Never before had I been confronted with the stark discrepancy between the deep-rooted cultural differences in coping with medicine and the desirable fact of a basic uniformity in medicine to such an extent and with such intensity as in the two months of my stay at Shinshu University as an clinical elective.

Being a medical student at the University of Hamburg and also having experienced the American medical system in the course of my studies, it was particularly interesting for me to realize the differences and similarities between these medical systems and that of Japan. Not only have I gathered valuable experience regarding medicine as a science, what was peculiarly revealing to me was the experience I have had with the medical education system as such.

The starting point for my “expedition” into the Japanese medical system was the so-called “Praktisches Jahr”, which German medical students are obliged to undergo in their last year of study. The purpose of this curriculum is to introduce students—to whom medicine has been mainly imparted from its theoretical aspect up to that moment—to the practical and vocational skills. As a prerequisite for obtaining the medical degree, the German licensure regulations provide that, by the end of this practical year, the student must have been involved in Internal Medicine, Surgery and one further subject of choice and have proven his knowledge, chiefly concerning methods in practice, in an oral examination.

On the basis of this educational program I had long considered gaining a comprehensive insight into the medical system and education of my home country, that of Japan. Thanks to a remarkable string of coincidences, I made the acquaintance of Professor Aizawa, who kindly took it upon himself to negotiate with the Medical School of Shinshu University. After a seemingly interminable wait for the application process to pass through the Japanese bureaucracy, he informed me in late March about his success in enabling the very first clinical elective for students abroad at Shinshu University. In spite of being already informed about the Japanese medical system and familiarized with the general schedule by Professor Aizawa, it was not until my arrival in the snow-covered city of Matsumoto that I could grasp the actual circumstances under which Japanese students study medicine.

Since there is no such “practical year” in Japanese medical education, I was engaged in the curriculum of the last year of medical studies, which was the equivalent in regard to the educational course. During my stay my fellow students and I were assigned to participate in courses and seminars in Internal Medicine. The aim of this term stretching over two weeks each in different fields of this particular subject was firstly to attain an overview of the diversity of medical science. Secondly and more importantly it had the function of introducing students to medical examination techniques, including the regular medical checkup. Remarkably, however the actual realizations of these assignments were completely dependant on the individual doctors. And this is where I would like to begin expanding on my comparative observation.

Without going into superfluous details on the specific departments, I must express my thorough astonish-
ment concerning the diverse range of ways of carrying out the education of medical students. On the one hand I had precious experiences with very enthusiastic doctors who meticulously organized their seminars after an ingenious curriculum and under whom students were given one patient case each to e.g. submit reports about. There is no doubt that students were naturally given the possibility to easily advance both scientifically and personally. In stark contrast to this, there were also cases in which the learning contents were not as obviously provided for the students as above, under which conditions students somehow—disregarding whether it was intended or not—learnt to demonstrate their enthusiasm and to encourage their self-reliance. In Germany as well in the United States, the approaches to medical education are respectively more unified and restricted. Tutors do not have a free hand to organize the students’ timetable at will and to spontaneously postpone seminars for unpredictable or personally prioritized matters. The strictly coordinated curriculum may not admit much flexibility, especially for the tutors, but to the same extent this kind of regulations is more favorable to prevent negligence of students and their essential education. Giving a blank check to the tutors can be assuredly of advantage as it offers various alternative teaching methods; however as far as the education of students is concerned, it seemed to me that such a method easily tends to degenerate into confusion.

In this connection I would like to mention the differences in practical teaching in brief. One of the special features of German medical education is probably the early contact with patients. Medical students are already confronted with communication with patients during their pre-clinical years since they are required to work with and assist the nursing staff in a hospital for twelve weeks. This enables students to observe patients, nurses and doctors in all possible communicational combinations. Moreover, students learn not only theoretically but also practically to deal with patients in the course of Psychology and Medical Sociology by interviewing real patients about their handling and attitude towards illness. Three more months of clinical training follow in the clinical semesters in order to experience illness and patients this time from a more medical point of view. And as the close of the medical studies there is the practical year which is—regarding the tasks and responsibility of the students including compiling the medical history of patients and drawing blood—equal to an internship in Japan.

In the United States the medical education is comparable with that of Japan in that students experience their first contact with patients during their clinical elective, taking place rather at the end of the studies. Remarkable about the USA is the financial opportunity which becomes apparent in the education of students. Medical students are coached by professors in a ratio of one to one and the specific fields are adjusted to each student’s needs and interests. Although students do not often have direct contact with patients—this being a reflection of the infamous “suing society”—it was striking that tutors allowed themselves to simulate patients and even allowed clinical examinations on their own bodies.

Of course this kind of education cannot be practiced either in Japan or in Germany for manifold reasons, partly based on societal and cultural backgrounds. However, in Matsumoto I realized that students seldom have contact with patients. The sole “patients” students are permitted to interrogate and examine are voluntary citizens who are given the description of their symptoms beforehand and merely repeat the provided information. Watching this absurd situation: students asking one fake patient questions they have thought up by themselves and on top of it the succeeding students repeating the whole process on the same patient one after another, I could only shake my head in bewilderment. This was the moment I perceived that Japanese students, despite being in the capable hands of renowned researchers, have a tendency to lack in communication skills.

It is by no means my intention to be so impudent as to criticize Japanese medical education. I am aware of the fact that there are deeply rooted societal differences and an irrevocable history behind any state of affairs. Undoubtedly there is partly not much freedom in the choice of behavior and it is perfectly legitimate that, inter alia, security reasons and other responsibility concerns act as an obstacle to intimate contact with

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2 Here I must qualify my statements by pointing out that these are solely based on my experience at medical schools I have directly been in contact with during my studies, i.e. the medical schools of the University of Hamburg, New York University and Harvard University.

3 Eight weeks in the case of the old regulations

4 =Famulatur
patients. Every culture has its own behavioral patterns and rules which must without doubt be tolerated and even conserved. Be that as it may, the important aspect in this is that each culture with its own identity has to make an effort to find its own way of progress adapted to its own specific culture and society. Therefore it cannot be expected from Japanese society to show openness and readiness to be examined by students, as is the case with German patients who have the probability of being checked up by students clearly in mind when admitted to a university or affiliated hospital. Even doctors are conscious about the fact that educating students is a prerequisite for their employment at an institution or university hospital. This awareness certainly exists in the minds of Japanese doctors, too. This appeared to be expressed on a personal basis in the form of recruiting students by attractive events etc. and not to be reflected in the preceding step of the actual education of students.

As I have already mentioned above, a society adapted to education and improvement is the key to success. Not only do I mean this to be carried out in the macrocosm of Japanese society, the adaptation already starts on the regional layer such as Shinshu University and its surroundings. What struck me as interesting and very ideal in Matsumoto was the unique nearness to the citizens which is incomparable with urban anonymity. There is a remarkable intimacy to the people and this automatically facilitates the cooperation of society in educating students, as could be proven by the anamnesis simulation. Of course this approach cannot be unilateral. The initiative must come from the students too and the self-esteem of some Japanese students suppressed by distrust from tutors can also be alleviated by this. But would it not be ideal if the patients’ frank trust in medical doctors could be applied to students as well, so that students could learn and profit more from this societal phenomenon?

It may be against the Japanese mentality of striving for equalization in society especially concerning education, but it is still vital to aim more egocentrically for the greatest benefit one may gain from the given circumstances. The familiarity of patients is only one of various examples. The briefly mentioned personal relations between students and doctors is another situation one could profit from more efficiently. The communication is more personal and hence much better than in other countries. I myself witnessed the friendly and close social intercourse while playing soccer and participating in one of the cherry-blossom viewings. Could not these unparalleled relations contribute to the breeding of doctors in the making, too, if expanded more into medical education? Personal encouragement in the earlier stage of studies, without babysitting but by supporting students, would possibly result in a more determined and orientated learning. Would the result of such an education with regard to both the scientific and personal developmental aspect possibly be an ideal doctor for the patient: one who can display both humane and scientific competence?

Another example of Shinshu—and Japan-specific features is the obligation to take a course in one foreign language during the basic studies. The ability to communicate in a language is one of the most desirable aspects of the internationalization of Japanese students, a key to new perspectives and possibilities. Regrettably, there is no opportunity later on at the university to continue learning the foreign language. The foundations of one of the most important aspects of international competitiveness is already laid and yet not further carried on. Would an offer of a subject-specific course, for instance a Medical English course, not contribute to enhance the flexibility and the aforesaid competitiveness in the world?

This brings me to my last topic complex: internationalization. Nowadays it has become impossible to overlook the intensification of international cooperation and bonds. Oddly enough, the medical system in Japan did not appear to place emphasis on this part of education. International adaptability and experience is simply unavoidable, and preventive of a restricted, inward perspective. It is essential to look out into the world and to learn from others in order not to be left behind in rapid progress and to stay competitive. A firm conservation of traditions and consequently of self-orientation may be virtuous but a transition into a more outward-looking, flexible progression beyond one’s borders is indispensable. It is obvious that I personally, as a student who visited Shinshu University as a “foreign” student, urgently propose that fellow medical students go abroad and gain an insight into new worlds. There is plenty of possibility to seize the opportunity both regarding the time schedule and the framework of foreign universities.

However, at this point, it is essential to draw attention to the subtle meaning of “becoming international”. The emphasis on internationality is in my opinion placed neither in the act of going abroad nor in the sole acquisition of medical knowledge in that country. The purpose of an exchange is the realization of differences in medical systems and furthermore, what is actually most vital, the reflection on one’s own roots, i.e. Japanese society. The lamentable phenomenon is that the more time a student passes abroad, the more he confines himself to blindly adhering to the foreign society and neglecting this essential retrospective cognition. It is the
contemplation of one's own status quo on the basis of the experience gathered abroad that induces the necessary improvement at home and not the scientific knowledge as such. It is utterly wrong to believe that internationalization solely refers to the indiscriminate adaptation of one's society to that of "progressive" countries. What is actually salient in these features is the ability one gains from internationalization to apprehend Japanese society from a new point of view and to scrutinize the pros and cons specifically for this country. This is what the international, global thought actually is there for.

Even though different countries undoubtedly differ in their approaches to medical education, it must not be forgotten that the roots of medicine remain the same. The reason medicine had begun to be practiced was to heal the sick and to improve health care. Consequently, it is one of the most important roles of medical schools and I dare say, the most momentous task to educate students in this more basic, "humane" part of medicine.

During the clinical electives the following Japanese proverb has sunk deeply into my mind: Medicine is a benevolent art. The most precious realization I could achieve during my elective at Shinshu University is the fact that, whatever the frameworks of cultural differences and the connected divergent approaches to medical matters, the fundamental thought of medicine, i.e. to heal the human as a whole complex, does not and should not differ in any country or culture.

This statement may appear quite banal and rather primitive but nowadays in many doctors' minds this starting point is more and more overwhelmed by all the unremitting scientific progress. Ergo it can be often observed that the focal point in the education of medical students drifts into the theoretical, solely scientific knowledge and that the actual human education encompassing the doctor-patient contact is thrust into the background. Is not the ability of overall perception of patients and their illness as a coherent complex the reason why human and humane doctors cannot be substituted for by technically affordable automatons?

There is no denying that these two months in Matsumoto made a valuable and stimulating contribution to both my personal development and my further career. In like manner I can only hope that my internship functioned as a trigger for Shinshu University's incipient opening towards the world. It would be delightful if the university could—in this particular respect: as a “pioneer” institution—contribute to the enhancement of Japanese medical education, and thus to the globalization of future medicine in Japan.

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Boys and Girls, Be Ambitious! 本稿が活字となっている頃には今年の信州大学卒業生の医師国家試験の合格率が明らかになっている。Good news であれば bad news であり、我々はそれを真摯に受け止めなければならない。国家試験合格率は医学教育のアウトカムの一端に過ぎない。本質的には医療の質と量を維持するために医学教育がどうあるべきかが問われている。

縁あって、2004年4月から約2カ月、山村 仁君の信州大学での内科臨床研修のお世話をした。山村君はのびのびとした好青年で信州大学の学生ともすぐにうっとうして、有意義な時間を過ごせた、と言って喜んで帰った。本学の学生諸君にとっても、地球のむこう側で医師を志して努力している一人の日本人の本音を聞き、discussionする貴重な機会となったことと思う。この接触が、山村君と本学の学生諸君にとって、国際的な視点をもった医療人として多様な価値観のもとに共通の道徳を求めて強く生きてゆくきっかけとなることを願っている。私自身も、彼との接触を通じて、医学教育、医師・医療について、また、未来を背負ってゆく若者の生きざまについて、改めて考えることが多かった。

本稿で彼は信州大学の医学教育についての感想を実に素直に述べている。多様な文化に触れ育ち、多様な文化が混ざるヨーロッパに生ける彼（略歴参照）らしく幅広い視点からの比較も提示されている。医学教育の方向を考えてゆく上で参考になる意見を多く含んでいる。

彼は2005年5月から国立ハンブルグ大学放射線科のレジデントとして、そして彼の信州大学でのclassmateもそれぞれに、医師としての第一歩を踏み出している。冒頭の写真は彼の誕生パーティーでのひとこまでの。最終学年の多忙な時間を割って本稿を綴ってくれた山村君に、そして彼を暖かく受け入れてくれた本学の多くの学生や教員の方々に心から感謝申し上げたい。

（信州大学健康安全センター 相澤 歩）