Japan’s Clinical Training System
—Current Status and Future Directions—

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Developments in Clinical Training

In 1968, the so-called intern system under which unlicensed medical doctors were required to complete a year of internship as a medical trainee was abolished amidst controversy over the status of the trainees and other contentions. Almost 35 years have now elapsed since regulations were laid down under the Medical Practitioners Law targeting a two-year voluntary clinical training system to replace the compulsory internship.

With the inauguration of this clinical training system, the university department system came gradually to hold the field, and a straight training system that was beneficial to both the trainees and to the departments, and in a sense to regional health care, became mainstream. The system, which enabled students graduating from faculties of medicine to select a “department” from among the faculties of their alma mater and to receive focused training in a specialized field, undoubtedly played a role in supporting the then current system of supplying doctors, in the sense that it cultivated medical specialists, enabling them to reach terminus ad quem more rapidly. Many people will recall the way in which medical specialists were lionized in the regions. However, such misconceptions promptly forced us medical professionals to undergo major self-examination.

I asked a doctor from the generation that went through the internship about his experiences, and he recalled his impressions of the time with vivid clarity saying, “As a physician it was one of the most significant years of my life. It enabled me to gain a distinct awareness of the joys and thrills of medicine.” For doctors like myself who went through the system after the period of internship was abolished, this emotion is one that we did not have the chance to experience. One hears such comments most frequently from the doctors who elected to undertake their one-year internship in a regional health care facility and not within their university. This is not merely nostalgia or a wistful longing for idyllic times past; as doctors we are now keenly aware of the need to heed the voices of these senior physicians.

Thereafter, a policy based on the vision of

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one prefecture one university, resulted in medical universities being newly constructed across the nation and the further deterioration of the situation. Medical universities in the regions were inundated with applications from the capital and the Kansai area, and graduating students targeted departments in the brand name medical universities in their home prefectures, making no contribution to the universities from which they had graduated. The result was the emergence of mammoth departments, and at the same time, the medical universities in the regions were left with insufficient incoming doctors even to operate their own hospitals.

As these circumstantial changes began to take shape, the detrimental effects of abolishing the intern system, together with those of the training system that replaced it, started to become apparent. Doctors who were unable to acquire the skills and knowledge to practice holistic medicine, what is known as primary care, so as to enable them to consistently undertake specialist training, diagnosis and treatment from the start of their careers, began to penetrate the ranks of medical professionals.

Such developments gave rise to concerns, and although guidance measures were repeatedly undertaken so as to introduce rotational training as opposed to straight training, after all the fanfare the undeniable impression is that the new system was a failure because universities have no emergency department infrastructure and the university doctors’ office system, as the supply source for medical doctors, has become a major obstruction.

Japan Medical Association Efforts

I decided to look into the Japan Medical Association’s assessment of the situation and discovered that the Association had early registered the problems with the training system and has undertaken measures to deal with them. In the decade spanning 1975 to 1985, reservations were already being expressed regarding the excessively specialized orientation of the training system, and specifically, in 1989 the Association compiled an “Interim Report from the Council for Clinical Training”, which was followed in 1991 by the publication of the “Council for Clinical Training Report (I)”. This report contained an indication on “The importance of coordinating under- and post-graduate clinical training, specialist education, and lifelong education”. It also pointed out the need to pay attention to both self-initiative and diversity over and above the decisions on the basic curriculum of clinical training, as being an important element in the collaboration between university hospitals and designated clinical training hospitals in the induction of trainees. Furthermore, the report advocated the promotion of open training hospitals in order to cultivate educational personnel, or so-called advisory doctors, recommending the participation of doctors in the field.

In addition, the report clearly spelled out “the need for government efforts in guaranteeing the status of trainee doctors and bringing about the necessary improvements in their working conditions so as to realize training without forcing the trainees to moonlight”. The “Council for Clinical Training Report (II)” was released in 1992. This report referred to a number of specific matters based on the content of the previous report. For example, it stated that “Training extending across a number of hospitals is effective. The content of training to be undertaken at each of the hospitals should be laid down as part of a planned curriculum where each of the components is mutually complementary from the outset”. The report further outlined the need for clear-cut methods of evaluating the training and proposed that it would be effective to structure a training curriculum including achievement targets for postgraduate clinical training within the curriculum for licensing medical doctors under the medical society licensing system. In addition, it proposed the establishment of a joint committee (tentatively named the Clinical Training Education Committee) comprising...
members from medical societies, medical associations, and other concerned parties, on the basis of the concept that the reciprocal convergence of facilities and advisors within groups of hospitals would be an effective means of improving training conditions.

Amazingly enough, these specific proposals were virtually identical to the matters contained in the “Interim Report (Draft)” of the “Medical Ethics Council, Medical Doctors Subcommittee Council on the Clinical Research System for Medical Doctors”, organized by the Ministry of Health, Labor and Welfare, which was finalized in April 2002. Furthermore, the 6th Report of the Council to Promote Lifelong Education of the JMA, which was released in 1994, pointed out the necessity of advancing further concrete discussions to promote reform of the postgraduate clinical research system, and proposed that a study be undertaken to identify the actual situation of postgraduate clinical education. It also indicated the need for a review of the entire process of educating medical doctors in order to clarify the distinct responsibilities of faculty education and postgraduate clinical research within the process.

Furthermore, with regard to the content of the training, the report specified that only compulsory items and standards should be fixed and that the identity of the institutions should be respected, that they should be given freedom to determine other components of the research program. It further indicated the need to establish a third party organization to oversee the overall planning of the research, decide the programs, undertake trainee quota allocation, assessments, and other related matters.

Having heard the arguments for legislating postgraduate clinical research, a string of similar proposals have subsequently been made by the national organization of national, public, and private university-affiliated hospitals and by a committee of the Ministry of Education, Culture, Sports, Science and Technology (MEXT). These proposals included indications on the formulation of a concrete curriculum, the need for decisions on research institutions to be made by trainee doctors after they have gone through a process of public application and selection, in other words, a matching system so that trainee quotas are decided for individual institutions, fixing student allocation at a certain level in order to enhance exchanges with other universities, and it appeared that the universities were finally developing a burgeoning sense of crisis.

The Content of Compulsory Clinical Training

In the midst of these debates, the Medical Practitioners Law was revised in November 2000, so that as of 2004 medical students will be required to undergo two years of postgraduate clinical training.

The key points of the revisions are as follows. After the revisions are enforced, individuals who have obtained a medical doctor’s license will be required (1) to undertake a minimum of 2 years training, in other words, to apply themselves to training either at their university hospital or at a designated clinical training hospital as defined by the Ministry of Health and Welfare (currently the Ministry of Health, Labor and Welfare); (2) to have this information recorded in the register of physicians upon completion of the training period, at which point they will be granted a “Completion of Clinical Training Registration Card”. In addition, (3) those individuals who are not registered will be required to receive permission from a municipal governor in the event that they want to open a clinic; and (4) any individual who opens a practice (the hospital director) will be required to consign its management to a physician who holds a registration card.

In short, as of April 2004, a number of restrictions will be placed on medical doctors who have obtained a license to practice but fail to complete postgraduate training. Naturally enough, although such individuals have not undergone training they will still have a
doctor’s license and will be qualified and authorized to treat patients covered by health insurance plans, they will also be able to open a practice by obtaining permission from a municipal governor. However, in reality it is assumed that close to 100 percent of doctors will receive the training, excluding a number who advance to the basic research course.

The Current Status of Clinical Training and Related Problems

University hospitals are designated as advanced treatment hospitals under the Medical Service Law. In terms of the spirit of the Medical Service Law, the essence of advanced treatment hospitals lies in the provision of progressive treatment and the undertaking of the research needed to do so, and moreover, in the provision of clinical training in advanced medicine. In consequence, severe limitations are imposed on the handling of those ailments with which hospital doctors are routinely confronted, which situation is inappropriate for implementing initial clinical training.

However, and regretfully, the fact of the matter is that at this time postgraduate clinical training is primarily being undertaken at university hospitals. According to the Ministry of Health, Labor and Welfare data, in 2000, a total of 15,554 doctors were receiving postgraduate clinical training, with students from the two years combined. A total of 13,489 doctors, or 86.7 percent, was actually receiving training in line with the current training system. Of these, 10,282 doctors were receiving their training at university hospitals, which in fact accounts for three-quarters of the total, or 76.2 percent.

The Japan Medical Association was given an opportunity to voice its opinions regarding the clinical training system at a debate set up by the Ministry of Health, Labor and Welfare, at which time they sparked controversy by stating that “In principle, postgraduate clinical training at university hospitals should be prohibited, in consideration of the fact that they are advanced treatment hospitals”. I do not, however, think that this statement is invalid. University-affiliated hospitals have a considerable responsibility to teach more advanced medical techniques and knowledge to doctors who have completed their initial clinical training, and allow them to undertake more advanced research.

The results of a questionnaire survey relating to clinical training, which was undertaken by the Japan Medical Association in 2001, also indicate an awareness of the problems being caused by the disproportionate weighting of training at university hospitals. Of trainee doctors currently in the system who feel dissatisfied with their training, 43 percent are dissatisfied with training in emergency medicine, 38 percent are dissatisfied with training at regional health care facilities (clinics, geriatric facilities, etc.), and 31 percent expressed frustration with the system for dealing with consultations or complaints from trainee doctors.

Many trainee doctors also voiced dissatisfaction about their income. In fact, according to this survey, 80 percent of respondents receive less than 300,000 yen per month in salary and allowances. In connection with the working conditions at university hospitals in particular, the press has recently been making much of work-related deaths (karoshi, or death from overwork) among trainee doctors, and this has become something of a social issue. Trainee doctors are concentrated in a number of university hospitals located in metropolitan areas and are unable to receive sufficient training, or, due to circumstances, are engaged in providing treatment as part of the hospital’s work force without adequate remuneration. The tone of the newspaper articles is understandable, given that these trainee doctors are fresh out of university and have their medical licenses but, due to circumstances, are being obliged to work for long hours whilst receiving only nominal training and insufficient pay.

The problem is also compounded by major regional differences, with only around 30 percent of graduates remaining at medical univer-
It is evident that if regional medical institutions and related facilities can collaborate in the formation of institutional groups, even without being designated to do so, then it will become possible for trainee doctors to receive their training across sizeable areas of the country. It is considered that the best method of implementing training is under an organic alliance of distinctive medical facilities. To put it another way, the construction of a system under which senior physicians at the frontline of activities in the regions can provide direct guidance to trainees to replace the existing university hospital-centered training, is considered to be the most important task at this time. In order to give this proposition concrete shape, there are plans to actually implement a pilot (model) training program in the regions.

In specific terms, this would not take the form of contractual relationships between university hospitals, university departments, and designated medical facilities, instead the plans are for local associations of senior doctors, the medical associations, to become guardians so to speak, to utilize all available medical resources in the region, and to implement training whilst evaluating the results by feeding the opinions of the trainees back into the program, in other words, order-made training. As of 2002, preparations are being advanced, mainly within the Tochigi Medical Association and the Oita Medical Association, with the aim of accepting a number of medical trainees for a 2-year period.

The local medical associations have formed institutional groups in conjunction with medical universities. They have established training committees to formulate training programs and select the medical trainees and are appraising the training facilities and evaluating the results of the training. It is hoped that this will mark the first step towards the continuous quest for better training approaches, in other words, the spread of ideal training techniques. This is based on the concept that the doctors belonging to the local medical associations will worry about the medical trainees as if there were their own children and will view the task of raising the next generation of doctors as being one of paramount importance that merits the efforts of every member of the association. I would suggest that the fault of the current training system lies in the very fact that it is not possible for these senior doctors to be seen in action, to directly communicate the joys and thrills of medicine to the medical trainees.

It goes without saying that the practice of
teaching is a tough task. It may be that young medical trainees who are armed with the latest knowledge pose a kind of threat. Nonetheless, if senior doctors in the regions neglect to teach the young trainees and leave the task to universities and a limited number of hospitals, they cannot then lay the blame for their dissatisfaction with the results at the doors of university education. It is necessary for these doctors to take on a role in the process of communicating the attraction and thrill of regional health care within the two-year period. After the training is complete, when these young doctors come to choose their individual specialist paths, they will invariably recall this training period. If we, the doctors in the regions, can be enthusiastic in our contact with these trainees, then the memories of the intern generation that I cited earlier can again be given objective reality today.

The treatment that trainees receive during the training period is also important. The trainees may be required to perform night duties and other tasks within the medical institutions in line with necessity, but it is hoped that they will be paid on a monthly basis so that they can afford to live without having to moonlight, that accommodation and social insurance costs will be kept to a minimum, and that their conditions will be on a par with doctors employed by local medical association, for example. Moreover, the medical trainees are being given membership of the intern generation that I cited earlier can again be given objective reality today.

One was recently discussing the training system with a close friend who commented, “Easy for you to say, but it is in fact very difficult to accept medical trainees. My hands are already full enough.” No doubt, this is the reality of the matter. However, once I had explained the significance of this training over again, he admitted, “There is a definite need for the system. However, I worry as to how much cooperation it will actually be possible to obtain”.

That said, when I discussed this matter with the key executive member of the Tochigi Medical Association, a doctor belonging to the Oita Medical Association, and the staff of Almeida Hospital, they voiced all-out approval of the concept and were convinced that it would be possible to gain the understanding of the majority of doctors. A related party at the medical association hospital also commented that “Much is expected from this training method as a new function for medical association hospitals”.

**The Impact on Medical Doctors**

I would now like to consider the various impacts that the enforcement of postgraduate clinical training is expected to have from a number of perspectives. Health care will assuredly change, although I am sure that this will emerge as an important tool in the ongoing structural reforms of the health care system. In the first instance, if the matter is examined in terms of regional health care, this move will likely see young doctors fresh out of university entering hospitals and clinics that were previously unable to accept medical trainees independently. Seeing young trainees being taught in clinical settings will also furnish patients in the regions with the opportunity to discover new facets to their primary physicians. This is a new direction in the medical world, one that is not biased toward the advanced medicine available in cities and at large hospitals, nor does it give weight to such medicine alone, and one that is likely to change the consciousness and flow of patients. There is no doubt that it will produce closer ties between hospitals and clinics in the true sense of the word.

Next, I would like to discuss the impact on the activities of the medical associations. Medical association hospitals are utilized as joint use facilities, and as I mentioned earlier, they will play a significant role as the nucleus of the training system. It should also be possible for
the medical trainees to be taught by local doctors with their own practices in fields such as ambulatory medicine, which are not available in medical association hospitals. It will be possible for the trainees to give thought to collaborative health care and cooperation, and of the sharing of roles, from the first step of practical medicine onwards. It should also be feasible for them to gain an understanding of the activities of the medical associations per se. Research that is performed in the closeted environment of hospitals is cut off from the activities of the medical associations, and it is difficult to anticipate that this will afford trainees with the opportunity to apprehend the role that is actually being performed by regional health care.

The legislation of postgraduate training is likely to deal a major blow to medical universities and university hospitals. Recent inquiries have turned towards exploring the possibilities of limiting training at the graduating university, and I suspect that the department system and the doctor's office system are entering a major transitional phase. It is anticipated that these systems will no longer act as a supply source for physicians, but that they will become a part of the specialized activities that are the true role of universities. It is also hoped that research with a global reach will show exponential growth. Furthermore, the move is expected to have a major impact on faculty teaching in the universities in order that the recognition afforded to individual graduates can be fed back into the reputations of the universities.

To reiterate a matter I mentioned earlier, it is anticipated that enforcing postgraduate training will also link to the resolution of the problem of providing health care in under-populated areas and medically underserved areas. Moreover, with graduates from numerous universities pitting themselves against each other, any disparities in the system should be rectified. There should also be some consolidation in establishing a standard way of writing medical records and the style of ordering.

**Conclusion**

I believe that the introduction of a new training system will have a major impact on the shape of the doctors' office system of the departments in universities and regional health care approaches, and that this will extend to cover the role of the medical associations and faculty teaching in the universities.

As I have mentioned, the Japan Medical Association is of the belief that bringing the initial clinical training system up to scratch is indispensable for breeding good doctors, and specifically, is proposing a training model under which there will be cooperation among multiple health care institutions led by the regions. The legislation of the postgraduate clinical training system will offer a unique opportunity to return to the original approach to doctors training via which senior physicians working in the regions will take on the role of teaching and rearing the young doctors who will lead the next generation. However, it is necessary to be aware that the fate of this opportunity — whether it is to be optimized or extinguished — will come down to the attitudes of each and every one of the doctors currently in active service.