American Physician in Japan: Teaching Out of Context

Brian Sanjay Heist, MD, MSc

I stepped inside *kaigishitsu ichi* (conference room 1) and froze. I had just completed a teaching session and had hustled up and down numerous flights of stairs through the hospital complex. With labored breathing and dilated pupils, I stared at a whiteboard on the far wall, 30 feet away, which displayed a scientific poster titled, "Thrombotic Thrombocytopenic Purpura with Myocardial Infarction." At that moment, the poster was slowly sliding down the board. The room had been empty in the morning when I left this poster, along with 2 others. Presently, in front of the whiteboard were 10 feet of carpet, followed by 4 rows of tables and chairs. On the table in front of each chair was a catered *bentou* box, and in each chair was a medical student munching on the *bentou*.

The resident who had prepared the poster was dressed in a suit, note cards in hand, anxiously looking to me for guidance. The hospital's pathologist, who had participated in the case being presented, leaned passively near the doorway. Not a single other resident or attending physician was there. It was certainly neither the room arrangement I had requested nor the audience I had envisioned for this inaugural poster session.

"12:05 PM, Saturday, March 7, 2009," read my cell phone screen. I was about halfway through my 3-year stretch as the American faculty-in-residence for a general residency program in Sapporo, Japan. I had taken the post immediately after completing my own residency and was hoping to introduce the Japanese residents to various facets of the US training experience.

Although I was aware that poster sessions were not popular in Japan, I had required the 18 third-year residents to complete a scholarly project and indicated that preparing and presenting a poster would fulfill the requirement. Because the hospital cared for a large number of rare and pathophysiologically intriguing cases, but had a limited tradition of encouraging residents to pursue scholarly work, I thought introducing clinical vignettes and poster sessions would be a surefire success.

Brian Sanjay Heist, MD, MSc, is Assistant Professor of Medicine, University of Pittsburgh School of Medicine.

Corresponding author: Brian Sanjay Heist, MD, MSc, University of Pittsburgh Medical Center, Shadyside Hospital, 5230 Centre Avenue, SON #206, Pittsburgh, PA 15232, 412.623.1239, heistb@upmc.edu

Received June 21, 2012; revision received October 6, 2012; accepted May 24, 2013.

DOI: http://dx.doi.org/10.4300/JGME-D-12-00170.1

The residents had been less enthusiastic. That year, I heard about numerous great cases, including a *Campylobacter* mycotic aneurysm, classic tetanus, and classic Lemierre's syndrome. Whenever I encouraged residents to develop their cases into posters, the reply was uniformly "I'll think about it," which in Japan is the unequivocal euphemism for "I'm not interested." Ultimately, I was able to persuade only 3 residents to complete a scholarly project, and each of them chose to present a poster. I remained optimistic, and in denial, rationalizing the reaction as hesitance to embrace new ideas from a new teacher.

Near the end of the Japanese academic year, the hospital hosted a weekend for medical students, and the poster session was scheduled for the lunch hour on the first day. I had designed a flyer and urged all the residents to attend. Needless to say, I had been eagerly anticipating this moment.

Now, with shoulders low, I went to the front of the room. The munching ceased. In English and Japanese I introduced the concept of a poster session and asked if anyone had ever experienced one. The audience replied with quizzical stares. The resident commenced her presentation. She had prepared diligently and, with clear English pronunciation, recited the background and H&P for her case. Then she paused. The audience members, many of whom had replaced their chopsticks with pens, were looking at the poster, at her, and at me with consternation. I asked them to share their questions and thoughts. More silence followed. The resident concluded her presentation and summarized it in Japanese, but the audience's faces remained unchanged.

After the first presentation, the session continued to deteriorate. The second resident was called away by a hospital emergency. As I began to present her case, the third resident arrived and said he had just a few minutes between procedures to present his poster. We quickly tacked his poster to the whiteboard, and in the short span it took the audience to eat 2 pieces of *norimaki*, he raced through his presentation and dashed back to the operating room.

After completing the presentations, I again solicited questions and comments from the audience. "What was wrong with the head MRI in the third case?" I asked. "I could not see it," someone finally responded softly. The sole remaining resident and I wheeled the whiteboard to the front table to review the cases. As we quickly moved around the poster to point out findings on imaging studies,

the back half of the audience rose to get a better view, jostling to form a huddle around the poster. At that moment, a hospital secretary announced that it was 1 PM, and everyone suddenly had to rush to the next scheduled activity.

My failure with the poster session provided motivation to reflect on the cultural differences between Japanese and Western education and the importance of understanding one's audience.

Among the features of Japanese medical training noteworthy to US physicians, 2 are particularly relevant to my experience. First, when it comes to didactics, Japanese residents are more accustomed to intense listening and furious note-taking than to discussion, perhaps because self-discipline and group harmony are more culturally valued than individual expression of opinion. Second, clinical training in Japan is reminiscent of training in the United States several decades ago. It is characterized by numerous bedside procedures, ranging from phlebotomy to intubation, less ancillary support, less consistent oversight, and an absence of work-hour restrictions. In this context, the Japanese residents' and American attending's images of what it means to be a physician may have been out of sync. Not only did the residents view a poster session as an extremely foreign concept but they also considered completing a poster for a foreign physician just another unwelcome task in their overloaded schedule.

In consideration of the international omnipresence of poster presentations, I remained determined to share this educational experience with my trainees. The next time, however, I described the poster session within an appropriate cultural context, highlighting the opportunity it afforded—namely participation in an international conference. Most importantly, I brought our chief resident to the Society of General Internal Medicine (SGIM) annual meeting, after which he reported back with a rave review of the conference and a slide show. (The shots of the Miami Beach backdrop might have helped.)

Fast forward 3 years to the 2012 SGIM Annual Meeting: I am perusing the aisles of clinical vignettes at a lunch-hour poster session to find the Japanese resident I have been seeking. He has a visitor at his poster, and I observe him explaining his case and answering questions enthusiastically. He is accompanied by 2 classmates, which makes a total of 11 residents from my former program who have participated in SGIM annual meetings. Consistently, they describe feeling empowered by their success in giving a presentation in an international forum and motivated to attempt bigger challenges—just like my current American trainees.