkei Medical Online physician members; n = 9,278.

[2] Survey conducted 11 July 2025 by MED ITALY/PRIZMA; n = 1,000.

[3] Wroblewski, Greggory *et al*, "Factors dissuading Japanese doctors from presenting more frequently at international conferences: more than just the usual suspect(s)?", Journal of Medical English Education, 2014, 13, 55-64.

[4] JSMO website: 1,859 as of 1 April 2026.

[5] JSMO Chairman's letter, 2025.

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Surgeons, pulmonologists, gastroenterologists, and so on—not medical oncologists—still prescribe and manage the lion's share of chemotherapy, targeted agents, and immunotherapy. Therefore, most patients are not in the hands of the correct doctors who are trained and certified in the clinically-required specialty of medical oncology.

To understand why this is the case, one must turn to the origins of cancer care in Japan.

Japan's cancer care developed around organ-specific, surgeon-led continuity of care. Surgeons handled diagnosis, surgery, and post-operative management. When systemic therapy (e.g., chemotherapy) arrived on the scene, surgeons grabbed that, too. Surgeons took cultural and professional pride in being the one man overseeing and executing the entire treatment plan of the patient rather than involving a systemic therapy specialist. They became self-appointed Jacks of all trades, allowing their hubris and arrogance to seduce them into believing they had expertise in areas for which they had none. Patients, of course, knew no better other than to trust the god in the white coat. And when the occasional patient sensed that something was off in his care, they were to shy or intimidated to press their surgeon for clarification.

This mentality ended up infecting the Japanese medical schools, which also lagged those of the United States.

For decades, Japanese medical schools did not have departments of medical oncology as free-standing fields. Internal medicine developed along organ lines. "Tumor," for example, was not a recognized subspecialty of the Japanese Society of Internal Medicine for a long time. Meanwhile, surgeons dominated the Japan Society of Clinical Oncology, the country's largest cancer society; they comprise 45 percent[6] of the membership today.

It was natural, therefore, for surgical and organ-specialist practices to absorb systemic therapy into their scope of work. With the arrival of the latest systemic technologies—modern multi-agent chemotherapy, molecular targeted agents, and immuno-oncology—Japan again missed the opportunity to catch up. It responded by having surgeons and organ specialists attempt to acquire the skills needed for the new technologies rather than increasing the number of medical oncologists who are formally trained in the technologies. Surgical departments and organ-based internal medicine departments jealously guarded their turfs at great injury and cost to the patient.

Surgery has always carried high social and professional status. Any new kind of underdog specialty such as medical oncology has to fight for recognition, training slots, and departmental space.

The result is a system in which the primary cancer doctor is still a surgeon or organ specialist who oversees and executes the treatment plan for the cancer patient, including the delivery of systemic therapy for which they have no specialist training. They are practicing medicine in an area for which they are not qualified, with a big caveat: "not qualified" as far as the primary record goes, not MHLW. It picks and chooses what suits itself from the primary record and United States, if anything, then makes up rules and policies for domestic Japanese medical practice. In Japan, the surgeons and organ specialists are fully qualified because MHLW says so, even though the doctors are engaging in practices that would be prohibited in the United States and most of the EU.

Meanwhile, medical oncologists are relegated to larger centers. They handle more complex or cross-organ cases and are gradually taking a larger share of drug therapy. They are not the quarterback of care in the way they are in the United States.

The cosy arrangement for surgeons and organ specialists was built by the people who still profit from it. An independent medical oncology service would mean surgeons and organ specialists would have to forfeit a portion of the patient revenue—perhaps a very large share of it—which runs contrary to existing incentives. So they maintain their grip on revenue from hospital beds and drug revenue.

English inability exposes doctors' turf wars

English illiteracy among surgeons and organ specialists reinforce the turf borders. They do not need to read, let alone master, the English record to keep their work and the revenue going. Organ specialists and surgeons can continue using chemotherapy and other new technologies within their own departments while citing Japanese-language reviews, medical society articles, or the limited number of translated papers as valid evidence.

It is another case of the Japan Galapagos effect: an arrangement—a system—that is sealed off, impenetrable, jealously non-inclusive, and siloed. Above all, it is unaccountable.

A free-standing medical oncology service would run contrary to all of it. Medical oncology demands a critical mass of doctors fluent enough in English to understand the application and use of the complexity of new medical technologies.

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[6] JSCO Medical Note interview with JSCO Chairman Takayuki Yoshino, 2024.

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Why and how did this behavior arise?

The feudal-like apparatus in Japanese medicine today

Ikyoku (sometimes romanized ikkyoku) is the closed pyramid hierarchy that runs each clinical department in a Japanese university hospital and its affiliated network. Tokyo University First Department of Internal Medicine, Kyoto University Department of Surgery (especially First and Second Surgery), Osaka University Departments of Surgery and Internal Medicine, Keio University Department of Surgery, and others operate the most famous and influential ikyoku.

Each university clinical department has a pyramid organization. At the peak of the pyramid is a professor-doctor, invariably a graduate of that particular university. He appoints associate professors and the chiefs of affiliated hospitals who, in turn, populate the ranks—the middle and lower levels of the pyramid—with the same school's graduates. Referrals, operating room fees, bed fees, and drug administration revenue circulate within the pyramid. These days, senior surgeons who control the pyramids enjoy surgical fees and the increasing revenue from targeted agents and immunotherapy. It is a closed system of incentives and distribution of patients (*i.e.,* money).

A surgeon who leaves the pyramid forfeits income from procedures and pharmaceuticals. Loyalty, therefore, is paramount. Junior members accept the rotations because the alternative is exclusion from that income.

Ministry bureaucrats and politicians protect the distribution. The MHLW designates cancer hospitals under criteria that have long accepted surgeons or organ specialists as being sufficiently qualified to practice systemic therapy. A hospital can be designated, subsidized, and advertised as a cancer center without a medical oncologist on staff. Officials who write these biased policies move through the same university networks. Many return to posts or foundations linked to ikyoku. Advisory councils are stuffed with the influential professors who head the pyramids. Politicians receive organizational support and campaign resources from the medical associations and alumni groups, all of which benefit from the arrangement.

If the MHLW required medical oncology departments to be in hospitals as a condition of designation as a cancer center, the number of currently "qualified" cancer hospitals would drop like a rock. It would also redirect subsidies, and weaken the advisory and electoral relationships. The very low clinical bar of the policies, therefore, remain in place. Surgeon-led service is sufficient for MHLW to designate a hospital as a cancer care center. The bureaucratic and political incentive is the preservation of an ossified system that rewards its members.

Pharmaceutical companies are key players. Marketing, speaker fees, advisory boards, and post-marketing studies are channeled through the ikyoku hierarchical pyramids and the Japanese-language professional societies dominated by them.

A larger cadre of medical oncologists who read the English primary literature and lead multinational trials would threaten to raise the cost and lower the predictability of promotion within the ikyoku. Domestic pharmaceutical and medical device companies and the Japanese arms of global ones fund the society congresses, the translated educational materials, and the domestic investigator meetings that help to keep the Galapagos system going. The corporate commercial incentives fit with the academic and regulatory incentives, for example, maintaining fewer and more controllable prescribers.

Cronyism flows through and binds the system together, making it highly stable and resilient to innovation and disruption. Doctors, universities, bureaucrats, politicians, professional societies, and companies are all heavily involved. The sophistication and robustness of the cronyism is staggering.

Incentives breed arrogance

Arrogance is a by-product of the incentives.

A surgeon inside the ikyoku is paid to manage the entire treatment course of the patient. The MHLW treats his department as sufficient for official designation as a cancer care center. The society guidelines he uses are written largely by colleagues from the same pyramids. The English primary record that would expose the severe limitations—even dangers—of this model is optional reading for doctors and everyone else in the system. Nothing penalizes the belief that one surgeon or organ specialist can master every speciality, therapy, and procedure. Reading pathology slides and radiology studies, performing interventional radiology procedures, administering systemic therapies, and more. What *can't* the surgeon do?

And the surgeon's opinion carries enormous weight. If he thinks a tumor is urothelial carcinoma, the pathologist report comes back with "suspicious of UC," even if no cells are found in the biopsy. If the surgeon changes his mind after a second biopsy and thinks the tumor is benign Inflammatory Myoplastic Tumor, the pathology report comes

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back with "suspicious of IMT." And after all that, he somehow finds time to perform surgery—the only field for which he actually studied, interned, and is formally certified for.

The belief hardens into arrogance. When outcomes sour, the secondary Japanese sources and the designation checklist certify the practice as adequate anyway. The external standard—the English-language record—that would expose the ignorance remains unread. Absence of contradiction is taken as proof of competence.

The heroic surgeon who "can do everything" is not a delusion. He is the perfectly rational occupant of a system that incentivizes and rewards his behavior while pushing aside the English record of evidence that would debunk all of this. Meanwhile, Junior members, hospital administrators, and ministry officials whose careers are enmeshed with the pyramid do not challenge the status quo. Companies that market through the surgeons and organ specialists reinforce the system.

Malpractice lawsuits are not a safeguard for the patient

Malpractice lawsuits would handily topple such a system in the United States. In Japan, malpractice lawsuits cannot penetrate the ikyoku.

Japan is not a litigious society. It has fewer medical malpractice lawsuits than the United States. Patient success rates run about 22 percent[7], which is very low even for Japanese litigation. Ordinary civil suits in Japan have a roughly 85 percent success rate. Most Japan malpractice suits end in settlement. Those that manage to reach judgment are hard for patients to win because the ikyoku and its attached parts lock arms against the patient. The hospital holds all the records. Expert testimony is hard to obtain. Moreover, negligence and causation must be proved against a clinical standard that shifts around. And, again, the English record, which can shine a spotlight on the offenses, is seldom considered by the plaintiff.

The result is reduced accountability. A surgeon or organ specialist who manages complex systemic therapy on the basis of Japanese-only sources or fails to involve a medical oncologist faces no risk that a court will view his behavior as negligent. MHLW designation criteria and society guidelines accept the existing Japanese arrangement as adequate.

Ineffective malpractice lawsuits are yet another incentive that lets the cronyism march on.

Patients are misled

How is the behavior justified, or at least explained, to patients?

Explanations of any kind are seldom asked by patients or offered by surgeons. When they do offer explanations to patients who sense that something is off, surgeons use arguments from authority. The following chestnuts are common:

Continuity of care. One doctor must manage everything. Handing the case to a separate specialist such as a medical oncologist will disrupt the continuity.

Implied competence. Because MHLW has designated the hospital as a cancer care, the surgeon or organ specialist is described to the patients as being competent in systemic therapy by virtue of that designation. Patients are never told that the most surgeons are not fluent in the primary English record nor have they undertaken the years of training to be a proper medical oncologist. Instead, MHLW designation equals competence. And because patients have, in general, blind faith in Japanese bureaucrats like the MHLW, they question nothing of this.

Practical routing. Referrals stay inside the pyramid and its affiliated network. Patients are reluctant to ask for second opinions for fear of insulting their surgeon or organ specialist and the possible repercussions to their treatment. The rare time when a patient has the both awareness and the courage to ask to be transferred to a dedicated medical oncology service, his request is rebuffed. Patients are intimidated with comments, such as the current hospital already provides the standard treatment, waiting lists elsewhere are long, or that continuity would be lost.

Japanese medical ethics are not a safety valve

The Hippocratic Oath carries little if any weight in Japan. Japanese medical ethics developed under the ikyoku system and under state and military authority. They have been shaped by duty to one's superior, to the institution, and to the patient as a member of a social order, not by an individual doctor's promise. Nothing could be further from Hippocrates. After 1945, the Hippocratic Oath was sometimes taught during the American occupation, when one

[7] Supreme Court of Japan, 地裁民事第一審通常訴訟事件・医事関係訴訟事件の認容率. Patient-side success rate in medical malpractice cases that reach judgment has ranged approximately 18–22 percent in recent years (e.g., 22.2% in 2020). Ordinary civil suits average 85 percent.

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could take the medical licence exam in English, but it never became the binding moral and ethical obligation as it is in the West.

Wartime Japanese medicine, which operated under military orders, is a good example of the difference,. Doctors drawn from the ikyoku system saw their role as fulfillment of duty to the Army and to their department, not as a breach of any sort of independent professional code. No Hippocratic-style oath constrained them.

After 1945, the American occupation introduced concepts such as informed consent, patient rights, and the Hippocratic Oath or the Declaration of Geneva. To be found in textbooks and in some hospital policies, these concepts sat adjacent to the ikyoku rather than reforming them.

The Japan Medical Association and medical schools now teach principles that include respect for the patient, confidentiality, and informed consent. In practice, though, decision-making remains paternalistic and family-centered compared to the United States or Europe. Doctors frequently defer to senior doctors inside the same ikyoku network. They involve family members in important medical decisions even when the patient is competent.

The ethics that would have prevented the rise of the ikyoku system elsewhere simply do not exist in Japan. Appeals based on ethics to those who are part of the system fall on deaf ears.

English inadequacy as a measure of cronyism

Returning to English, the English-language deficit is the easiest metric in an audit trail of the cronyism. It is also an indicator of where not to seek medical care.

Pivotal trials[8] and guideline revisions of essential importance to the proper practice of medicine appear first, and usually only, in English. Japanese medical training and MHLW policies do not require doctors to have the ability to read or discuss that record.

Japanese sites enroll disproportionately few patients in global trials, mainly because of the burden to the Japanese doctor and staff of the trial protocols being in English. A 2025 survey of Japanese clinical research coordinators (CRCs) found that 72 percent named "language (English)" as a barrier when overseas sponsors attempt to run multi-regional clinical trials (MRCT) in Japan—the single most common response, far higher than clinical trial costs in Japan (52 percent) and regulatory factors involving the Pharmaceutical and Medical Device Agency, (PMDA) and MHLW (36 percent).[9]

At ASCO, one observes that Japanese attendees seldom present papers or engage and debate with speakers to the extent of attendees from other countries. Their participation is mainly one of a passive, quiet observer.

A lamentable, but unsurprising situation.

Yet, it is the perfectly predictable result of incentives that impose no penalty for ignorance of the primary record and no reward for mastering it. Every actor who benefits—the professor-doctor who keeps the revenue, the MHLW official who writes policy and cancer hospital designation criteria, the politician who keeps the association support, and the pharmaceutical company that keeps its prescriber base stable—gains from a system in which the English record has been ordered to be irrelevant. Brushing aside the primary record is a mechanism to maintain the status quo.

The inability or refusal to use the primary record is, therefore, direct evidence of the closed system of incentives. An open system would have made English fluency a condition of certification, designation, and payment.

The comparison between Japan and the US is direct

Medical oncology in the United States also faced resistance, but half a century earlier than Japan.

Chemotherapy was dismissed in the 1940s and 1950s by the medical establishment as futile. Academic chairs blocked papers and even called practitioners of what would eventually become medical oncology "charlatans." Surgery and radiation were immovable as the Gold Standard treatment for solid tumors. Efficacy data, the National Cancer Act of 1971, and advocacy of The American Society of Clinical Oncology (ASCO) changed everything. Medical oncology as a board-certified speciality won formal recognition in 1972. Within a few years, medical oncology became the quarterback of systemic therapy in most American clinical settings.

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[8] A pivotal trial is the key clinical study whose results form the primary basis for a regulatory authority's decision on whether to approve a drug, biologic, or medical device for marketing.

[9] Fujiwara N, Iguchi M, Kono M, Hirokawa A, Tsutsumi N. Clinical research coordinators' perceptions and practical challenges in multiregional clinical trials in Japan: An exploratory survey. Clin Eval (臨床評価). 2026;54(2):W21–W30.

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Japan's version of medical oncology entered much later. Surgeons and organ specialists thwarted it from the outset within a highly resistant and slow moving ikyoku system.

The injury is immeasurable

Patients pay the bill for all of this.

Regimens that are routine in the United States, or Hong Kong or Seoul for that matter, reach Japanese hospitals months or years later, or only inside the MHLW-designated university centers. Excruciating pain, suffering, agony, and despair are caused by the players in, or attached to, the ikyoku. And the cost of that bill to the patient? Mental, physical, spiritual, emotional, and financial ruination. The humanity of it all.

I am one of those patients. My loved ones—family, friends, and acquaintances—number among them, too.

When I asked my urological surgeon in Osaka for a medical oncologist to join my care team, his answer was succinct: "Medical oncology is not part of our medical culture in Japan." To his credit, he found and consulted one. But he also admitted that the pressure on him from his department chairman and the hospital president to follow the MHLW guideline was enormous. His decision to pursue a different path in consultation with the medical oncologist got him into hot water with his bosses.

Repeating such "maverick" actions can dampen a doctor's career progress in the ikyoku system. Actions outside the boundaries can expose the problems within the boundaries.

Likewise, a patient who remains inside the arrangement receives services that preserves the revenue keeping ikyoku afloat. The same patient who boards a short flight to Hong Kong or Seoul receives the care that the primary record justifies. Meanwhile, Japan deliberately maintains a cadre of doctors and MHLW regulatory standards that are not fully validated against that same record.

No doctor—no player in the ikyoku system—is compelled to play this game. Surgeons could yield drug revenue to allow the creation of new, valid, independent services. MHLW bureaucrats could write cancer hospital designation policies that demand medical oncology. Politicians could refuse support from associations that are tied to the status quo. Pharmaceutical companies could direct education toward doctors who use the English record. Instead, each chose the financial return available from the closed arrangement of incentives.

They make conscious, rationale choices of economic self-interest based on the incentives before them, all of which are perfectly legal. The English-language deficit is the fingerprints left behind from those choices. The safety valves that have allowed such perverse incentives legally arise and to endure are weak or do not exist:

(i) checks and balances in the legislature, judicial branch and government bureaucracies to prevent conflicts of interest between politicians, jurists, and bureaucrats with doctors and industry;

(ii) medical ethics that a binds a doctor to his patient in the way of the Declaration of Geneva or equivalent, not to parties in a social structure; and

(iii) redress of injury through courts that use equal application of the law.

A pattern of exceptions appears

The National Cancer Center (NCC) is an outlier among MHLW-designated cancer hospitals. Departments of Medical Oncology exist at its two campuses. They provide substantial volumes of systemic therapy, while most other designated hospitals continue to leave the bulk of drug treatment under the control of surgeons and organ specialists.

How did this outlier arise?

In short, the institutional incentives at NCC differ from most other hospitals. NCC's funding depends on its prestige status. That status depends on international recognition; NCC is in competition with the ikyoku domestically. Whereas the universities having the most prestigious ikyoku are public, courts have treated ikyoku as a private association of physicians. NCC's funding has a purely political source. To capture the quality of the prestige necessary, international engagement is necessary. Medical oncology capability is one of the strongest sources of that engagement. Ordinary designated hospitals operate under MHLW rules and revenue arrangements.

The NCC publishes in English, joins international trials, and maintains English reporting, so staff who routinely use the primary record in English are required. The same English requirement exists, at lower intensity, at many other university and designated hospitals that have not built comparable medical-oncology departments. What distinguishes the NCC is the combination of mandate, resources, and status, of which English is one element rather than the decisive driver. English-language participation is one element of that mandate, not its primary cause.

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The Cardiovascular Institute Hospital (CVI) is a different kind of outlier. It is a private, disease-specific hospital operated by a foundation rather than a university. It has no ikyoku. Its physicians are employed directly by the foundation, and its research and clinical work are organized around a single specialty. This is uncommon in Japanese tertiary care, where the dominant model remains the university ikyoku. CVI's specialists routinely present papers at overseas conferences and demonstrate procedures such as cardiac catheterizations for complex cases at overseas hospitals.

As it turns out, there are numerous institutions and clinics like CVI hiding in plain sight. They are private specialized institutions that operate outside the ikyoku. Cardiology, gastroenterology, and anesthesiology (pain management) count among the many specialties that can be found in these private practices. Takahiro Fuji Clinic, Yasashii Clinic Hiroo, Japan International Clinic, Sakura International Clinic, Clove Clinic Setagaya, and many others have doctors who are fluent in English and actively use the primary record. They present papers at conferences and engage enthusiastically in international collaborations.

These are the hidden champions of medicine in Japan.

Not only are these institutions and clinics profitable, they have the latest equipment and therapies. Most are fully digitized and engage with patients on SNS. Something as simple and as common sense as being able to book appointments on one's smartphone and communicate using social media messaging are the norm at the hidden champions. All of this befuddles ikyoku hospitals that sit on legacy technologies and are handcuffed by their own ill-considered rules. The hidden champions enjoy very high patient ratings, much higher than the mediocre ones of ikyoku hospitals, and are oriented around patient satisfaction first. They enthusiastically seek feedback and ideas from patients for improvements and new services. While some of the doctors have come from prestigious medical schools in Tokyo and Osaka, most have come from lesser known schools in the more remote prefectures of Japan, and then done residencies or fellowships in the United States.

A solution emerges

Ikyoku operate as a cartel.

Alternative career paths exist, but are either unknown to doctors or the capital requirements for those alternatives are too expensive. And do not overlook the seductive draw of prestige to work in ikyoku, which distracts attention from alternatives. The incentive problem is straightforward. A poor placement means the professor-doctor assigns a doctor for reasons other than competence. The costs of a poor placement fall on the patient.

This is why the pattern of successful exceptions has emerged, and is apparently growing. Japan still has a free market. Yes, the market is severely warped by regulations and cronyism, but it still chugs on. As patients get more savvy from alternative sources of information such as A.I., and doctors and students likewise get more access to international sources—in English, yes, but in Mandarin and many other languages, too—the palate of options increases for them. The allure of gunning for a coveted few positions at a prestigious Japanese medical school begins to wane as people realize the best medical schools in Japan are mediocre on the international stage.

One hopes that the successes of the hidden champions become better known among patients, the general public, and young doctors, allowing the growth of a new market and different path.

If that happens, the ikyoku will not be destroyed; they will just slowly become irrelevant.

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