

The Future of Hospital Medicine in Japan: Lessons From the United States Hospital Medicine System

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Purpose: To compare hospitalist roles and training systems between the United States (US) and Japan, identifying strengths and challenges to guide development of Japan's emerging hospital medicine program.

Methods: A qualitative, descriptive narrative study was conducted during a 10-day observational site visit to the Veterans Affairs Ann Arbor Healthcare System and University of Michigan Hospital in October 2022. Two experienced Japanese hospitalist authors independently observed clinical rounds, interprofessional meetings, and educational sessions. Data were collected through direct observation and structured discussions focusing on care-team structures, workflows, multidisciplinary collaboration, educational approaches, and quality improvement activities. The authors subsequently developed a comparative analysis report of Japan-US differences. Guided discussions based on this report were conducted with experienced US hospitalists and a pioneer physician of General Medicine in Japan to obtain expert commentary on the analyses. No quantitative data analysis or specific analytical software was utilized for this narrative comparison.

Results: The US hospitalist model demonstrated group practice approaches with shift-based schedules supporting work-life balance. Multidisciplinary teams actively incorporated residents and students in patient care, quality improvement, and teaching. Japan's traditional attending physician model emphasized continuity of care but showed high workloads and limited multidisciplinary integration. Japanese hospitalists faced challenges including extensive work hours, fewer specialized training opportunities in quality improvement and patient safety, and less robust team-based learning environments.

Conclusion: Incorporating elements from the US model—such as group practice with shift-based systems, enhanced multidisciplinary collaboration, and structured educational and quality improvement initiatives—could address workload issues and foster professional development in Japan's hospital medicine system while preserving valued aspects of continuity of care. These findings provide specific actionable guidance for healthcare administrators, medical education directors, and policymakers involved in developing Japan's hospitalist system, as well as to practicing Japanese hospitalists seeking to enhance their professional practice environments and educational frameworks.

Keywords: health systems comparison, quality improvement, medical education, multidisciplinary care

Introduction

Hospitalists are physicians dedicated to the specialized care of patients within a hospital setting.¹ Over the last 20 years, the hospitalist workforce in the United States (US) has expanded to exceed 50,000 professionals, establishing hospital medicine as a cornerstone of the US healthcare system.² In the care of older adults with multimorbidity, the expertise of hospitalists has been linked to reductions in both the length of hospital stays and overall hospitalization costs.^{3,4} Hospitalists were also instrumental during the peak of the COVID-19 pandemic.^{5,6} Beyond direct patient care,

hospitalists assume leadership roles across various facets of healthcare, including patient safety, quality improvement (QI), and medical education.^{2,7,8}

Hospitalists are anticipated to play an increasingly vital role in inpatient care in Japan,^{9,10} a nation confronting challenges associated with a rapidly aging population and a declining birthrate, the lowest among countries within the Organization for Economic Cooperation and Development (OECD).¹¹ These demographic shifts place increasing demands on inpatient services and physician workforce sustainability, motivating exploration of efficient and effective care models. Furthermore, concerns regarding physician workload and burnout in Japan underscore the need to examine different approaches to hospital care delivery.^{12–15}

In Japan, General Medicine is a specialty encompassing family medicine physicians and hospitalists under a unified board, is a relatively recent discipline, formally established in 2018. However, the precise definition and role of “hospitalists” in Japan remain somewhat ambiguous. Their duties often extend beyond inpatient care to include outpatient services and sometimes provide urgent care,¹⁶ differing from the primarily inpatient focus seen in the US. Thus, the term “hospitalist” itself is not yet universally adopted or understood in Japan. Furthermore, hospital medicine is being introduced as a subspecialty within this broad field of General Medicine in 2023,⁹ presenting challenges given that General Medicine itself is still developing its distinct identity compared to the long-established field of internal medicine, which traditionally manages the majority of complex adult inpatients. Given this evolving landscape and lack of clarity, it is instructive to examine the Japanese hospital medicine system and its training environment by contrasting them with those in the US, where hospital medicine is firmly established.

Therefore, our aim was to compare the roles and training systems of hospitalists in the US with those developing in Japan. We achieved this by observing the hospital medicine system at two US academic institutions and engaging in detailed discussions with US hospitalists. This comparative analysis is timely as Japan shapes its own hospitalist system. By analyzing observed practices in the US system and contrasting them with the nascent Japanese system, we sought to identify potential lessons and areas for consideration relevant to Japanese healthcare leaders, policymakers, and educators. This study provides insights intended to inform the development of hospital medicine practice and training in Japan, recognizing that any potential adaptations would require careful consideration of the unique Japanese context. In this paper, we present a summary and discussion of our observations, culminating in considerations for potentially enhancing hospital medicine practice and training in Japan.

Methods

Study Design and Setting

This qualitative study employed a descriptive narrative design, utilizing qualitative data gathered through direct observation and in-depth discussions with Japan and US physicians. In accordance with this methodological approach, we conducted standardized observational checklists, formal interview protocols, and specific qualitative data analysis software were not utilized. Two Japanese hospitalists (TS, KK) conducted a 10-day site visit (October 3–13, 2022) at two US institutions: the Veterans Affairs Ann Arbor Healthcare System (AAVA), a government-operated facility within the larger VA integrated healthcare system, and its academic affiliate, the University of Michigan (UM) Hospital, a major academic medical center. The investigators systematically documented observations and synthesized comparative analyses between Japanese and US hospitalist practices. Subsequently, guided discussions were facilitated by US hospitalists and a pioneering Japanese physician in the Japanese hospitalist system to further interpret the collected narrative findings.

Participants, Data Collection, and Analysis

Participants

The study team comprised four Japanese physicians and two US hospitalists. The primary observers were two experienced Japanese hospitalists (TS and KK, with 13 and 12 years of clinical practice in Japanese university/community teaching hospitals, respectively). These observers visited AAVA and UM, focusing particularly on hospitalist practice and training within inpatient general medicine teams at AAVA. An additional investigator (TW) had dual professional experience as a researcher and

educator at both UM/AAVA over a year, and Shimane University Hospital, providing valuable cross-cultural contextual understanding. Two US physicians were experienced hospitalists and faculties at UM/AAVA (NH, SH). A pioneering physician of General Medicine in Japan (YT) and the US physicians (TW, NH, SH) served as expert consultants for data interpretation.

Data Collection

Data collection consisted of direct observation of clinical team activities, including: daily rounds (both bedside and conference room formats), team meetings, handoffs, educational conferences, and patient care interactions. Observations focused on key domains: team structure, workflow patterns, communication processes, roles of various team members (including trainees), multidisciplinary collaborations, integration of educational activities into clinical workflow, and typical daily schedules. Informal discussions were conducted with US authors (NH, SH, and TW) and other attending physician hospitalists, residents, students, and non-physician professionals at AAVA and UM.

Analysis

The visiting investigators independently documented field notes while joining different care teams. These notes were then synthesized through repeated discussions among the Japanese observers (TS and KK) and the investigator with dual-system experience (TW), producing a comparative analysis report of Japan-US differences in hospitalist practice. Guided discussions were subsequently conducted with experienced US hospitalists (NH, SH) and a pioneering physician of General Medicine in Japan (YT) to provide expert commentary on the preliminary comparative analyses. These discussions explored specific domains: team structures, workload management strategies, shift scheduling systems, dynamics of multidisciplinary collaboration, educational approaches for trainees, quality improvement activities, and perceived strengths and limitations of the US system compared to the Japanese context.

Rationale for Site Selection

Michigan Medicine (MM), UM's academic medical center, has a historically prominent department of internal medicine.^{17,18} UM established one of the first university-owned hospitals in the US and remains a leading healthcare institution and teaching facility.^{17,18} The Chair of Medicine at AAVA (Sanjay Saint) is a prominent figure in hospital medicine, known for work in healthcare quality and safety research (eg, device-related infection prevention),¹⁹ and faculty development.^{20–22} This fosters a strong academic hospital medicine division. Both institutions are highly rated (MM for its internal medicine program,^{23,24} AAVA with a 5-star CMS rating).

Given UM/AAVA's national prominence in academic hospital medicine, commitment to quality and education, and AAVA's characteristics (VA teaching hospital with an average length of stay somewhat comparable to Japanese teaching hospitals –13 days in VA hospitals, 16.1 days in Japan²⁵), these sites were deemed informative for a comparative study aimed at understanding differences and potential lessons. However, we acknowledge these institutions may not reflect the diversity of all US hospitalist practices (eg, community or private settings).

Results

Comparative Analysis of Hospital Medicine: Japan and the United States

Drawing upon the observed distinctions between hospital medicine in Japan and the US, we discuss the potential applicability of US practices to enhance the developing hospitalist system in Japan. This discussion is structured around the relative advantages of each system and offers potential recommendations for Japan. [Table 1](#) provides a comparative overview of selected characteristics of hospital medicine practice in Japan and the United States. It is important to note that these points are based on the authors' experiences, discussions, and observations during the site visit to UM/AAVA, supplemented by cited literatures.

Difference in Hospital Practice

Hospital Practice in Japan: Attending Physician System and Continuity of Care

Japan maintains a high density of hospital beds (12.6 beds per 1000 population based on OECD data for 2021).²⁵ The attending physician system is widely prevalent in Japanese hospitals. This system places considerable responsibility on individual

Table 1 Characteristics, Advantages, and Potential Disadvantages of the Japanese and the United States Hospital Medicine Practice

	Japan	USA
Characteristics in practice	•Doctors per capita: 2.6 ^a •Beds per capita: 12.6 ^b •Universal insurance coverage •Attending physician system •Physicians conduct (invasive) procedures •Provides outpatient care	•Doctors per capita 3.7 ^a •Beds per capita 2.8 ^b •Shift work •Mix of private and government insurance •Procedures are conducted by specialized staff •Specialized to inpatient care •Perioperative co-management
Advantages	•Continuity of care (accountability to the patients) •Fewer handovers	•Focus on inpatient care •Standardized handover •Advanced multidisciplinary team practice •Focus on quality and safety •Advanced education system
Disadvantages	•Difficult to focus on the ward patient management •Lack of standardized handover•Insufficient multidisciplinary cooperation •Lack of perspective in quality of care and patient safety •Inadequate education system •Long working hours	•Discontinuation of practice in terms of transition of care •Frequent handovers

Notes: a: Value for Japan updated based on recent World Health Organization data (2.6 physicians per 1000 population, 2022). Value for USA from Ref 45, b: Reference 25 (OECD data, 2021),

Abbreviations: USA, United States of America; OECD, Organization for Economic Co-operation and Development.

attending physicians, who may be expected to be available for after-hours calls or ward visits, sometimes irrespective of formal on-call status. In contrast to the primarily inpatient focus observed in US hospitalists at UM/AAVA, physicians often functioning as hospitalists in Japan frequently provide both outpatient and inpatient care. This dual role can offer continuity of care when patients seen in outpatient settings require hospitalization. Furthermore, Japanese hospitalists are often proficient in a broad spectrum of bedside procedures, as reflected in curricula like that of the Japanese Society of Hospital General Medicine. A cross-sectional study in 2022 indicated that internal medicine physicians in Japan involved in inpatient care work approximately 49.6 hours per week (198 hours per month).¹²

Hospital Practice in the United States: Group Practice, Nocturnist Systems, and Work-Life Balance

The US has a lower hospital bed density (2.6 beds per 1000 population based on OECD data for 2021).²⁵ At the visited institutions, hospital medicine operates under a group practice model with shift-based schedules. Many US hospitals utilize nocturnist systems, where dedicated night-shift physicians manage overnight care. While necessitating handoffs, this reduces the after-hours workload for daytime hospitalists. Rather than managing inpatients across diverse conditions and performing numerous procedures themselves, US hospitalists at these sites frequently coordinated care involving specialists for specific interventions (eg, procedural services, interventional radiology for central line placement). US hospitalists commonly work schedules like 7 days on, 7 days off. Data from a US survey suggests average working hours around 67.3 hours per week during “on” weeks, potentially totaling around 134.6 hours over a 14-day work period within a typical 14-on/14-off schedule.²⁶ The authors perceived this shift-based group practice model, combined with nocturnist systems, as contributing to a different work-life dynamic compared to the traditional Japanese attending physician model.

Differences in Team Structure and Responsibilities

Care Team Structure and Responsibilities in Japan: Medical Students as Observers

A typical Japanese inpatient-ward care team, based on our observations, consisted of an attending physician, 1–2 senior residents (with > 3 years of experience), 2–3 postgraduate year 1 (PGY–1) interns and PGY–2 residents, and 0–2 medical students. Teams typically manage approximately 20 inpatients. Senior residents are integral to internal medicine training programs, while

transitional-year training for specialties outside internal medicine were uncommon. The attending physician or senior resident generally assumes primary responsibility for patient care. Medical student involvement in direct clinical care was observed to be less active compared to the US. While Japanese medical students participate in history taking, physical examinations, and may perform simple procedures under supervision and contribute to chart documentation, their role seems predominantly observational, with limited active engagement in patient management. They never allowed to order tests or prescriptions even under supervision of senior physicians. Attending physicians are assigned to patients, while residents and interns typically rotate between care teams typically every 1–2 months.

Care Team Structure and Responsibilities in the United States: Active Participation of Students

At AAVA, a typical inpatient general medicine care team comprises 4–5 UM (University of Michigan) medical students, 2–3 PGY-1 residents (from Internal Medicine or Medicine/Pediatrics residency, or preliminary year interns in Neurology or Ophthalmology), and often includes Psychiatry interns rotating for a one-month inpatient medicine rotation. Each team is led by a resident at the PGY-2 level or above in Internal Medicine or Medicine/Pediatrics and manages up to 16 patients. Attending physicians supervise teams in half-month rotations.

US medical students actively participate in comprehensive patient management from admission to discharge. Their responsibilities include drafting initial orders (requiring co-signature by a resident or attending), contacting consultants, coordinating care, and preparing discharge summaries. Unlike in Japan where medical students typically assume an observational role, US students are permitted to place clinical test and prescription orders under the supervision of attending physicians when deemed appropriate. This hands-on approach contributes significantly to their clinical education and preparation for residency training.

Differences in Team Rounds, Schedules, and Education

Team Rounds and Daily Schedule in Japan: Education Often Outside Work Hours

Team rounds in Japan exhibit varied structures, including team room discussions (card- flip rounds), patient presentations on wards, and bedside presentations. Pre-rounds (information gathering before rounds) are not consistently practiced. Following bedside rounds led by the attending physician, residents, and students, the attending physician and senior residents often provide outpatient care 1–3 times weekly. Didactic lectures by attending physicians are occasionally provided, sometimes scheduled outside of regular work hours.

Team Rounds and Daily Schedule in the United States: Integrated Learning Opportunities

While the structure of team rounds is broadly similar to Japan, notable differences exist in the US. At UM/AAVA, residents and students receive overnight updates from the night-shift team leader. This is followed by pre-rounds, during which team members gather patient information, conduct focused assessments, review overnight events, and formulate assessment and treatment plans. A typical weekday schedule observed for trainees and attending physicians at UM/ AAVA is shown in [Table 2](#).

Team rounds then commence, attended by a supervising attending physician, nurse care coordinator, and clinical pharmacist—a multidisciplinary approach that enhances comprehensive patient care. Rounds incorporate card-flip discussions, patient presentations on the wards, bedside discussions, conversations with patients and families, and importantly, integrated educational components throughout the process. The attending physician provides critical teaching points during rounds and actively solicits input and teaching from all team members, fostering a collaborative learning environment.

Afternoon time for attending physicians is frequently dedicated to assisting senior residents, teaching, patient care management, and research meetings, prior to handoff to the night shift. Furthermore, faculty members (attendings, chief residents, professors) regularly conduct educational conferences and lectures several times per week in the afternoons, with protected time specifically allocated away from clinical duties to ensure participation—a structural element that emphasizes the institutional commitment to education.

Table 2 Weekday Schedules for Inpatient-Care Team; Students, Interns, Residents, and Attending Physicians at the University of Michigan/VA Ann Arbor

Time	Activity	Participants Involved	Notes
07:00–08:00	Sign-out from Night Team / Pre-rounding	Residents, Interns, Students	Gather patient data, focused assessments
08:00–11:00	Team Rounds (Card flip, Ward presentations, Bedside)	Attending, Residents, Interns, Students, Pharmacist	Includes teaching, patient interaction
11:00–12:00	Interdisciplinary Team Meeting (Mon/Wed/Fri) / Follow-up tasks	Attending, Residents, Interns, Students, Pharmacist, Nurse Coordinator	Discharge planning, address barriers
12:00–13:00	Noon Conference / Lunch	Residents, Interns, Students, Faculty	Protected educational time
13:00–16:00	Patient Care Tasks, Consults, Admissions, Discharges, Teaching	All team members	Attending supervises/assists residents
16:00–17:00	Afternoon Teaching / Resident Report / Prepare Handoff	Attending, Residents, Interns	Focused teaching, summarize day
17:00 onwards	Handoff to Night Team	Day Team Residents/Interns to Night Team	Standardized sign-out process

Notes: This table illustrates a typical weekday schedule for an inpatient general medicine team at the observed US institutions (UM/AAVA), highlighting the integration of patient care, multidisciplinary collaboration, and educational activities throughout the day. Actual timings and activities may vary.

Differences in Multidisciplinary Team Practice

Physician-Centric Team Practice in Japan: Static Multidisciplinary Cooperation

Multidisciplinary team collaboration is important for comprehensive patient care.^{27,28} Based on observations, non-physician and non-medical professionals appear not to be consistently integrated into inpatient care teams in Japan. While patient information may be shared in conferences, real-time, dynamic problem-solving was observed to be less frequent. For example, when pharmacists do not actively participate in ward rounds and patient assessments, medication adjustments and pharmaceutical care implementation may be delayed. Additionally, observations suggested that differing perspectives between physicians and non-physicians sometimes appeared to impede open discussion. The multidisciplinary cooperation in Japanese inpatient care could be characterized as more “static”, with less dynamic real-time interaction and integration compared to the US sites observed. This difference in collaborative approach may have implications for workflow efficiency and care coordination.

Dynamic Real-Time Multidisciplinary Team Practice in the United States

Multidisciplinary patient care is implemented in daily practice at AAVA. Nurse care coordinators and clinical pharmacists serve as integral members of each inpatient team. They participate in daily rounds, review orders, coordinate follow-up care, perform medication reconciliation, and facilitate real-time care plan adjustments. Each team is also supported by a dedicated social worker. After rounds, brief interdisciplinary team meetings occur 2–3 times weekly, attended by representatives from various disciplines (nursing, pharmacy, social work, physical therapy, dietetics, and others). These meetings focus on addressing discharge barriers and patient/family needs, supporting timely care transitions. The multidisciplinary collaboration observed at AAVA is characterized by real-time cooperation and integration of diverse professional perspectives into daily patient care.

Quality Improvement Activity Opportunities During US Residency Training (Observed at UM)

The UM residency program incorporates a dedicated four-week ambulatory rotation focused on patient safety and quality improvement (QI) education through hands-on project work. Each team comprises a faculty facilitator, a QI specialist, and 4–6 residents, meeting three times weekly for experiential learning. While formal participation is limited to 4 weeks,

successful projects may evolve into longer-term longitudinal initiatives. In contrast, based on the authors' personal experiences at both institutions, Japanese residents have fewer structured opportunities for routine QI participation during their training period.

Discussion

Drawing upon the observed distinctions between hospital medicine practices in Japan and at the visited US institutions, we discuss the potential applicability of certain US approaches for enhancing the developing hospitalist system in Japan. This discussion is structured around the relative advantages of each system, particularly in medical training and quality improvement activities. We consider potential advantages and challenges, especially within the context of Japanese internal medicine/general medicine practice, and offer considerations for Japan while acknowledging the need for careful adaptation to the unique Japanese healthcare environment.

Relative Advantages of the Hospital Medicine Systems in Japan and the United States

The established educational system and academic infrastructure observed at UM/AAVA appear to contribute to the effectiveness of hospital medicine in the US, potentially leading to improvements in inpatient care and safety.^{2,29} The US system demonstrates strengths in group practice, shift-based work models, structured multidisciplinary collaboration, and a strong emphasis on QI and patient safety integrated into training and practice. The adoption of these approaches gained prominence in the US, underpinned by early evidence suggesting their capacity to improve inpatient care efficiency.³⁰ While the Japanese hospital medicine system is still developing a distinct hospitalist identity, it offers the inherent advantage of care continuity through the traditional attending physician model with fewer handoffs.³¹ However, this study did not measure comparative outcomes or definitively demonstrate the superiority of one system over the other.

Adopting elements of the US group practice approach, with appropriate adaptation to the Japanese healthcare context, could assist Japanese physicians in achieving improved work-life balance while maintaining quality of inpatient care. The US shift-based model, such as a 7-day on/7-day off schedule, provides physicians with dedicated time for personal pursuits, research, and rest, which may be particularly beneficial in addressing physician workload and burnout concerns prevalent in Japan.^{13–15}

Considerations for Enhancing the Hospital Medicine System in Japan

To mitigate the substantial workload and potential for burnout associated with the Japanese attending physician model,^{13–15} exploring a gradual evolution towards elements of group practice and nocturnist programs, learning from the US experience, could be considered. Currently, many Japanese physicians, including those functioning as hospitalists, concurrently manage inpatient wards and outpatient clinics,³¹ resulting in demanding schedules. While the traditional physician system in Japan emphasizes continuity of care,³¹ the sustainability of this model warrants careful consideration, especially as the need for specialized inpatient expertise grows. Adopting aspects of a multidisciplinary, group-based practice might help redistribute workload and potentially reduce excessive working hours per physician. Implementing elements like nocturnist systems could enhance physician well-being. Although group practice necessitates handoffs, standardized protocols and effective electronic systems, as employed in the US,^{32–35} can help manage risks associated with care transitions. Providing remote access to electronic records could also increase flexibility and improve work-life balance. Integrating multidisciplinary collaboration more deeply into practice models can further optimize workflow, improve communication, potentially shorten hospital stays, and enhance patient safety.^{36–38}

Adjusting Inpatient Care Team Composition for Enhanced Multidisciplinary Integration

In Japan, hospitalists are expected to possess broad expertise across multiple specialties and ensure continuity of care as the central figures in inpatient management.¹³ While these physicians demonstrate extensive medical knowledge to cover a wide range of clinical conditions, the Japanese hospital system appears to place less emphasis on the integration of multidisciplinary team members into daily practice compared to models observed in other healthcare systems such as AAVA. To potentially enhance both patient care and medical education, consideration could be given to actively incorporating non-physician professionals (nurses, pharmacists, social workers, therapists, dieticians, etc) into daily

inpatient care teams and rounds. Such an approach, emulating the dynamic collaborative models observed in US institutions such as AAVA, could facilitate task-sharing, optimize resource utilization, improve interprofessional communication, and provide richer learning environments that expose medical students early in their education and residents early in their professional careers to team-based care.^{39,40} Furthermore, this enhanced multidisciplinary teamwork might support Japanese hospitalists in more effectively co-managing complex patients across various medical conditions, potentially improving both efficiency and quality of care.^{41,42}

Developing Hospitalists as Leaders in Clinical Care, Patient Safety/QI, and Research

To foster the academic maturation of hospital medicine in Japan, encouraging hospitalists to contribute not only in clinical care but also in patient safety, QI, and related research might be valuable. While traditional clinical research remains important for academic medicine, hospital medicine research in the US often emphasizes QI and safety initiatives,^{7,43} reflecting a focus on system-level improvements in inpatient care. Academic advancement for US hospitalists can be linked to scholarly publications, including QI and patient safety domains.⁴⁴

In contrast, a survey study from 2000 indicated that research within general medicine departments at Japanese university hospitals prioritized clinical research, public health, and preventive medicine, with less emphasis on medical quality and safety research.¹⁰ Given this difference, Japanese hospitalists might benefit from increased engagement in QI and patient safety activities alongside related scholarship. This expansion of focus could enhance both patient care outcomes and hospitalists' professional development.

To support this evolution, Japanese stakeholders could potentially collaborate to develop educational approaches that incorporate clinical practice, healthcare quality and safety, research, and leadership domains. These approaches might draw upon established competency frameworks such as the Society of Hospital Medicine Core Competencies,¹ which provide a comprehensive blueprint for hospitalist development beyond clinical expertise alone.

Expanding Teaching Opportunities and Roles for Hospitalists in Japan

The presence of hospitalists in US teaching hospitals appeared to enrich the educational experience for medical students and residents.⁴⁵ At UM/AAVA, a collaborative practice engaged in by all members of the medical team including faculties and learners. US trainees perceive hospitalists as effective teachers.⁴⁵ To enhance medical education, particularly within internal medicine/general medicine training programs, and cultivate future hospitalists in Japan, creating more formal and informal teaching opportunities could be valuable. This might involve integrating hospitalists more formally into residency and medical student education programs, providing protected time for teaching activities, and recognizing teaching contributions. Furthermore, promoting peer learning through multidisciplinary collaboration, as observed, appears essential for development of learners.^{39,40} Incorporating various healthcare professionals into ward rounds and educational activities may not only improve patient care but also provide valuable interprofessional learning experiences, potentially fostering a culture of teamwork and mutual respect.

Practical Implications and Considerations for Adaptation in Japan

The observations from UM/AAVA suggest potential avenues for refining Japan's hospital medicine approaches, but direct transfer is unlikely feasible or desirable. Implementation would require careful consideration of Japan's unique context.

Economic and Policy Feasibility

Implementing models that incorporate increased shift work (eg, nocturnists) or comprehensive quality improvement (QI) programs would require substantial investment in both personnel and finances. Such investments would need to address several key areas: increased staffing costs to ensure adequate coverage, dedicated funding for QI training and infrastructure development, and strategies to overcome potential workforce shortages. Additionally, regulatory challenges related to working hours and scope of practice would need to be addressed.

As discussed in the introduction, evidence suggests that hospitalist systems may reduce both length of hospital stays and overall hospitalization costs.^{3,4,30} While Japanese healthcare institutions operating under the Diagnosis Procedure Combination system—a per-diem payment system with rates that decrease across three periods based on length of stay—

face reimbursement incentives designed to optimize rather than minimize hospitalization duration,⁴⁶ hospitalist systems could potentially contribute to more efficient clinical processes and appropriate discharge timing, ultimately supporting national healthcare cost containment efforts.

Cultural Adaptation

Japanese healthcare culture places a strong value on continuity of care provided by a single attending physician, fostering deep physician-patient relationships. Shift-based models inherently disrupt this continuity, which might face resistance from both patients and physicians. Established team hierarchies, communication styles, and different philosophies regarding medical education also need consideration. Any adopted changes must be culturally sensitive and likely implemented gradually.

Implementation Approach

While a detailed implementation blueprint is beyond this study's scope, principles for implementation might include: initiating pilot programs in willing institutions to test specific elements (eg, enhanced multidisciplinary rounds, limited shift scheduling), developing targeted training initiatives for hospitalists and other team members, engaging all stakeholders (including patients) in the planning process, and adopting a phased approach with ongoing evaluation and refinement.

Limitations

This study has several important limitations. It is a descriptive narrative report based on observations during a brief (10-day) site visit to a single academic medical center (UM) and its affiliated VA hospital (AAVA). However, this limitation was mitigated by the involvement of investigator TW, who brought unique cross-cultural expertise through dual institutional affiliation. TW spent over a year conducting international research and clinical education at UM/AAVA and collaborated with TS and KK on the initial observation report that formed the foundation for our guided discussions. This cross-cultural perspective strengthened our comparative analysis of hospitalist practices between Japan and the US.

Second, although UM and AAVA are leading institutions, the findings may not be generalizable to the diverse range of hospitalist practices across the US (eg, community hospitals, private practice models) or to all hospitals in Japan. However, the selected institutions represent academic medical centers with established hospitalist systems, providing valuable insights into well-developed models that may inform future directions for hospital medicine globally.

Third, the perspectives presented reflect the experiences and opinions of the participating authors and are based on qualitative observations and discussions, not a systematic quantitative analysis or comprehensive survey of hospitalist systems. Nevertheless, the multi-disciplinary composition of our research team, including both American and Japanese clinicians, enabled triangulation of perspectives that enriches the validity of our observations.

Fourth, the study did not include systematic collection of patient perspectives on care experiences, which further narrows our understanding of the compared systems.

Fifth, our reliance on informal observation and discussion limits direct replicability. These methodological constraints are further complicated by the currently ambiguous and evolving definition of "hospitalist" in Japan, which presents a significant challenge for establishing valid comparisons. Our methodological approach, however, allowed for authentic, real-world observations unconfined by rigid protocols, potentially capturing nuances that might be missed in more structured studies. Given the qualitative, descriptive design, formal statistical analysis was not performed, and the study cannot establish causal relationships or definitively prove the effectiveness of one system over another. Therefore, the findings should be interpreted with caution.

Despite these limitations, this work provides valuable initial insights into cross-national differences in hospital medicine. Further research is necessary, including broader comparative studies across multiple diverse institutions in both countries, incorporating quantitative metrics (eg, workload, patient outcomes, costs, burnout rates) and patient perspectives, and utilizing more structured methodologies over longer periods. Such expanded approaches would develop a more comprehensive understanding and better guide the optimal development of hospital medicine in Japan.

Conclusion

Japanese and US hospitalists, through observations at AAVA and UM, collaboratively identified key characteristics of both hospital medicine systems. This exchange provided valuable insights for hospital medicine development in Japan. US system principles—group practice models, multidisciplinary teamwork, integrated quality improvement, and structured education—offer potential guidance. However, these elements require culturally appropriate adaptation to the Japanese healthcare context, respecting established internal medicine practices and the value placed on care continuity. Successful implementation could enhance physician career development, improve care delivery, strengthen medical education, and advance hospital care quality and safety throughout Japan. These findings inform strategic planning as Japan develops its distinctive approach to hospital medicine.

Ethical Considerations

This study comprises descriptive narrative analysis of healthcare systems based on professional observation and discussion. No research on human subjects was conducted (no patient interventions or collection of identifiable patient data). Therefore, formal ethical committee approval was not required for this comparative systems observation.

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Disclosure

TW has previous professional experience at AAVA and Shimane University Hospital, as noted in the Methods section. The authors report no other conflicts of interest directly related to this work.

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