Summer hospital clerkship in Tsukuba

June-July 2014

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I. About Japan

The Land of the Rising Sun is an archipalgo off the coast of East Asia, the 3rd economic power of the world and a highly developed country, often perceived as the land of electronic innovation and futurism, yet at the same time, it is paradoxically well-anchored in its timeless traditions.

It stands to reason that this paradox found in technology may also be found in medicine. Japanese medicine tends to incorporate aspects of both modern western medicine and traditional medicine, Kanpo. Kanpo is well integrated in the Japanese healthcare system and medicines are strictly manufactured and evaluated. They are widely prescribed by Japanese physicians.

Japan has the highest average life expectancy in the entire world and its population currently has the highest proportion of elderly citizens. As of September 2014, it is estimated that 33% of the Japanese are above 60 years old. As such, there is a growing need for young doctors to support this aging population and its chronic diseases.

The Japanese value teamwork and respect for elders above many things, and this also rings true for healthcare workers. The experience and teachings of older physicians are highly valued. The word *sensei* can stand for both Master and Doctor, which feels very appropriate and representative of this way of thinking.

Hospitality is also a core value of the Japanese people, following the principle of *omotenashi*, which refers to treating a guest with warmth, respect and selflessness.

To many westerners, Japan is attractive in a strange but beautiful way. Most of us use technology from Japan and are, to some extent, familiar with Japanese culture. In France, most young people born in the 80's and later have grown up watching Japanese animation and playing Japanese video games, and translated manga became very popular in the late 90's. As a country, it seems both close yet foreign because of its traditions. For this reason, many French people my age are very curious about Japan and have expressed a wish to visit it at some point.

However, to most French medical students, doing an internship in Japan sounds intimidating for a few reasons. It seems most average French people are not very confident in their English speaking abilities and think they would not be comfortable speaking it exclusively for a long period of time, even though nowadays every student learns English in middle and high school. In my opinion, this speaks to a larger problem of education in France.

Japan also has a reputation of having an expensive cost of living, though it seems to be roughly equivalent to France in this regard. But for this reason, many French students prefer to choose cheaper countries for their internship abroad, for example Vietnam, which also has many ties to France due to history.

And, contrary to the Japanese core values described above, the French also tend to be loud-mouthed, "brutally honest" and always complaining, which can lead to conflict… though not all of us are like this !

II. Medical studies in Japan

They are not completely unlike French medical studies.

Getting into medical school can be done directly after graduating from high school, by passing a selective entrance exam for the university the student chose. Medical studies in Japan are very expensive compared to France.

Japanese students must validate 6 years of study before becoming residents. The first two years are dedicated to learning scientific subjects, and classes become progressively more "medical" as the years go on.

Medical clerkship is done in the 5th and 6th years. Students rotate between departments every 2 weeks (compared to every 2-3 months in France), sometimes only one week for departments such as radiology. As such, Japanese students have the opportunity to see all departments. In Tsukuba University Hospital, there are generally 3 to 5 students per department.

Depending on departments, students are given helpful papers at the start of the clerkship, which may be texts and illustrations for lectures, goals they must accomplish (such as filling out a detailed report on a patient of their choosing)… and even an enquête so they may rate the department and suggest improvements !

Clerkships are usually all day long, unlike France where they are only in the morning, but in fact there are often lectures in the afternoon all week long, done by attending physicians, so hospital practice is not actually "all day long". If there are no lectures, then students are usually allowed to leave the department after having completed their daily tasks, and return in the evening for the evening round.

In in-patient departments, students usually follow around 3 patients each and must examine them daily, write progress notes and make presentations during rounds and staff meetings with the professor.

Like in France, students cannot take official medical decisions by themselves, but they also seem more restricted with regards to medical procedures due to Japanese law. For example, arterial blood gases and stitches are done by residents. They usually get a more hands-on approach during their junior residency.

At the end of each clerkship, students usually have a meeting with the head of department to discuss what they have learned and what they thought of the clerkship (see above : the enquête).

After 6th year, students must pass an exam to validate their year, which encompasses all they have learned. Unlike France, there is no competitive ranking but students must get a certain grade to pass and be able to get the title of M.D.

After graduating, they become junior residents for 2 years. Unlike French residents, they have no specialty yet and rotate in various departments. They are able to take medical decisions and perform medical duties by themselves. *(This includes injecting contrast in CT-scan patients, which is done by radiologic technologists in France : as such, junior residents in radiology may spend hours doing injections.)*

Junior residents are to be addressed as their family name followed by -*sensei*… most unlike France where we just call them by their first name !

After 2 years, they become senior residents for 2 more years, which has no true equivalent in the French system. They are free to choose a specialty, depending on availability and their curriculum vitae, unlike France where this is done via a one-time national competitive exam at the end of 6th year. There is no significant difference in salary between specialties in one university hospital, as such, some specialties which are highly coveted in France due to high salary like radiology may not be so in Japan.

After this, they become chief residents, who teach and supervise the senior and junior residents. Above them are the attending physicians, and the professors.

A single patient is thus taken care of by one chief, senior, junior residents and a student, and typically rounds are made of all residents and students. Attending physicians may also attend rounds, participate in staff meetings and provide valuable advice and experience.

It should be mentioned that in Japan, medical records tend to be written following the "SOAP" and Problem Oriented Medical Record principles. This is a very standardized procedure, which involves writing down the Subjective (what the patient says), Objective (clinical examination, biological and radiological findings), Assessment (comprehensive list of the patients' problems) and Plan (decisions taken with regards to said problems).

This method allows for a very clear and organized medical record system which is unfortunately not used in France.

Although medical studies are, of course, mostly done in Japanese, Japanese physicians seem to be much more familiar with English medical words and abbreviations than the French. It is not rare to see things such as "ESR" and "GFR" on Japanese blood tests, whereas in France, these are translated in French ("VS" and "DFG"). We also use English abbreviations, such as HCG, but much less.

In the university of Bordeaux, all classes are taught in French with no exception, and medical English classes are only mandatory in the 2nd year, after which they become entirely optional.

III. Tsukuba, its university and campus

Tsukuba is a city in Ibaraki prefecture, around 55 km to the north-east of Tokyo. Sometimes called "Tsukuba Science City", it was founded in the 60's to become a center of scientific research, allowing to decentralize the overpopulation of the Tokyo area and create a new Japanese intellectual center. After years of building research facilities and the campus, the surrounding towns and districts fused to officially become the city of Tsukuba in the 80's.

Its easy accessibility from Tokyo, especially since the opening of the Tsukuba Express line in 2005, makes it a very attractive research center for the Japanese.

Tsukuba has been getting nearly half of the national public R&D budget for the past decades. The University of Tsukuba is among the best performing in Japan, and as such the entrance exam is very selective. There are many foreign researchers and students on campus. It is best known for its research in physics, robotics, economics and social sciences.

In particular, as far as the university hospital is concerned, this means that proton therapy is quite famous and very well researched in Tsukuba, and the affiliated robotics company Cyberdyne has created the HAL exoskeleton, made to help disabled and elderly patients. One of the HAL suits can be seen in the entrance of Tsukuba University Hospital.

The campus of Tsukuba is the largest in all of Japan, with an area of over 250 hectares. It is divided in small areas and many shops and convenience stores can be found in or around it so students may have access to most everything for their daily life.

The university hospital is located in the south-west of the campus, near Oikoshi area.

Housing

As far as I know, foreign medical students who only stay for a month or two are housed in one of the two medical residences slightly further up north, next to the Hirasuna Community Center. There is a convenience store and a bus stop right next to the building (which takes you to Tsukuba center) and the hospital itself is within 10 minutes by foot.

I was living in Medical residence n°2, also called Lecturers' residence. Rooms are clean and not too small (around 16 square meters) and include a shower, toilets, kitchen stove, balcony and air conditioner (very important in summer). Seemingly, each floor has its own free cloth washing machines.

Room fee is around 15000¥ per months, not counting gas and electricity bills. (Turn off the air con before leaving !)

Helpful structures for foreign students

OPIMA (Office for the Promotion of International Medical Affairs) is the first contact a foreign student will have with Tsukuba and remains the main anchor for any advice or problem you may have. On the first day, the student is greeted by a member of OPIMA, in my case Ms. Fukaya, and is taken to move into the dormitory room. They will also help if you need to buy everyday items such as shampoo and soap !

The OPIMA office is located on the 4th floor of the B building (and you will get lost at least a few times). This is where you must pay dormitory fees, get shown to your new department at the start of a new clerkship, and they will also help with paperwork such as the clerkship performance evaluation.

TIMSA (Tsukuba International Medical Students Association) is perhaps somewhat less serious in the administrative sense but no less important : they are a group of Japanese students who wish to meet foreign students and speak English, and they work closely with OPIMA. They plan all sorts of events such as barbecues, dinners, Mount Tsukuba hiking, visiting Tokyo… and are also available to answer questions about daily life in Tsukuba.

IV. General medicine clerkship

My first clerkship was done in general medicine from 06/02 to 06/13. General medicine is one of those clerkships where students rotate every week instead of every 2 weeks, as such my rotation was divided in two : the first week was spent in Tsukuba University Hospital with Pr. Maeno's team, and the second week was spent in Mito Kyodo General Hospital with Pr. Kobayashi's team.

First week : Tsukuba

The first week was composed of outpatient clinic in the morning and lectures and case studies in the afternoon. We were 3 students, and each of us was assigned a resident to follow every morning. We could be assigned either to the outpatient clinic in the university hospital or to the outpatient clinic in the Medical Center, a smaller hospital on the other side of the road. I spent 4 mornings with the university hospital resident team and one with an attending physician in the Medical Center.

The very large majority of patients do not speak English, so I couldn't interview them. However, the doctors translated their record for me (they could all more or less speak English and were more or less shy, but the most outspoken ones were usually the ones who had been abroad for work or holiday) and let me do clinical examinations.

There was one exception however : on Wednesday, a couple of Russian patients came to consult who could not speak Japanese well. As such, I was the one to perform interview and clinical examination and write the medical record for both of them.

Pathologies were very varied, as befit a general medicine department : ALS, allergic rhinitis, a strong suspicion of cancer, anemia and pregnancy planning, angioedema…

In the afternoon, there were lectures and/or case studies every day. Lectures were about various aspects of general care, such as : how to recognize a psychosomatic disorder, palliative care, the importance of primary care for a community. *(This is an important subject in Japan : as the population is getting older with more chronic diseases, primary care physicians are first in line to care for families and communities. However, because of how Japanese residents can freely choose their specialty, there are not enough primary care physicians in Japan compared to the growing demand.)*

There were a few case studies throughout the day : the first one, right after the lecture, was done by us. We did a full presentation of a patient we had seen in the morning, and the doctor who listened (usually Pr. Maeno himself) would then give us a short lecture based on the patient's case : for example, how to act with a suspicion of tonsilitis, or exploration of anemia.

On Friday afternoon, we attended a lecture in the Medical Center on traditional Japanese herbal medicine, called Kampo, with a physician who practices it and watched him treat his patients. Although it was only a brief introduction, it is quite important for medical students to be aware of this alternative medicine, as it is very

popular in Japan and many patients regularily take at least one or two Kanpo medications.

Second Week : Mito

As the Tsukuba clerkship is supposed to last only one week, for my second week, Pr. Maeno suggested I go to the nearby city of Mito, the largest city in Ibaraki prefecture. Mito hosts a general hospital, which means that patients here are much less "specialized" and complicated than patients in the university hospital, who are generally told to go there because they could not get a diagnosis anywhere else. Unlike the first week which was solely out-patients, this was an in-patient general medicine department

In order to go there, I took the car with 3 fellow Japanese 6th year students who were doing a clerkship in Mito. One of them was to be my "partner" for the week : we followed his patients, examined them and wrote progress notes together.

Our team was small, composed of renowned clinician Pr. Kobayashi, a senior resident, a junior resident, my partner and myself. This small team made for a very friendly environment, as the low number meant everyone spoke English more frequently and we were quite close-knit, eating lunch and often dinner together.

Every morning, the day started with a large staff meeting of all the smaller Fellow-Senior-Junior teams like ours, along with surgeons, cardiologists and pathologists, to discuss new or difficult cases. Then the day would usually be spent seeing our team's patients : although my co-student only had to write progress notes for 2 of them, we spent our free time checking on all the other patients and relaxing in the library while waiting for the round or an evening lecture.

Our two official patients both combined geriatry and infectiology, as one was a case of Ludwig's angina, constipation, confusion and dementia while the other was a case of confusion, fever and anorexia.

On the last day, we both presented one patient each to our team in a small room - both in English !

As Mito is a one-hour car ride from Tsukuba, we slept in a student dormitory near the lake. Although I had heard many terrifying things about this dormitory, it turned out to be all right, each room had its own futon, toilets, shower, air conditioner, fridge and microwave. To this day I still haven't figured out why it is supposed to be so bad.

As an aside, the next Tuesday, Pr. Kobayashi drove to Tsukuba to host a small seminar on cardiologic semiology for 6th year students, where we could practice on high-tech robots to hear many kinds of heart sounds.

Short case study example :

65 year-old male, consulting as an out-patient for weight loss and tiredness. Personal history includes aortic valve replacement, gastric ulcer, colon polyp, drinking and smoking (now stopped for a few years). No family history.

The patient reports having lost 6 kg in a little under a year, now weighing 50 kg.

He describes a shortness of breath that has been growing more important for the past few months, such that it has become hard for him to move and even eat. His voice is very quiet, and use of accessory respiratory muscles can be seen on his neck.

Physical examination is normal outside of the neurological exam. Fasciculations can be seen in his forearms, and his shoulders and back appear amyotrophic while exhibiting hyperreflexia in the right patellar reflex. Muscle strength is diminished mostly in the upper limbs, with deltoids testing at 3/5 and an incapacity to grasp small objects. Overall, the patient appears to move very weakly when asked to lie down, stand up, walk during examination.

There are no sensory defects.

A pulmonary function test was ordered, showing a severe restrictive syndrome.

Biology shows signs of denutrition with no other anomaly.

Brain CT-scan is normal.

This patient was subsequently hospitalized in neurology on a strong suspicion of Amyotrophic Lateral Sclerosis and to pursue further tests to exclude differential diagnosis.

V. Neurology clerkship

My second clerkship was done in the neurology department of Pr. Tamaoka, from 06/16 to 06/27, on the 6th floor of the Tsukuba University Hospital. This was a more traditional in-patient unit, much like the ones I am used to in France. This was a 2 week clerkship and I was with 3 other 5th year students.

It is quite a large department, with around 20 patients at a given time. Not all patients are located on 6th floor : a few of them were scattered among the other floors, which made the rounds (twice a day) quite sportive. In France, patients belonging to one department are also sometimes hosted in another department, but this is quite rare and seems to be more common practice in Tsukuba.

Consequently, the patient list was rather large… and all in Japanese. I spent quite some time on the first day translating the names and diseases with a very nice and patient attending physician, and I learned to recognize disease names by figuring out the kanji they were made of : brain, muscle, pain, cerebellum, inflammation, loss of strength, meninges, blood vessel…

There were 2 junior residents, 3 senior residents, 1 chief resident, along with a number of attending physicians and 4 of us students. This was quite a change from the weeks I had just spent in general medicine. Unfortunately, this means that people spoke English much less as there was a much larger Japanese-speaking audience. When I was in a smaller audience however (such as lectures), people usually switched to English for me, and I am very grateful to the senior resident and two attending physicians who made a lot of efforts to speak to me often.

One patient was cared for by an assortment of chief/senior/junior residents, as is often the case in traditional in-patient units like this.

Patient pathologies were quite diverse and more unusual than I would have thought : there was a big focus on immune disorders such as pachymeningitis, limbic encephalitis, inclusion body myositis, multiple sclerosis, myasthenia, and even a couple of cases of dermatomyositis and neurosarcoidosis. There were also cases of ALS (the patient I saw in general medicine was now hospitalized with a definitive diagnosis and was hooked up to a non-invasive permanent respirator), spino-cerebellar atrophy and Parkinson syndrome.

Japanese students had 2 patients and I chose to focus on only one whom I later presented on a staff meeting, as the difficulty of not being able to talk to patients by myself and medical reports being all in Japanese made things very hard for me. Later on, during the nephrology clerkship, I would become more used to functioning in an in-patient setting like this, allowing me to follow 2 patients, and my nephrology co-students were less shy which made it easier to communicate. Because of this, I regret not making the most of my neurology clerkship, however it was still an interesting experience because I had never been in neurology before, and neurological semeiology is very rich.

Typically, a day would be made of a round at 8:30, accomplishing daily tasks, lectures which were usually late in the morning or in the afternoon and an evening round around 17:00. Depending on days, there were additional activities : we were encouraged to follow patients for lumbar punctions, biopsies and imaging, and

Tuesdays and Fridays had EMG in the afternoon.

Lectures were mostly about neurological semeiology, such as practicing deep tendon reflexes on each other, explanations of important syndromes, how to write a good medical report in neurology, and explanation and interpretation of complementary tests such as EMG and muscle biopsy.

Once a week, we would have a lunchbox paid for by pharmaceutical laboratories while they showed us a Powerpoint presentation of whatever medication they wanted to promote. One evening also involved a seminar on temporal epilepsy hosted in a nearby luxurious hotel, complete with delicious buffet. Although it was all in Japanese, everyone always encouraged me to come, if only for the free food !

As an aside, one of the drugs presented was natalizumab, a monoclonal antibody used for MS. Although it has been authorized in Europe for 8 years, some countries like Japan did not, due to a link with an increased risk of progressive multifocal leukoencephalopathy. As such, clinical studies are being done to prove that benefits outweigh the risks and to authorize natalizumab in Japan.

Short case study

49 year-old woman complaining of cramps, decreasing strength and muscle pain for 3 months. This increasing tiredness along with a mild loss of appetite drove her to see a doctor. She is overweight, does not drink nor smoke. She has a history of operated ovarian cancer.

She mentions skin erythema on the extensor side of her arms and hands, which appeared in the past month but does not bother her too much as it is not itchy.

Physical examination is normal aside from neurological exam, which finds symmetrical decreased muscle strength in upper limbs (particularily shoulders) as well as decreased tricipital and stylo-radial reflexes. There is no pyramidal syndrome.

Blood tests reveal a mild inflammatory syndrome and increased CPK.

Shoulder MRI find a hyperintense T2 and contrasted T1 signal of the left triceps. No anomaly of the brain or spinal cord.

EMG shows a myogenic pattern in muscles of the upper arm.

Corticoids were introduced and proved successful in decreasing her muscular symptoms and skin rash.

Due to these findings and her history of ovarian cancer, dermatomyositis is strongly suspected. A muscular biopsy and a skin biopsy are done, both of which confirm the diagnosis.

A thoraco-abdomino-pelvic CT scan was also conducted, which found suspicious peritoneal nodules and a pelvic cystic mass.

The team of residents and fellows caring take of her had a meeting with the patient and her parents, to announce the diagnosis of dermatomyositis and a likely relapse of her ovarian cancer.

VI. Nephrology clerkship

My third clerkship was done in the nephrology department on 8th floor, from 06/30 to 07/11. Head of department Pr. Yamagata is involved with exchanges between Bordeaux and Tsukuba and insisted I take a clerkship in his department, for which I was glad as, like neurology, I had never had the opportunity to rotate in nephrology before.

This department worked very much like neurology, in that it was a large in-patient unit with a hemodialysis center on 2nd floor, with many residents. Fortunately, the nephrology department is located in the new Keyaki building, with enough computers for everyone to check and write progress notes.

Overall, it was more English-friendly than neurology, as the patient list was in English (though full of opaque nephrology abbreviations which required some figuring out) and my 3 fellow 5th year students were very willing to help and talk (one of them had lived in the US, which made things easier). Over the last few weeks, I had also gained more confidence, and so I followed and presented 2 patients for this clerkship, and even dared to write progress notes in English. Nephrology patients tend to have a complicated history, so in order to present mine, I asked residents and students to translate… though after a while, I spent my free time on a Japanese-English translation website as to not bother them too much. I became quite the expert in copying and pasting kanji.

Patient pathologies included diabetic nephropathy, IgA nephropathy, lupus related nephropathy, cholesterol cristal embolism, AA amyloidosis, nephritis… a lot of which resulted in chronic kidney disease, and many patients were undergoing hemodialysis. I will admit it was quite hard for me to remember patients and diagnoses, as clinical examination in nephrology is not as rich as neurology, and due to the rounds being in Japanese, sometimes I was a bit lost… whereas neurology was easier to figure out : *"this is the woman with the cerebellar syndrome", "this is the man with the extra-pyramidal syndrome"*, etc.

Daily activities were very much like neurology, which included 2 rounds (again with patients scattered), taking progress notes and lectures for students. Weekly events were staff meetings where we presented patients (with one for dialysis patients and one for the others), pathology staff meetings and pharmaceutical company-sponsored free lunch (of course).

We were also able to see a renal biopsy and surgery to make an arterioveinous fistula for the hemodialysis.

Lectures were either late in the morning or in the afternoon, topics included acute kidney injury, chronic kidney disease, types of dialysis, renal biopsy, base-acid balance.

On the last day of the clerkship, Thursday 10th (as practice was cancelled on Friday 11th due to typhoon Neoguri), we met with Pr. Yamagata to give our impressions. I heard that my fellow students talked about how difficult nephrology was to understand, and was relieved to know that this is what medical students think everywhere in the world.

Short case study

56 year-old woman complaining of loss of appetite for 2 months. Hospitalization was suggested after she became very tired and mildly confused in the past week and fell down at home.

This patient has a long history of rheumatoid arthritis, diagnosed in 1990. She has received all kinds of treatment for it, including intra-articular corticoid injections, gold salts and bucillamine (from 1994 to 2008). She has had many arthroplasties over the years to relieve her joint pains and she now has prosthetics in both knees, both elbows and her right hip.

In 2006, she developped non-insulinodependent diabetes.

In 2008, during a routine examination, it was discovered she had proteinuria. Further renal function tests revealed kidney failure. Bucillamine was stopped and replaced by newer drugs for RA.

However, in spite of this, her renal function kept decreasing slowly throughout the years but the patient mostly wanted to be left alone.

2 months ago, she started losing appetite and has since lost 10 kg.

On entrance, her serum creatinine and urea levels suggested a very severe worsening of her chronic kidney disease. The patient had an ulcer on her left leg.

She underwent hemodialysis for 2 weeks and regained appetite and weight, which suggests her weight loss was due to hyperuremia and hypercatabolism caused by RA and the ulcer.

However, fatigue, anorexia and weight loss are all signs of malignancy and as such, an extensive malignancy check was conducted, with fibroscopies, ultrasounds and CT scans.

Hemodialysis was stopped after 2 weeks as her GFR returned to its base value.

This patient's chronic kidney disease can be explained by several factors :
-Nephrotoxicity of old RA drugs such as gold salts and bucillamine
-Diabetes
-AA amyloidosis due to RA

VII. Radiology clerkship

My last clerkship was in the radiology department of Pr. Minami, from 07/14 to 07/25. Like general medicine, radiology is another one of those 1-week rotations. For the first week, I was with 4 other 5th year students and I was alone with the doctors for the second week.

I had already done 2 radiology clerkships in France, including short bouts of teaching 4th year and 5th year students the basics of imaging, but I chose to take one again because it is my favorite specialty and I would like to become a radiologist if I can.

It is in many ways similar to France. Patients are not seen by medical students and instead the practice focuses on seeing the imaging processes and interpreting the exams. Students are given a timetable and are assigned to different posts : CT, MRI, ultrasound, gastro-intestinal imaging (gastrography and barium enema). The department also includes interventional radiology, such as embolisation of aneurysms and arterioveinous malformations. However, nuclear imaging remains a separate department, just like in France.

Like the other clerkships in Japan, it also includes lectures every day, usually late in the morning. They were mostly about the basis of MRI and CT reading, the impact of medical irradiation and the cost of imaging. Japan has a high count of artifical radiation exposure because CT scans tend to be over-prescribed ; as such, they are trying to educate doctors to cut down on unnecessary imaging.

There is also a daily staff meeting in the evening and sometimes larger pluridisciplinary meetings which students must attend, in which patient cases are reviewed for educational or discussion purposes.

In the afternoon, students are usually free to leave, but must return for the staff meetings.

On my first day, I got to see gastro-intestinal imaging, which was interesting experience as I had never seen it before. Then I participated in CT, MRI and interventional radiology the next days, always paired with another student.

For the second week, Pr. Minami asked me what I wanted to do, as I would be alone with the staff. I chose to partake in CT and MRI reading with residents and fellows, as they are the tests I am most interested in, especially MRI. Sometimes they gave me scans to read, and then after some time we would review them together. Most of the cases were difficult for me but it was fun and interesting to do.

I got along quite well with the staff because of my interest in radiology, and was even invited to the welcome party for the new residents in an izakaya. Thank you !

VIII. Personal impressions

These 2 months in Japan were a wonderful experience, both from a clinical and human point of view.

I had never been abroad alone, so this was a very daunting experience at first. I was supposed to come with friends, but due to last minute unfortunate events, they had to cancel their trip and I ended up by myself.

I had the advantage of knowing Japan a little : I had been there for 1 month in 2003 as I visited my brother's in-law family in Kitakyushu. Thanks to my brother and his Japanese wife, I was used to hearing them speak a mixture of English and Japanese, and I have been able to read katakana and hiragana for a long time *(for reasons I won't fully disclose here) (reasons that involve Pokemon video games when I was 10 years old).* However, I cannot speak Japanese (and I am very shy !), but I sometimes understand very basic sentences, such as the ever useful "Shall we go eat ?". My memory of this stay in Japan is very positive and I had been interested in coming back ever since, though I never had the opportunity to do so before now.

I think I was lucky to be able to take this clerkship elective, as I chose to repeat my 6th year to better prepare for the French competitive national exam and thought I wouldn't be accepted because of this. I was afraid I wouldn't be good enough, but it seems the clerkships have turned out all right and I am very glad for this positive outcome which gives me more confidence.

It was a very enlightening experience to see both the similarities between French and Japanese medical studies and the differences in thinking : most notably, I found it very interesting how medical records are written using POMR and SOAP and think French doctors could benefit from such a clear and organized way of thinking about their patients.

Also, in France, students (especially in 6th year as I am) tend to focus too much on the 6th year exam and its objectives and disregard diseases that are not included in the curriculum, because there is so much pressure to learn what you need to know for the exam ; as such, anything you *don't* need to know is usually seen as unimportant. So it was relaxing to be outside of this stressful environment and be able to "enjoy" unusual diseases such as ALS, angioedema and dermatomyositis, which are usually never talked about by French students.

Due to how long clerkship rotations are in France, I was able to choose departments in Japan I never got to see in France, such as neurology and nephrology, both of which I find very interesting. I had done a general medicine clerkship before, but I think you can never have enough of it because it is so diverse and every doctor should know the basics of primary care. I was also glad to experience more radiology as I want to become a radiologist, but because of how specialty choice works in France, there is no guarantee I can ever become one as it is one of the hardest specialties to get.

Although I came alone, I met many people thanks to OPIMA and TIMSA, as well as the University of Bordeaux who contacted a biology student from Bordeaux staying in Tsukuba so I could meet her friends, most of them foreign students from

Europe, Africa and mainland Asia. This made for a very interesting experience as we stayed in touch, and all together we enjoyed restaurants, izakaya (even with hospital staff sometimes !), visiting Tokyo and hiking in Mt.Tsukuba and Mt.Fuji. I also went to Kyoto following their advice. I can never thank all of these lovely people enough for being so friendly to me !

With special thanks to the biology student, fellow 5th year nephrology clerk and OPIMA for helping me retrieve my smartphone I had forgotten on Mt.Fuji !! My old iPhone will never forget this high altitude trip and I will never forget your kindness !

All in all, this was a beautiful experience and opportunity I never thought I could get the chance to have.

Thank you !

Appendix : Advice and everyday life

How to get to Tsukuba University Hospital from the airport

Both of Tokyo's main airports, Narita and Haneda, have a shuttle bus service to go to Tsukuba Center, every 2 hours or so. Information counters can be found easily in airport halls. Signs and writings are usually bilingual Japanese-English, though it should be noted that Tsukuba is one of the very few Japanese cities to be written in hiragana (つくば) rather than kanji, making it easy to read for beginners.

From the bus terminal in Tsukuba Center, you must take bus line 10 or C10, which must be taken at gate number 6. C10 is a loopline around the campus which can go one way or the other. The bus stop for the university hospital, 筑波大学病院入口 *Tsukuba Daigaku Byouin Iriguchi***, is the 4th stop from the terminal, provided C10 goes clockwise… it goes one way or the other right after the 3rd stop. If it doesn't go straight, it is better to get off as soon as possible, at the メディカルセンター病院 *Medical Center Byouin*, then walk to the hospital. Bus costs 170¥.

***Byouin* 病院 (hospital) and *iriguchi* 入口 (entrance) both are basic words which are important to know, especially 入口 which has the decency to be very easy to read for a foreigner !

How to take the bus in Japan

(This does not apply to airport shuttle buses.)

The best course of action is to observe how the Japanese do it, but basically :

-You must enter by the center door and get off by the front door !

-If you are not getting on at a terminal, you must take a small ticket when you enter (which makes a rather satisfying "ding !" sound).

-It is better to prepare the *exact* fee before getting off. Check the number on your ticket and the matching fee, as bus fee in Japan is based on distance.

(-Do not get up before the bus has stopped, gaijin.)

-You must pay the exact fee in a little machine next to the driver. If you don't have change, the machine will take your large coins and 1000 bill and spit out smaller coins so you can complete your fee. This is confusing the first time but the driver usually helps !

Withdrawing money

In Japan, everything is usually paid in cash. Paying with credit card is becoming more common, but it usually doesn't work with foreign cards so you are better off with cash.

Most ATMs do not work with foreign cards either.

The easiest way to withdraw money is to go to a Seven-Eleven store (open 24/24) bearing the "ATM" mention : these ATMs take foreign cards and can also be set in English.

Major post offices also have foreign-compatible ATMs.

Conbini stores

Short for convenience store, these small shops can be found nearly everywhere in cities and are open 24 hours a day. You can find everything basic there : food (including bento), coffee machine, bathroom stuff, electric appliances, magazines… It is thus possible to buy a toothbrush, a multiplug adapter and a cafe latte along with withdrawing copious amounts of cash (see above paragraph) at 4:00 a.m if you ever feel like it !

The most common conbini stores are Lawson, Seven-Eleven and Family Mart. There are sometimes 100¥ shops, where nearly everything costs 108¥. There is one near Oikoshi area which is a 8-minute walk from the medical residence and may quickly become your main base of operations if you are on a small budget.

Language barrier

You will never speak any French (unless someone asks "Say something in French !", *bien sûr*), so everything will be done in English and Japanese.

In general, most Japanese do not speak English very well, just like French people. However, in the hospital and on campus, it is easy to find someone who can speak English (most doctors and students speak it well), but in daily life outside the campus, things can get harder. It is better to know very basic Japanese words and sentences to make communication slightly easier.

Knowing how to read Japanese also helps a lot. Learning katakana first is the easiest and most rewarding because words written in katakana are foreign, usually English, sometimes German… sometimes French ! As such, understanding katakana requires no understanding of the Japanese language itself and you can recognize words by how they are pronounced. (Sometimes this is not as easy as it sounds, for example シンチ *Shinchi* for "Scinti"(graphie), which is pronounced differently in French and is hard to figure out outside of context.)

For example : A drink called タピオカ・メロン・オレ reads literally as "Tapioca melon au lait", which requires no French translation, though the idea of a milky melon-flavored drink with tapioca bubbles in it is anything but French.

The main problem for a foreigner is kanji, which are symbols shared with Chinese and look very complicated, although some of them are very distinctive and easy to understand, such as Entrance, Mountain, Forest, Water, Fire, Up, Down. Unfortunately, the Japanese use kanji in their daily life a lot more than you may think (including medical records… and names, which leads to the ever embarrassing *"I'm sorry, what is your name again ? I can't read your name tag"*), which can make things difficult. There is no trick here other than trying to learn some of them !

Internet

My dormitory had no LAN internet, unlike (it seems) most other dormitories on campus for more permanent residents. However, WiFi is available in the hospital ; usually locked but you just have to ask someone in your department for passwords so you may check your emails and Facebook. There are also cafés such as Starbucks which have free WiFi.

For those who would prefer a more permanent internet access on their smartphone, it is bizarrely hard, for such an advanced country, to get 3G/4G access as a short-term visitor, unlike countries like Vietnam where you can very easily buy a prepaid SIM card in the streets. A quick Google search should give you a brief

overview of the problem… There are indeed options (most notably with B-mobile company), but I suggest you pack some anti-headache medicines before truly diving into this thorny subject.

For internet addicts who cannot go a single day without having their laptop and everything else connected to the internet, the best option is to rent a Pocket WiFi for as many days as you wish. Rental fee is around 3€/day.

Going to Tokyo and getting around Tokyo

Tsukuba is located 50 km away from Tokyo, which makes it the main source of entertainment and tourism (other than Mt. Tsukuba and its amazing array of merchandize dedicated to the frog that is its symbol).

It is very easy to go to Tokyo using the Tsukuba Express, a train which takes 45-55 minutes to get there. No need to plan for exact times, as trains run every 15 minutes or so at usual hours, however they stop around 11:30 p.m. : be careful not to miss the last train… or plan for a night in Tokyo. Its terminals are Tsukuba Center and Akihabara station, making anime and manga fans everywhere very happy. A ticket costs around 8.70€ and can be easily bought at vending machines in the station. Machines can be set in English.

You can also take the bus to Tokyo, which is cheaper but slower.

Getting around Tokyo is very easy** when you take the subway : every sign is written in English and buying a ticket works exactly like the Tsukuba Express.

***(However you will need some serious genius-level intelligence to get the Shinkansen tickets right the first time around with no explanation. It seems to involve 2 tickets for 1 trip, sometimes. Don't worry, you will get it wrong like every other foreigner.)*

To make transit easier, you can buy an IC card of Suica or Pasmo brand so you don't have to buy a ticket every time. They are very, very convenient.

Tourist guidebooks offer good guidelines for sightseeing, but the best option is to go there with someone !