

Misperceptions of medical education in Japan: How reform is changing the landscape

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Abstract. A number of Western physicians have highlighted shortcomings in Japanese medical education over the years. In recent years, however, there has been dramatic change in the system of medical education in Japan that renders some of these observations inaccurate and others worthy of several caveats. Using a recent review article in the *Keio Journal of Medicine* as a starting point for discussion, the author responds to a number of historical concerns about medical education in Japan and includes updated information on recent reforms. (Keio J Med 56 (2) : 61–63, June 2007)

Key words: Japan, medical education, clinical clerkship, residency

Introduction

For many years, Western-trained physicians have highlighted shortcomings in Japanese medical education.^{1–5} In particular, major deficiencies in clinical skills, such as completing a history and physical exam have been described.^{2,6,7}

The most recent contribution comes from Rao,⁸ a professor of medicine at University of Pittsburgh, who bases his comments on accumulated experience from periodic visits over three years to Keio University School of Medicine. Rao's manifold review is a valuable addition to a sparse literature, and his earnest, frank commentary adds a number of incisive insights. (Indeed, I found it remarkably stalwart of the *Keio Journal of Medicine* to publish a manuscript so censorious of its own medical school!) Rao correctly identifies a lingering paradox of medicine in Japan: Why such enviable health outcomes despite a dysfunctional medical education system? His ultimate conclusion is not unlike predecessors in the literature who call attention to, and plead for reform of, striking deficiencies in medical education in Japan.

Purpose

The vast majority of Rao's impassioned observations I

completely agree with, and indeed I have no intent here to question them. The few areas I must claim inaccurate or misleading are ones that are commonly misconstrued. Thus, the purpose of this article is to draw attention to and deepen the discussion of some intricate issues challenging the status quo of medical education in Japan.

Caveats

Rao writes from the experience of a monolingual English visiting professor at a premier private medical school working primarily with a small set of medical students as well as some faculty and residents. As my experience differs, and as past experience undoubtedly colors the lens through which we make interpretations and conclusions, let me mention how my experience differs.

I write as a bilingual English-Japanese American medical student with three banks of relevant experiences. The first is dozens of relationships since 1998 with Japanese medical students, many of whom are now practicing clinicians, at Tokyo Medical University, Tokyo Women's Medical University, Tokyo University, and Keio University. The second source is one year spent employed at Ehime University from 2001 to 2002, teaching medical English to medical students and faculty. And the third is one month spent on a clinical clerkship in internal medi-

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cine at Yokohama City University in 2006.

Commonly heard opinions that Rao and others make of medical education in Japan can be divided into four categories:

1. **The Japanese medical education system is stagnant.**
2. **Undergraduate medical education should be the primary target for reform.**
3. **Japanese physicians are trained as subspecialists and lack the ability to practice general internal medicine.**
4. **Japanese medical students have poor spoken English.**

To be sure, there is abundant supporting evidence for each of these statements. However, these claims also deserve caveats. Here I point out some of the recent developments that render these statements unfairly extreme and inaccurate.

Misperception 1. The Japanese medical education system is stagnant.

A number of dramatic reforms, particularly in postgraduate medical education, have been made to Japan's system in the last several years, just as Rao was beginning his experiences in Japan. Reports of these reforms are just now beginning to make their way into the literature.^{9,10}

First, the Japanese Residency Match Program (JRMP) was established. This system, which is similar to that of the US, is a very important development because it offers graduates the opportunity to self-determine their site of residency training, be it a narrowly focused university hospital program or broad-based community one.

One of the surprises is the steady gravitation of more graduates to the community-based residency programs. In the 1980s, 80% of medical graduates began training at university hospitals.¹¹ Since the first Match results were released in late 2003, the percentage training at university hospital programs has dropped precipitously. By fall 2005 it had dropped to 48%, and the latest figures from fall 2006 show that percentage holding steady at 49%.¹⁰ In other words, whereas the vast majority of students used to train in university hospitals, nowadays a slight majority are choosing community programs.

Second, the Ministry of Health, Labor, and Welfare (MHLW) made a two-year-long internship mandatory to practice clinical medicine. This internship is essentially a general residency, a series of medical and surgical rotations in which the intern is unassociated with any specialty. Seven specialties (internal medicine, surgery, emergency medicine or anesthesiology, pediatrics, psychiatry, community-based medicine, and obstetrics/gynecology) are included. At six months in length, inter-

nal medicine occupies the largest single portion. Observant critics will be hasty to note that the required rotations in internal medicine and surgery are usually merely a series of subspecialty rotations strung together. Nonetheless, it is a major step in standardizing clinical competency across Japan.

Misperception 2. Undergraduate medical education should be the primary target for reform.

This is not the most appropriate target *at this time*, and the reason lies within the very nature of Japanese education. A much more practical and realistic target, if less ideal, is postgraduate medical education, that is, residency training and beyond. Rao eloquently describes the frustrating passivity of his Japanese students, and I endured identical pains in my tenure teaching medical English at one of Japan's national universities. Unfortunately, a few weeks' exposure to an American model of critical thinking and group discussion is woefully inadequate to overcome a passivity that he acknowledges to be "culturally ingrained."

Given this, starting reform at medical school is tragically tardy, and expecting wholesale reform in education so easily is farcical. Take one example: Trying to get Japanese undergraduates, which includes medical students, to take their studies more seriously would require eliminating the preceding years of so-called "entrance exam hell" that cause them to relax once reaching the "Disneyland" of college life.

Of course, there are piecemeal areas of undergraduate medical education reform in Japan. Focusing on enhancing and broadening these reforms is also a simpler and more realistic approach. For instance, Rao deplores the "absence of any bedside clinical instruction." However, the Objective Structured Clinical Exam (OSCE) is a requirement in place at all Japanese medical schools.³ OSCE in Japan is still more form than substance—students view it as easy to pass and perform exams on peers, hardly mimicking real clinical practice. Nonetheless, serious preparation for OSCE would be an excellent opportunity for more clinical instruction. Creating more physical exam practice sessions including both real and standardized patient experiences would be a good step in that direction.

Misperception 3. Japanese physicians are trained as subspecialists and lack the ability to practice general medicine.

This is one of the most distressing concerns. It has been raised by Western general internists as well as family practitioners who have tried to introduce their respective specialties, with limited success, in Japan.⁶ However, the last five years or so have shown some promising signs.

One development in recent years is of general medicine

departments -- called *sōgō shinryōbu* in Japanese. Aware of longtime criticisms of insufficient education in primary care, the MHLW has supported the movement to create departments related to primary care, and their numbers are growing rapidly in both university and community settings.⁶ Nagoya University, thanks to the leadership of Dr. Nobutaro Ban, is the site of one of the most progressive of these departments.

Also, for the first time the majority of medical graduates are entering community-based residencies, a setting away from the ivory tower which should increase in the number of young physicians in Japan with more real world and hands-on clinical experience.

Misperception 4. Japanese medical students have poor English.

The same characteristic of passive diffusion of rote factual knowledge discussed earlier, combined with a homogenous population having little exposure to native English speakers, results in most Japanese medical students and doctors being uncomfortable, if at times downright incapable, of functioning in a *spoken* English environment.

However, by and large academic physicians in Japan are most concerned with publishing and staying current with the literature, meaning that *written* English is of much more importance to them. And indeed their written skills when isolated to medical English is more than adequate. Although the spoken English of most Japanese medical students and physicians is poor, it is unfair to categorize their entire English language level as such.

This language barrier unfortunately contributes to native English speakers' perception of Japanese medical students as subpar. For instance, Rao bemoans, Japanese medical students "would not measure up to even the most average student of comparable chronological seniority in the US." However, second-language communication is a major factor here: anyone with the experience of trying to write a creative story or explain a technical concept in her second or third language knows how utterly handicapped one feels. Personally, no matter how fluent my Japanese, I will always sound more intelligent giving a case presentation in English rather than Japanese.

There is a tendency to *vastly underestimate* the height

of this language barrier. It is utterly unrealistic, as Rao suggests, to envision that it would be "reasonably easy" for a typical Japanese medical student to surmount the language barrier "after a few weeks of immersion in American society."

It is distressing, then, to read Rao's discussion of Japanese student's English skills, which smacks of American-style ethnocentrism. He writes that students had difficulty with "idiomatic English" and even those with excellent English "did have an accent." Everyone, even Americans, has an accent. Clinicians like Rao should adapt to surroundings and avoid idiomatic English as much as possible when outside the U.S. In the Netherlands, when I want tap water, I order "water without gas." As silly as it sounds to me, I adjust my English to the local expression rather than obstinately clinging to my American preference. In short, simply *knowing* about the language barrier as an American clinician venturing to Japan is inadequate. One must also *appreciate and accommodate* that reality.

References

1. Gillespie CA, Gillespie HE, Carr JE: Contrasts between Japanese and American medical education and clinical practice. *Mil Med* 1984; 149: 393–396
2. Hefelfinger D: Graduate medical education at Chubu Hospital, Okinawa, Japan. *Acad Med* 1998; 73: 1274–1276
3. Onishi H, Yoshida I: Rapid change in Japanese medical education. *Med Teach* 2004; 26: 403–408
4. Shoji T, S Y: The Current State of the Health Care System in the United States. In: *Fundamentals of the Health Care Big Bang [Iryou bigguban no kiso chishiki]*. 1999: 112–116 (in Japanese)
5. Tierney LM, Jr.: An experience in Japanese academic medicine. *West J Med* 1994; 160: 139–145
6. Murai M, Kitamura K, Fetters MD: Lessons learned in developing family medicine residency training programs in Japan. *BMC Med Educ* 2005; 5:33
7. Takayama J: Direct observation in a resident clinic in Japan. *Pediatric Research* 2003; 53: 532 Part 532 Suppl. S.
8. Rao RH: Perspectives in medical education--1. Reflections on the state of medical education in Japan. *Keio J Med* 2006; 55: 41–51
9. Kozu T: Medical education in Japan. *Acad Med* 2006; 81: 1069–1075
10. Teo A: The current state of medical education in Japan: a system under reform. *Med Educ* 2007; 41: 302–308
11. Ushiba D: Trends of medical education in Japan. *Med Educ* 1985; 19: 258–265