Market Research & Consulting
SEED PLANNING
Medical Business Unit

Understanding Japan's Medical Specialties vs. U.S.: An FAQ for Overseas Clients

This guide explains key differences in Japan's medical specialty structure and healthcare roles compared to the U.S. Understanding these differences is crucial for effectively targeting the right professionals in Japanese healthcare market research. We provide mappings and examples to illustrate how certain U.S. roles translate (or don't translate) into the Japanese context, and why adjustments are needed when recruiting experts in Japan.

Organ-Specific Specialists in Oncology

In Japan, cancer care is largely led by organ-specific specialists rather than general "oncologists." Historically, Japan has had relatively few dedicated **medical oncologists**; instead, the physician who treats a cancer patient is typically the specialist of the organ where the cancer arose [1]. For example, a patient with lung cancer is usually treated by a **pulmonologist or thoracic surgeon** (respiratory medicine specialist), and a breast cancer patient by a **breast surgeon**, rather than by a separate medical oncology doctor. The medical oncology subspecialty in Japan only began formal certification in the late 2000s (around 2008), and the number of certified medical oncologists remains limited (just over 1,000 as of 2015) [2]. This is a stark contrast to the U.S., where **medical oncologists** (clinical oncologists specializing in chemotherapy and drug therapy) are numerous and often manage cancer treatment across organ types.

Implication: When an overseas client asks to target "oncologists" in Japan, we often must **translate that request into the appropriate organ-specific specialty.** In practice, Japanese patients' chemotherapy or drug treatments are frequently handled within organ departments (e.g. breast surgery department for breast cancer), so those **organ-specific physicians** are the relevant experts to engage. The table below provides a general mapping of common cancer types to the typical specialist in the U.S. versus in Japan:

Cancer Type	Typical U.S. Specialist	Equivalent Japanese Specialist
Breast Cancer	Medical Oncologist (and Breast Surgeon for surgery)	**Breast Surgeon** (surgical specialist who often also oversees drug therapy for breast cancer)
Lung Cancer	Medical Oncologist (Thoracic Oncologist) or Pulmonologist	**Respiratory Medicine Physician** (Pulmonologist) or **Thoracic Surgeon** (handles both surgery and often chemotherapy management for lung cancer)
Colorectal/GI Cancer	Medical Oncologist (GI Oncologist) or Gastroenterologist	**Gastrointestinal Surgeon** (or GI physician) (specialist of digestive organs who manages treatment of colon/stomach cancers)
Prostate/ Bladder Cancer	Medical Oncologist (Genitourinary Oncologist) or Urologist (for surgery)	**Urologist** (surgical urology specialist who also directs treatment for prostate/bladder cancer, including coordinating any drug therapy)

Cancer Type	Typical U.S. Specialist	Equivalent Japanese Specialist
Head & Neck Cancer	Medical Oncologist (Head-Neck Oncologist) or ENT specialist	**Otolaryngologist/Head & Neck Surgeon** (ENT surgeon who treats cancers of the head and neck region)

Why this difference? The Japanese system evolved with a focus on organ-specific practice. Traditionally, each organ specialty handled "its" cancers from diagnosis to treatment [1]. Only more recently have "general" oncology departments emerged at cancer centers, and even now they often co-manage care with organ specialists. Thus, an American-style **oncologist** (who treats all types of cancer with chemotherapy) is relatively rare in Japan's healthcare landscape. Overseas researchers must ensure they identify the **correct Japanese specialists by organ** to get meaningful insights on cancer treatment. For instance, a study on lung cancer in Japan should recruit respiratory medicine doctors or thoracic surgeons, rather than looking for a large pool of "medical oncologists" (which would miss many key treaters).

Specialties That Do Not Exist as Standalone Fields in Japan

Several medical specialties that are well-established in the U.S. (often with their own board certifications) do **not exist in Japan as independent disciplines.** Instead, their functions are absorbed by other specialties. Below are a few notable examples and how their roles are handled in Japan:

- **Interventional Cardiologist (U.S.) → Cardiology Specialist in Japan:** In the U.S., an interventional cardiologist undergoes specialized fellowship training to perform cardiac catheterizations and stent placements. In Japan, there is no separate "interventional cardiologist" license or department – these procedures are done by physicians who are certified cardiologists (internal medicine cardiology specialists) with additional catheterization training. In other words, a Japanese **cardiologist** covers both general cardiology and interventional procedures (such as angioplasty) within the cardiology department, rather than a distinct specialist title.

- **Geriatrician (U.S.) → General Internist or Gerontologist in Japan:** Despite Japan's large elderly population, **geriatrics is not a widely established standalone specialty** in Japan. There is no ubiquitous equivalent to a board-certified geriatrician managing care for older adults as a primary specialty. Instead, care of the elderly is typically handled by **general internal medicine doctors or family physicians**, sometimes in departments labeled "Geriatric Medicine" or "General Medicine." These physicians address geriatric syndromes as part of their practice, but often their training is in internal or general medicine rather than a dedicated geriatrics residency. (Japan does have a Geriatrics Society and some focus on geriatric research, but the role "geriatrician" is far less common than in the U.S., and the overall number of geriatric specialists is low relative to need.)

- **Pain Specialist/Pain Management Physician (U.S.) → Anesthesiologist or Orthopedic Doctor in Japan:** In the U.S., pain medicine is a recognized subspecialty (physicians from anesthesiology, physiatry, neurology, etc. become "pain specialists" focusing on chronic pain management). Japan does not recognize "pain medicine" as an independent clinical specialty for physicians. Typically, **anesthesiologists** in Japan often run "pain clinics" or manage pain control (especially for acute and cancer pain), leveraging their expertise in analgesia. For chronic musculoskeletal pain (like back pain or joint pain), **orthopedic surgeons** may fill the role, since patients with chronic back or neck issues often see orthopedics. In cancer care, **palliative care physicians** (often from internal medicine backgrounds) may handle pain management as well. The key point

is that there isn't a separate cadre of "pain management doctors" with their own clinics as seen in the U.S.; rather, the responsibilities are covered by these other departments.

- **Nuclear Medicine Physician (U.S.) → Radiologist in Japan:** Physicians specializing in nuclear medicine (handling PET scans, radioactive diagnostics and therapies) are a distinct group in some countries. In Japan, nuclear medicine is generally a **subdivision of radiology**. Imaging departments in hospitals include nuclear medicine as part of radiology, and doctors who perform and interpret nuclear scans are usually **radiologists** with training in nuclear medicine. There is a Japanese Society of Nuclear Medicine and certification within radiology, but a doctor would typically be referred to simply as a radiologist (or sometimes "radiologist (nuclear medicine subspecialty)") rather than a separate nuclear medicine physician in daily practice. Likewise, **interventional radiology** is practiced by radiologists (no separate IR-only practitioners outside of radiology).

Implication: When a client's research brief includes targeting a specialty that doesn't formally exist in Japan, it is critical to **re-define the target**. We identify which Japanese specialty covers that role's functions. For example, if a project asks for interviews with interventional cardiologists, we will recruit experienced **cardiologists** who perform interventions. If they want pain specialists, we may need to speak with **anesthesiologists** who run pain clinics. This translation ensures we actually reach the experts who do that work in Japan. Educating clients on these differences upfront prevents mis-targeted recruitment and strengthens the study design.

Absence of NPs and PAs; Role of Nurses in Japan

Another major structural difference is that Japan **does not employ Nurse Practitioners (NPs) or Physician Assistants (PAs)** in its clinical system. In contrast to the U.S., where NPs and PAs often act as mid-level providers who can diagnose illnesses, prescribe medications, and manage patient care (under varying degrees of physician supervision), in Japan these roles are essentially nonexistent or not legally recognized. Only licensed **physicians** are allowed to independently diagnose conditions and prescribe treatment. In fact, until recently, nurses in Japan were strictly required to work under a doctor's direction for any medical judgments – they were not allowed to diagnose or prescribe medication without a physician's order [3].

- **Nurse Practitioners:** Japan has started some programs to train "Japanese Nurse Practitioners" (JNPs) at the master's level, but even those nurses cannot practice like American NPs. Legally, even a certified JNP must operate **under physician instruction** for medical acts [4]. They do not have independent prescribing authority or the right to make treatment decisions on their own. Essentially, their role is an enhanced form of nursing practice, but **not an independent provider**. The JNP system is new and not widespread; most hospitals in Japan still do not utilize nurse practitioners in the way U.S. healthcare does.

- **Physician Assistants:** Japan does not have an established role for physician assistants at all. There are no accredited PA programs or national certification for PAs in Japan [5]. Healthcare duties that might be handled by PAs elsewhere (such as surgical first-assisting, minor procedures, etc.) in Japan are typically handled either by doctors (residents, fellows) or by nurses and technicians in a limited supportive capacity. A person trained as a PA from abroad would not find a corresponding job title in a Japanese hospital – they would likely have to become licensed as a nurse or physician to work in clinical care [5].

- **Registered Nurses:** Japan has plenty of registered nurses, but their scope of practice is **more restricted to traditional nursing functions** – bedside care, monitoring patients, performing physician-directed tasks, patient education, etc. Nurses do **not have prescribing rights** or authority to decide treatment plans. Even highly experienced nurses cannot start a new medication or change a treatment without a doctor's order. In outpatient clinics in Japan, the model is usually physician-led: the doctor sees the patient and makes decisions, while the nurse's role is supportive (taking vitals, doing injections or IVs, patient guidance). Compared to the U.S., Japanese nurses have less autonomy in clinical decision-making (they "play a smaller role in patient care" in terms of directing care) [6] . There are advanced nursing certifications (e.g., nurse specialists in fields like oncology or wound care), but those are credentials for expertise – they do not confer the legal authority that an NP license would in the States.

Implication: For market research, this means **we should not target NPs or PAs in Japan because they are not present or empowered to answer many clinical questions.** If an international client suggests interviewing nurse practitioners or physician assistants (common in U.S. research), we must advise them that Japan's healthcare only uses physicians for those duties. Similarly, questions about **prescribing, treatment choice, or product adoption cannot be directed at nurses** in Japan – nurses cannot make those decisions, so they would not be valid respondents. Instead, **only physicians** (the treating doctors) can speak to those topics. Japanese nurses can provide valuable insights on **nursing care, patient support, and implementation issues**, but if a research topic is, for example, "choice of medication therapy" or "evaluation of a new medical device for use," the nurses in Japan are not the decision-makers for those matters. We would focus on physicians for those questions.

Wide Scope of Physician Authority in Japan

Given the lack of mid-level practitioners, Japanese **physicians hold an unusually broad scope of authority** in patient care and even in hospital management decisions. Doctors in Japan wear many hats that, in the U.S., might be shared with non-physician professionals or administrators:

- **Clinical Decision-Making:** Virtually all aspects of diagnosis and treatment are physician-led. From selecting a drug regimen to deciding on surgery vs. medication, it is the doctor's call. There isn't a culture of multidisciplinary committees overruling a doctor's prescription choice (the national insurance may set some coverage rules, but within those guidelines the physician decides the patient's care plan). Every prescription must be written by a physician (unlike the U.S. where NPs/PAs can prescribe under their licenses). This means Japanese doctors may spend more time on tasks that U.S. doctors might delegate.

- **Prescribing Rights:** Only physicians can prescribe medications in Japan. Nurses or pharmacists cannot substitute their judgment for a doctor's prescription. A patient cannot receive a prescription drug without a physician's order. This exclusive prescribing right reinforces the physician's central role in therapy decisions (even minor adjustments require contacting the doctor).

- **Hospital Equipment and Service Adoption:** In Japan, **senior physicians – department chiefs, hospital directors, and leading professors – are the key decision-makers for major purchases or adoption of new technology/therapies in hospitals**. Many hospitals (especially private ones) are physician-run or were founded by doctors, and even in public or university hospitals, the chief medical officers are usually doctors. As a result, when a new imaging device, surgical robot, or diagnostic service is considered, it is typically the doctors (often the professor or head of the department) who evaluate it and have significant influence on whether the hospital acquires it.

Doctors often drive the introduction of new drugs as well by advocating for them on the hospital formulary.

- **Limited Role of Non-Physician Decision-Makers:** Roles that are important in U.S. healthcare business decisions – such as **procurement managers, hospital IT managers, or insurance (payer) representatives – do not have the same power in Japan's system.** For instance, a U.S. hospital might have an administrative committee or procurement department that vets and approves capital equipment purchases, and insurance companies or pharmacy benefit managers decide drug formulary placement. In Japan, by contrast, purchasing decisions heavily rely on physician preferences. One industry analysis noted that because many local hospitals are run by physicians, the **doctors are the key decision-makers for most major hospital purchases** [7]. There is a group purchasing system emerging for cost savings, but even so, if the leading doctors at a hospital want a certain device or implant, their recommendation carries decisive weight. Likewise, Japan's healthcare payment is a uniform national fee schedule — there aren't multiple private insurers denying coverage — so **private payers do not intervene in care decisions**. Essentially, if a treatment or device is approved by the government (MHLW) and listed on the fee schedule, the decision to use it at a given hospital comes down to the physicians and their hospital administration (which often is physician-led).

- **Distributor Influence:** An important aspect in Japan is the role of medical device and drug **distributors** who work closely with physicians. Instead of independent hospital procurement committees, many hospitals rely on trusted distributor companies (and reps) who supply equipment and products. Physicians collaborate with these distributors to get the products they prefer into the hospital. The distributor acts as a facilitator, but the **physician's endorsement is what drives adoption.** In practice, a senior doctor saying "we should use this new stent or this new MRI machine" is usually the critical factor, with the distributor handling logistics and the hospital administration rubber-stamping if budget allows. This is different from the U.S., where value-analysis committees or non-clinical executives might have more say.

Implication: Physicians (especially senior ones) are the pivotal stakeholders for any market research about medical product adoption or decision-making in Japan. If we need to understand how a new drug, device, or service would be evaluated in Japanese hospitals, we must talk to the physicians in charge (e.g. department heads, influential specialists) because they hold the authority that might be split among pharmacy directors, procurement managers, or payers in other countries. It is usually not fruitful to interview a non-physician administrator about such decisions in Japan, as they will likely defer to what the doctors decide. This physician-centric decision culture means our research sampling needs to be weighted heavily toward the **key doctor influencers** in the relevant field. For example, for a new imaging equipment study, interviewing radiology chiefs or hospital directors (who are MDs) would be crucial, whereas interviewing a hospital purchasing manager alone would miss the true decision influencer.

Implications for Market Research in Japan

Understanding these structural differences helps us plan and execute Japan-specific research projects more effectively:

- **Target the Right Specialists (Translating Titles):** Always verify the equivalent Japanese role for any given target **before recruiting**. Do not assume a U.S./EU title exists in Japan. For instance, if a client wants to survey "oncologists" about a cancer therapy, we will likely recruit **organ-specific cancer treaters** (surgeons or physicians in that therapy area) rather than look for general medical

oncologists. If the topic is cardiac stents, we recruit cardiologists (especially those doing catheter interventions), since Japan has no distinct interventional cardiologist designation. We proactively explain these mappings to clients using tables like the above, to ensure they agree that the chosen Japanese experts match the intent of their research. This may involve some client education, but it is essential for getting valid insights.

- **Physician Interviews for Treatment & Adoption Topics:** In Japan, **physicians are almost always the appropriate interviewees for questions about treatment decisions, prescribing habits, adoption of new drugs, or choosing medical devices.** These are within the physician's exclusive domain. If a research question is "How do you decide to prescribe Drug A vs Drug B?" or "What influences the hospital to start using a new surgical tool?", the respondents must be doctors (the relevant specialty, and often those in leadership roles). We should prioritize senior physicians like department heads or professors for topics involving **hospital-level decisions or new technology adoption**, as they often drive those choices (as discussed above). Junior physicians can speak to usage and patient treatment pathways, but major adoption usually depends on senior staff.

- **Use of Non-Physician Respondents (with Caution):** There are certainly areas where **non-physician healthcare staff** can provide valuable insights in Japan, but these tend to be in domains other than medical decision-making. For example, **nurses** in Japan could be interviewed about **care coordination, patient education, workflow, or how a new process might be implemented on the ward**. They can discuss challenges in patient adherence or nursing workload or how they support the physician's plan. However, we would **not interview nurses about drug selection, prescription preferences, or device purchasing** – those lie outside their authority in Japan (unlike maybe interviewing a nurse practitioner in the US about prescribing). Similarly, **hospital pharmacists** in Japan can discuss dispensing or counseling, but they do not decide formularies independently (formularies are typically decided by a committee of doctors). And since private insurers don't dictate coverage on a hospital level, interviewing "payers" is usually irrelevant in Japan's context (the "payer" is the national system).

- **Clarify Client Expectations:** It's important to set expectations with global clients that successful fieldwork in Japan may require a different mix of experts. We emphasize that **recruitment must identify the de-facto decision-makers**, which might mean adjusting the sample. For instance, if a client asked in the U.S. for 5 oncologists and 5 oncology nurses, in Japan we might recommend 5 organ-specialist physicians and perhaps 5 nurses only if the questions pertain to nursing care – otherwise, maybe 10 physicians instead. We justify these changes by explaining the unique role distinctions: e.g., "In Japan, **only doctors can speak to treatment adoption**, so we will include more physicians and not include nurses for those questions, to ensure valid data." This kind of consultation protects the study from misguided sampling.

- **Leverage Japanese Data and Sources:** When explaining these differences, we often cite local regulations or society guidelines. For example, pointing out that **nurses cannot prescribe or make diagnoses under Japanese law** [3] and that **PAs are not recognized in Japan** [5] reassures the client that we are following the realities of the Japanese system (not just an opinion). We also highlight data such as the number of medical oncologists being relatively low in Japan [2] to show why we need organ specialists. Providing these facts (from MHLW, Japanese medical societies, etc.) in our documentation helps the global pharma or research teams understand the rationale behind our recruiting strategy.

- **Case Example – Device Adoption:** Suppose a client wants to research the adoption of a new MRI machine and in the U.S. they might talk to hospital procurement managers, finance officers, and

radiologists. For Japan, we would advise focusing on **senior radiologists and perhaps the hospital director (who is often a physician)**, and possibly a distributor perspective, rather than a standalone procurement manager. We'd explain that the **hospital director or department chief will decide the MRI purchase in Japan** [7], and the purchasing manager mostly handles the paperwork. By adjusting the target roles, the research will capture the true decision process in Japan.

In summary, conducting healthcare market research in Japan requires an awareness of its **physician-centric model** and a willingness to adapt target criteria away from a U.S. blueprint. By understanding that oncology is organ-driven, some specialties don't exist, nurses and mid-levels have limited authority, and physicians carry broad decision-making power, we can **design studies that recruit the right experts** and yield credible, actionable insights. Our role as your research partner is to navigate these nuances and ensure your Japan market research is both compliant with local realities and aligned with your overall research objectives. We will continue to provide guidance and justification for any localization of target profiles – helping you successfully reach the **true decision-makers and influencers in the Japanese healthcare system**.

Sources:

- Rawlinson, R. The Japanese Healthcare Revolution – Noting that tumors in Japan are typically treated by the organ's specialist (e.g., pulmonologist for lung cancer) and that formal medical oncology is a newer field (about 1,060 certified medical oncologists as of 2015) [1] [2].
- Pacific Bridge Medical News – Explaining that Japanese hospitals are often physician-led, with doctors as key decision-makers for major purchases [7].
- Japanese Nursing Law/Practice – Until recently, nurses in Japan could not diagnose or prescribe without a doctor's order [3], and Japan has no independent physician assistant role (no PA programs or national certification) [5].
- BMC Nursing (2020) – Describing the Japan Nurse Practitioner (JNP) system: even with advanced training, JNPs must work under physician instruction and cannot make treatment decisions autonomously [4].
- Fraser Institute – Observing that Japanese clinics are physician-led with nurses in a more limited care role (reflecting the greater authority of doctors in patient care) [6].

---

[1] [2] The Japanese healthcare revolution - The Planning Shop
https://planningshopintl.com/resource/the-japanese-healthcare-revolution/

[3] Nursing in Japan - Wikipedia
https://en.wikipedia.org/wiki/Nursing_in_Japan

[4] Japanese nurse practitioners' legal liability ambiguity regarding their medical practice: a qualitative study | BMC Nursing | Full Text
https://bmcnurs.biomedcentral.com/articles/10.1186/s12912-020-00458-2

[5] Q: What is a Physician Assistant Japan job?
https://www.ziprecruiter.com/e/What-is-a-Physician-Assistant-Japan-job

[6] fraserinstitute.org
https://www.fraserinstitute.org/sites/default/files/health-care-lessons-from-japan.pdf

[7] Role of Physicians and Universities in Sales in Japan
https://www.pacificbridgemedical.com/news-brief/medical-device-sales-in-japan-role-of-physicians-universities-explained/