

THE UNREAD RECORD

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

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Nearly all current evidence in medical oncology is published in English. Yet, most Japanese doctors cannot string two coherent sentences together be they reading, writing, or speaking. Laborious for them; excruciating for the listener.

A system that certifies, designates, pays, and promotes physicians without requiring them to read or discuss that evidence has made the primary record officially optional and operationally irrelevant. The observed deficit—fewer than 30 percent able to read a paper unaided, reliance on secondary Japanese sources, low trial enrollment, silence at international meetings—is then the direct, countable result of those incentives. Nobody uses the literature and conferences to the fullest extent demanded of a competent doctor because fluency in the primary literature brings no revenue, no appointment, no designation, and no political or commercial return. No bucks. No aggravation with English. The unread record, therefore, measures the closure.

The saga of medical oncology in Japan

Medical oncology is the poster child for this behavior. The field exists in Japan, but it developed very late, remains small and grossly underpowered compared with Western systems. Surgeons and organ-specific specialists dominate cancer care including much of the systemic drug therapy. This is a well-documented structural and historical feature of Japanese oncology, not a total absence.

The Japanese Society of Medical Oncology (JSMO) was founded around 2002–2003 from an earlier research group and began formal certification of “cancer drug therapy specialists” (i.e., medical oncologists) only in 2006, a shocking *forty years* after the United States.

As of the early-to-mid 2020s there were roughly 1,600–1,850 certified medical oncologists for a country of 125 million people and 1 million new cancer diagnoses per year. This is a sharp rise from 867 in 2013, but still far lower per capita than in the US or much of Europe. Many prefectures have only a handful; some designated cancer hospitals have none. By 2020 only about half of Japan’s designated cancer care hospitals even had a dedicated medical oncology department (up from 39% in 2013). In many places surgeons, pulmonologists, gastroenterologists, breast surgeons, and so on still prescribe and manage a large share of chemotherapy, targeted agents, and immunotherapy. The certified specialist is present in the statistics. He is not the physician who holds most patients.

Japan’s cancer-care model grew around organ-specific, surgeon-led continuity of care. Surgeons (digestive, thoracic, breast, gynecologic, urologic, etc.) traditionally handled diagnosis, surgery, postoperative management, and, when systemic therapy became available, the chemotherapy as well. There was cultural and professional pride in one physician overseeing the entire course rather than handing the patient off to a separate drug specialist.

The trade-off: academic infrastructure lagged. For decades most medical schools lacked independent departments of medical oncology or clinical oncology as a free-standing field. Internal medicine developed along organ lines; “tumor” was not a recognized major subspecialty of the Japanese Society of Internal Medicine for a long time. The Japan Society of Clinical Oncology, the country’s largest cancer society, has historically been heavily surgical. Surgeons comprise more than 70% of the membership.

Systemic therapy was absorbed into existing surgical and organ-specialist practices rather than having given rise to a new dominant specialty. When modern multi-agent chemotherapy, molecular targeted agents, and immuno-oncology exploded in complexity, Japan initially responded by having organ specialists acquire those skills rather than rapidly expanding a pure medical-oncology workforce. Turf issues with both surgical departments and organ-based internal medicine departments slowed the creation of independent tumor-medicine units.

Broader physician shortages, long working hours, and the prestige hierarchy of Japanese hospitals also play roles. Surgery has traditionally carried high status; a new, cross-organ specialty had to fight for recognition, training slots, and departmental space. The result is a system in which the primary cancer doctor is frequently still a surgeon or organ specialist who coordinates and often delivers systemic therapy for which they have not undertaken the years of specialist training required, for example, in the United States. Jack of all trades.

Medical oncologists are concentrated in larger centers, handle more complex or cross-organ cases, unknown primary, soft-tissue tumors and are gradually taking a larger share of drug therapy, but they are not yet the default quarterback of care the way they are in the United States.

The continuity model was built by the people who still profit from it. When regimens grew complex, those surgeons and organ specialists absorbed the skills rather than cede the beds and the drug revenue. An independent medical-oncology service would have split that revenue. It was not created at scale.

Why and how did this happen?

21st Century Japanese feudalism.

Ikyoku is the enforcement mechanism. *Ikyoku* (sometimes romanized *ikkyoku*) is the closed personnel pyramid that runs each clinical department in a Japanese university hospital and its affiliated network.

Each university clinical department is a pyramid headed by a professor, almost always a graduate of that university. He appoints associate professors and the chiefs of affiliated hospitals; those men staff the ranks with the same school's graduates. Referrals, operating time, beds, authorship, and drug-administration revenue travel inside the chain.

A surgeon who leaves the pyramid loses the path to the combined procedural and pharmaceutical income. Loyalty is therefore rational. Cross-pyramid hiring on merit is rare. The senior surgeons who control the pyramids capture both the surgical fees and the expanding revenue from targeted agents and immunotherapy. Junior members accept the rotations because the alternative is exclusion from that income. This is not tradition. It is a closed distribution of money and patients.

Ministry bureaucrats and the politicians who oversee them protect the distribution. The Ministry of Health, Labour and Welfare designates cancer-care hospitals under criteria that have long accepted surgical or organ-specialist departments as sufficient for systemic therapy. A hospital can be designated, subsidized, and advertised as a cancer center without a medical oncologist. Officials who write and apply the criteria move through the same university networks; many return to posts or foundations linked to those networks. Advisory councils are stocked with the professors who head the pyramids. Politicians receive organizational support and campaign resources from the medical associations and alumni groups that benefit from the existing designations and fee schedules.

Requiring medical-oncology departments as a condition of designation would shrink the set of qualifying hospitals, redirect subsidies, and weaken the advisory and electoral relationships. The criteria therefore remain written so that the surgeon-led service counts as adequate. The bureaucratic and political incentive is the preservation of a countable, unchanged system that continues to reward its existing counterparties.

Pharmaceutical companies reinforce the closure. Marketing, speaker fees, advisory boards, and post-marketing studies are efficiently directed through the *ikyoku* hierarchies and the Japanese-language societies those hierarchies dominate. A larger cadre of medical oncologists who read the English primary literature, lead multinational trials, and select agents by data the companies do not control would raise the cost and lower the predictability of promotion. Domestic firms and the Japanese arms of global firms therefore fund the society congresses, the translated educational materials, and the domestic investigator meetings that keep prescribing inside the known pyramids. The commercial incentive aligns with the academic and regulatory ones: fewer, more controllable prescribers.

English ineptitude as a measure of cronyism

The English-language deficit is the audit trail of this cronyism. Nearly all pivotal trials, toxicity data, molecular criteria, and updated guidelines appear first in English. Japanese training, board examinations, charts, society programs, and ministry designation checklists do not require the ability to read or discuss that record. Surveys from 2018–2020 found fewer than 30 percent of Japanese physicians able to read an English clinical paper without aid and fewer than 15 percent comfortable in English discussion at meetings. JSMO and related reports note that a majority of both certified specialists and organ-specialist prescribers rely on Japanese guidelines and translated summaries. Japanese sites enroll disproportionately few patients in global trials; language burden on protocols is routinely cited. At ASCO and ESMO large numbers of Japanese attendees use translation or later digests and do not intervene.

These are not private failings. They are the 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 who keeps the revenue, the official who keeps the designation simple, the politician who keeps the association support, the company that keeps the prescriber base stable—gains from a system in which the English literature remains optional. The inability or refusal to use the primary sources is therefore direct evidence of the closed circle. An open system would have made fluency a condition of certification, designation, and payment. This system did not.

Resilience of the status quo

No Meiji, Taishō, or Occupation reform broke the circle. The modern medical faculties were founded in the Meiji period on the German model. Each clinical chair received appointment power and control of affiliated hospitals at the outset. The pyramid was the design, not a later corruption. The Taishō years expanded the universities and provincial hospitals and reproduced the same chains. No statute required cross-school hiring or separated systemic therapy from the organ surgeon. The Occupation public-health reforms addressed infectious disease and practitioner licensing. They left university departmental governance, school-based appointment power, and organ-specialist dominance untouched. Postwar growth simply replicated the prewar *ikyoku*.

Later Japanese measures—the 2004 clinical-training system, JSMO certification after 2006, cancer-control legislation—added pathways and categories. None rewrote the professor’s control of staffing and revenue, the designation rules that accept surgical departments as sufficient, or the incentive that leaves the English primary record optional. The arrangement has therefore continued without a historical break.

Is the power pyramid shifting?

Slowly, yes.

Government cancer-control plans, the growth of JSMO certification, requirements for designated cancer hospitals, the sheer complexity of modern regimens (especially immuno-oncology and molecular targeting), and increasing recognition of the need for dedicated expertise are expanding the medical-oncology footprint. Surveys show more hospitals creating departments and more certified specialists.

Surgical and organ-specialist dominance remains strong, however, and shortages of medical oncologists are still widely reported. The specialty’s place in the formal residency and subspecialty hierarchy is still relatively modest compared with classic internal-medicine fields. Medical oncology is real and growing in Japan, but it arrived decades later than in the US and Europe, was never given the institutional head-start that surgery enjoyed, and therefore still sits lower in the traditional power and volume hierarchy of cancer care. The pattern is historical and structural rather than a deliberate rejection of the specialty.

America’s journey

Medical oncology in the United States faced significant resistance and institutional hurdles when it emerged, though the details and eventual outcome differed from Japan’s experience.

Effective systemic therapies (nitrogen mustard, methotrexate, alkylating agents, early hormonal therapy) began appearing in the late 1940s–1950s, mostly for hematologic cancers and later solid tumors. Early practitioners were often called “chemotherapists.” The American Society of Clinical Oncology (ASCO) was founded in 1964 by a small group of these physicians. Medical oncology was formally recognized as a subspecialty of internal medicine by the American Board of Internal Medicine in 1972–1973, with the first certifying exams around 1973–1974.

Contemporary accounts describe a “rough and tumble road” and note that “no other specialty we know of struggled as much.” Many academic chairs of medicine viewed treating advanced cancer with drugs as futile or even charlatanism.

One prominent chair reportedly called medical oncologists “charlatans” and vowed they would never practice in his department. Major internal medicine meetings initially refused to accept papers on medical oncology, which is one reason ASCO scheduled its own annual meeting at a conflicting time. Even some leading cancer researchers (including Sidney Farber) opposed combining toxic agents. Using drugs in combination was initially anathema in internal medicine circles.

Before the 1960s, surgery and radiation were essentially the only active treatments for solid tumors. Surgeons and radiation oncologists delivered much of the non-surgical medical care for cancer patients. The idea that internists specializing in systemic therapy should take a central coordinating role was new and contested. Advanced cancer was widely seen as a death sentence if it could not be surgically removed. Treating dying patients was sometimes viewed as fruitless, and early chemotherapists faced professional stigma. B

y around 1980 the specialty had stabilized as a recognized part of internal medicine, helped by growing evidence of efficacy (especially in leukemias, lymphomas, and later adjuvant therapy for solid tumors), the National Cancer Act of 1971, and ASCO’s advocacy.

The comparison is direct.

In the United States the main source of resistance was the internal-medicine establishment plus skepticism of chemotherapy itself; surgeons were already dominant but the fight was also intra-medicine. Time to formal recognition

was roughly 20–25 years from early chemotherapy use to board certification in 1973. The outcome was that medical oncology rapidly became the dominant coordinator of systemic therapy and overall cancer care in most settings, accelerated by the National Cancer Act, NCI infrastructure, and ASCO advocacy.

In Japan the main source of resistance has been strong, persistent surgeon and organ-specialist dominance and turf issues with both surgery and organ-based internal medicine. Formal recognition arrived decades later; JSMO certification only from 2006, and departments remain sparse.

The outcome is that medical oncology is still secondary in many hospitals. Surgeons and organ specialists continue to manage a large share of drug therapy. Institutional support has been weaker, with few dedicated departments for a long time and a slower cultural shift. The US version did face real opposition, professional stigma, and institutional barriers. It was not smoothly welcomed. Once efficacy data accumulated and formal board recognition plus federal cancer infrastructure arrived in the early 1970s, it achieved a central role relatively quickly.

Japan’s version arrived much later into a system already deeply structured around organ-specific surgeons, so the power-pyramid problem has proven more persistent.

The patient pays the measurable price. Regimens already routine in Hong Kong or Seoul—molecularly selected, sequenced with current immunotherapy, managed by physicians working from the original reports—reach many Japanese hospitals months or years later, or reach them only inside the designated university centers.

Outside those centers, or inside them under a surgeon using the secondary summary, dose intensity, toxicity handling, and timely discontinuation vary more widely because the prescriber’s volume of any single modern protocol is low and his information is filtered. Trial access that would deliver the next agent early is concentrated where the pyramids and the designations already sit. A patient who remains inside the arrangement receives the care that preserves the revenue, the checklist, the political support, and the company relationship. The same patient who boards a short flight receives the care the primary record already justifies. The difference is not surgical technique. It is the deliberate maintenance of a prescriber base and a regulatory standard that do not require the evidence.

The patient also pays for the arrogance that is the predictable product of the incentives.

A surgeon inside the *ikyoku* is trained, certified, promoted, and paid to manage the entire course: diagnosis, operation, postoperative care, and systemic therapy. The ministry designation treats his department as sufficient. The society guidelines he uses are written largely by colleagues from the same pyramids. The English primary literature that would show the limits of that model is optional. Nothing in the daily circuit—referrals, revenue, status, or regulatory approval—penalizes the belief that one organ-trained physician can master every subsequent regimen.

The belief therefore hardens into arrogance. The surgeon does not experience the cases in which molecular selection, immunotherapy sequencing, or cumulative toxicity exceed what an organ specialist reliably handles, because those cases are either absorbed inside his own service or referred only within the pyramid. When outcomes lag, the secondary Japanese sources and the designation checklist still certify the practice as adequate. The external standard that would expose the gap remains unread. Over time the absence of contradiction is taken as proof of competence.

The same structure supplies the audience. Junior members, hospital administrators, and ministry officials who depend on the pyramid for appointments, subsidies, or political support do not challenge the claim. Companies that market through the existing prescribers reinforce it. The surgeon who “can do everything” is not an individual delusion. He is the rational occupant of a system that rewards the claim, withholds the evidence that would refute it, and punishes anyone inside the pyramid who yields the patient or the revenue to a specialist who might read the record he has chosen to ignore.

No participant is compelled by circumstance. Senior surgeons could have yielded drug revenue to create independent services. Ministry officials could have written designation rules that demanded medical-oncology capacity. Politicians could have refused association support tied to the status quo. Companies could have directed education toward physicians who use the English literature. Each chose the return available inside the closed arrangement.

These were conscious, deliberate choices of self-interest. The English deficit records the choice: when the primary evidence is optional for money, status, designation, and election, the evidence stays unread. The certified medical oncologist can be counted. He does not take the patient from the surgeon who holds the referral, the revenue, the designation, and the secondary sources that all parties have agreed are sufficient. The cure next door remains next door because the people who profit have no incentive to import it.

The same closure now sits on Japan’s demographic and technical legacy. The birth rate is low, the population is aging, and the number of working-age physicians will shrink while cancer incidence remains high. Inter-generational deadlock inside the *ikyoku*—senior professors retaining appointment power and revenue while junior members wait—slows any internal correction. Hospital information systems and administrative processes in many designated centers

still rest on architectures introduced between the 1970s and 1990s; they are adequate for counting designations and fee claims, not for rapid incorporation of external evidence or for flexible reallocation of cases across specialties. If the pyramids, the designation criteria, and the optional status of the English record are left intact, the interval between international standard and domestic delivery lengthens further as physician numbers fall and legacy systems continue to route patients and payments inside the existing chains.

The unread record will then measure not only present cronyism but the compounding cost of an arrangement that Meiji design, Taishō expansion, and Occupation silence all left unbroken, and that depopulation will make more expensive to maintain.

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