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## WEB PAPER

# I came, I saw, I reflected: A qualitative study into learning outcomes of international electives for Japanese and British medical students

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## Abstract

**Background and aim:** Although medical students have increasingly more opportunities to participate in international electives, their experiences are usually unstructured and the literature referring to their learning outcomes, educational environment, and assessment is scanty. This study was undertaken to clarify qualitatively what students learn from their international electives.

**Methods:** We carried out semi-structured individual interviews with 15 Japanese students studying clinical medicine in British medical schools and six British students studying in Japanese medical schools. The thematic synthesis method was used in analysing the transcribed data and triangulation by multiple researchers was used to achieve higher reliability.

**Results:** The main learning outcomes identified were skills in history taking and physical examination with clinical reasoning and in management of diseases rarely seen in the students' own countries; awareness of clinical ethics and merits and demerits of different systems of healthcare and medical education; sensitivity to issues in doctor–patient relationships and work ethics; enhancement of cultural competence; and personal development.

**Conclusions:** Most learning outcomes of international electives are culture- or system-dependent. Students achieved outcomes related closely to medical professionalism, mainly through reflection. International electives may give students opportunities to learn both professionalism and cultural competence.

## Introduction

In today's era of globalisation, the world is increasingly interconnected. This obviously has an influence on the world of medicine; an international perspective on healthcare is becoming ever more important for healthcare professionals (Mutchnick et al. 2003; Niemantsverdriet et al. 2004). The growing need to acquire this perspective is affecting curricula in medical schools. One result is the growth of opportunities for medical students to participate in international electives (Miranda et al. 2004; Gupta and Farmer 2005).

Although in some countries medical students have been engaged in international electives for decades (Drain et al. 2007), the literature referring to their learning outcomes, educational environment, and assessment is still scanty (Mutchnick et al. 2003; Niemantsverdriet et al. 2004). Due to a lack of structure in many international electives, they tend to become opportunities for medical students merely to travel to foreign countries rather than to study medicine. As the number of medical students participating in international electives is increasing, it is important to make the programmes more structured, to incorporate them within a specific desired educational environment, to clarify the desired learning outcomes, and to subject the outcomes to valid and reliable assessment.

## Practice points

- Cultures and systems are the two key factors affecting what medical students learn in international electives.
- Students who participate in international electives learn many professionalism-related outcomes, for example, understanding of healthcare systems, doctor–patient relationships and the doctor's work ethic.
- It is possible that students participating in international electives will behave more professionally as well as in a more culturally competent manner in the future.

We undertook an exploratory qualitative study to clarify what medical students learned from their international electives. We evaluated an existing programme carried out for Japanese and British students who had studied clinical medicine in the UK and Japan, both mainly in hospital settings (Japan Medical Education Foundation 2006). The clarification of learning outcomes of international electives resulting from this study may help medical students and faculty members to understand the potential and actual benefits to students accruing from international electives better and to structure the programmes better.

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## Methods

### Setting

The Japan Medical Education Foundation (JMEF), funded jointly by all the medical schools in Japan, has been organising and funding international electives for Japanese medical students for more than 15 years. Through this programme, 16–20 medical students, selected based on their IELTS (International English Language Testing System) score and interviews by JMEF staff, visit the UK every year to study clinical medicine. The learning outcomes of this programme are unspecified, but participants are requested to write free-format self-reports upon their return to Japan. A few years ago, the JMEF began organising international electives for British students to study clinical medicine in Japanese medical schools. There is no official selection process for the British students; however, they are requested to make a presentation about their international elective at their medical school upon their return to the UK.

### Participants

In March 2006, in total 16 Japanese final (sixth)-year medical students from 14 medical schools all over Japan participated in international electives run by the JMEF for 4 weeks to study clinical medicine in the UK. They were divided into groups of four, and each group visited one of the following British medical schools: Newcastle University Medical School, University of Southampton School of Medicine, St. George's (University of London), and Peninsula Medical School (University of Exeter and Plymouth). All but one of the participants in the electives that year were individually interviewed by H. Nishigori using a semi-structured format, in Japanese, about what they had learned in the UK during or soon after they completed their electives by the end of March 2006.

In addition, in autumn 2005, five British final (fifth)-year medical students from two medical schools were placed through the JMEF in clinical clerkships in Japan which lasted for 1–6 weeks. Four participants studied at Juntendo University School of Medicine and one at Jikei University. All five British students were individually interviewed, in English, by H. Nishigori using a semi-structured format, about what they had learned in Japan 10 months after they finished their electives (in autumn 2006). A further interview was also carried out in July 2006 with a British doctor who participated as an undergraduate medical student in an international elective at Jichi Medical University in Japan in 2000. At the time of this study, these six interviewees were the only British participants in international electives in Japan who had been placed through the JMEF. The profiles of the interviewed students are shown in Table 1.

A semi-structured individual interview format was chosen because it is the most widely used one in qualitative research and it enables interviewers to delve deeply into social and personal matters in anticipation of the emergence of new themes during the interview (Dicicco-Bloom & Crabtree 2006). The quality of the interviews was based on the first author's

**Table 1.** Student profiles.

	Japanese students (15)	British students (6)
Sex	Male (6) Female (9)	Male (2) Female (4)
Period (weeks)	4w (15)	1w (1), 4w (1), 5w (1), 6w (2), 10w (1)
<sup>a</sup> Specialty rotated	<sup>b</sup> GI (7) Rheumatology (5) Pulmonary medicine (4) GI surgery (4) Oncology (3) Acute medicine (2) Paediatrics (2) Orthopaedics (2) Nephrology (1) Cardiology (1) Infectious disease (1) Neurosurgery (1)	Paediatrics (2) General surgery (2) <sup>c</sup> ENT (1) Cardiology (1) Oncology (1) Endocrinology (1) GI (1) Pulmonary medicine (1) Community medicine (1)

Notes: <sup>a</sup>Most students rotate more than one specialty.

<sup>b</sup>Gastrointestinal medicine.

<sup>c</sup>Ear, nose, and throat.

experience in medical education in both Japan and the UK (Nishigori 2005) and on his completion of a qualitative interview training course run by the Department of Primary Caré at the University of Oxford. Each interview was conducted wherever interviewees preferred (e.g. at a university hall of residence or café near the station) and lasted 30–120 min. All the students consented to be interviewed and received a small gift in exchange for their participation. Ethical approval for this study was granted by the Institutional Review Board at Nagoya University Hospital.

### Analysis

All the interviews were tape-recorded and transcribed verbatim immediately after the interviews. The data were iteratively read by the first author and analysed by the thematic synthesis method, in which, first, text coding was performed, followed by developing descriptive themes as a second step, and generating analytical themes was the last stage (Thomas 2008). We chose this approach because it is suitable for analysing relatively unstructured, text-based data in an inclusive and rigorous manner (Ziebland & McPherson 2006). The second author read the Japanese transcripts separately and discussed the identified themes with the first author. The third author read the data from English transcripts separately and checked the quality of the themes identified by the first author. This triangulation process was adopted to achieve higher reliability of data analysis.

## Results

Nine learning outcomes of international electives were identified and are described below and shown in Table 2 with their frequencies. Excerpts from the representative transcripts follow, set in italics. The students were serially numbered, Japanese and British students separately, in order of appearance of their comments below, starting with the code numbers J1 and B1. The outcomes of the participants did not differ significantly according to the medical schools they were

**Table 2.** Main identified learning outcomes and their frequencies.

Learning outcome	Japanese students (n = 15)	British students (n = 6)
History taking and physical examination with clinical reasoning	11 (73%)	–
Management of diseases rarely seen at home	8 (53%)	4 (66%)
Clinical ethics	4 (27%)	5 (83%)
Healthcare system	14 (93%)	6 (100%)
Doctor–patient relationships	10 (67%)	6 (100%)
Work ethic	9 (60%)	4 (66%)
Medical education	15 (100%)	6 (100%)
Cultural competence	15 (100%)	6 (100%)
Personal development	15 (100%)	6 (100%)

from, the schools they visited, or the medical students' personal background.

**History taking and physical examination with clinical reasoning** (outcome noted in 11/15 of Japanese and 0/6 of British medical students' responses)

While the Japanese students were in the UK, they learned how to take the history of a patient and perform physical examination using clinical reasoning. In Japan, many doctors rely heavily on investigations like laboratory studies or imaging in diagnosis, and in Japanese medical education there is little emphasis on the teaching of history taking and physical examination (Matsumura 2002). Therefore the Japanese students were conscious of making up for this deficit in the Japanese medical education curriculum when taking histories and performing physical examinations during their course of study in the UK.

*'What we were asked was to take a history and do a physical examination and think of differential diagnoses. After doing the examination, I talked with my supervisor about differential diagnoses based on the information I got. It was quite interesting.'* (J1)

*'Physical examination skills must be my biggest learning outcome.'* (J2)

**Management of diseases rarely seen at home** (outcome noted in 8/15 of Japanese and 4/6 of British medical students' responses)

Both Japanese and British medical students learned to manage diseases that are rarely seen in their own countries because of epidemiological differences.

*'I learned how different the epidemiology is here. For example, we have a lot of patients with virus induced hepatic cancer in Japan, whereas in the UK there were more patients with alcohol induced hepatic cancer.'* (J2)

*'There are a lot of HIV patients in the UK. I have never seen any patient with HIV in Japan.'* (J3)

*'When they saw a suspicious lesion in the stomach, they would inject some dye to see whether it was malignant or not [dyeing endoscopy]. I have never seen that here [in the UK], so that was quite interesting.'* (B1)

**Clinical ethics** (outcome noted in 4/15 of Japanese and 5/6 of British medical students' responses)

Students encountered different clinical ethical values when seeing patients. This exposure to other values enabled them not only to understand the different values better but also to reflect on their own. Each country has its own religion and culture, and students learned overseas that different clinical ethical values apply to patients from different cultures or religions.

*'...They [in Japan] would like continue to [...] ventilate kind of probably brain-dead patients, just keep the babies alive, whereas here [in the UK] they probably will not do that... Whereas in Japan, yes, the neonates definitely had that 'keep-tubed-patients-alive-as-long-as-possible'. I think now it is a cultural belief: 'that is the way things should be done.'* (B2)

*'Sometimes [here in the UK] you have this Do Not Resuscitate directive so that [...] even the doctor can decide on the patient's interest and like that. It is not worth keeping the patient alive if it is just going to be for another month on the ventilator being brain dead and everything. Whereas in Japan, I think the case is that [they] do everything. We saw that in the pediatric wards, that they were keeping alive, with all this expensive, state-of-the-art machinery, babies that you could see that they did not have a chance in life. I mean, I am not the one to judge obviously, you see that is my own opinion. People have different views.'* (B3)

**Healthcare system** (outcome noted in 14/15 of Japanese and 6/6 of British medical students' responses)

Japanese and British students both gained knowledge of a different model of healthcare and had opportunities to reflect on their own country's healthcare system. Students observed a different healthcare system directly and considered what the ideal system should be like. As it is difficult for medical students to learn about their own healthcare system within their home countries (Agrawal et al. 2005), this is potentially one of the most valuable learning outcomes of international electives.

*'I think it's especially good for elderly people to have their own GPs, like in the UK. In Japan [which has no GP system] patients have difficulty deciding where to go.'* (J4)

*'The NHS [in the UK] gives people free healthcare service, which is really good, but it has waiting list problems [...] whereas the American system is more private. I think the Japanese system is located somewhere in the middle...'* (J2)

*'I always wondered why Japanese doctors are so busy. I found it might be because Japanese patients can come to the hospital too easily...'* (J5)

*'In Japan, they would do ultrasound, they would do CT, they would do MRI, they would do every single test under the sun, just to make sure, which I thought was really interesting.'* (B3)

*'Infant mortality [in Japan] is one of the lowest [...], and the life expectancy is one of the highest.'*

*So that in itself reflects a very good medical system...'* (B4)

*'And [it was good] just to see how the healthcare system works in a different country, because obviously I know how the system works here [in the UK]. [...] It was very, very interesting [...] just to see what sort of advantages and disadvantages there are and what [remains] to be improved on ...'* (B1)

**Doctor–patient relationships** (outcome noted in 10/15 of Japanese and 6/6 of British medical students' responses)

Both Japanese and British students encountered different doctor–patient relationships from what they had seen at home. Most Japanese students noted that British doctors talked with patients on a more equal basis. British students found that Japanese patients were very much more cooperative. From this result, we see that a traditional paternalistic doctor–patient relationship still exists in Japan. Students learned that they had to adapt their consultation style to patients from a different culture.

*'I found doctors talked with patients more equally. I was really impressed when I saw one of the patients arguing with his doctor. He also remembered all the drugs he was taking!'* (J6)

*'I think the main difference is the patients in Japan were very, very cooperative, sort of, 'what the doctor says, the patient would do and no questions asked.' [...] The doctor would say, 'Okay, we are going to do an endoscopy.' 'Okay doctor, let's do it.' So I think that was the main difference [...] between Japan and here [in the UK].'* (B1)

*'If you were to like to name the doctor–patient relationship, we would call it quite paternalistic. But [...] if it works, everybody is happy. If the patient is happy, the doctor is happy, then why not have this kind of relationship?'* (B3)

**Work ethics** (outcome noted in 9/15 of Japanese and 4/6 of British medical students' responses)

Most Japanese students found a substantial difference in the work ethic they witnessed in the UK. Some were even shocked or expressed discomfort when seeing doctors working in shifts. However, other (mainly female) students responded positively that, as doctors, they would be able to strike an appropriate balance between work and private life in the UK system. Although most British students recognised that many Japanese doctors were dedicated to their work, they also preferred an appropriate balance. The background to this outcome is a recent change in the work ethic in the UK, where the idea of self-sacrifice has been mostly replaced by that of sharing workloads in a healthcare team. From this result we found that a traditional, altruistic work ethic still exists in Japan. Irrespective of the respective merits and demerits, by encountering different models of doctors through their international electives, students had opportunities to think about what it means to work as a doctor.

*'I felt envious of a part-time consultant I met. She seemed to achieve a good work-life balance...'* (J5, female)

*'I don't like doctors' going home at 5pm. I know it is just an emotional feeling, and I understand that it [the British shift work system] is good theoretically, but I just don't like going back home leaving patients [before the job is done].'* (J7)

*'What I found was that [Japanese doctors] were very [...] dedicated to their work. [...] Work came first and then everything else. [...] I think they love what they do, ... perhaps it is sort of [...] the way that they are brought up in a way that you have to work hard and be loyal to your work.'* (B1)

*'I mean personally, I would like to have a better balance between work and private life [not like Japanese doctors] [...].'* (B5)

**Medical education** (outcome noted in 15/15 of Japanese and 6/6 of British medical students' responses)

Through their exposure to different approaches to medical education and encounters with students studying in other systems, both Japanese and British medical students discovered different ways of teaching and learning and reflected on the education they had received. Most students from both countries noted the need for an appropriate balance between theory and practice in medical education.

*'In this medical school (UK), students have more chances to learn by seeing patients. Even first-year students come to the ward. Whereas in Japan, we learned medical theories in classrooms for about 4 years...for example, when I heard a heart murmur from my patient in the ward (in the hospital in the UK), I found it was much easier to learn the relationship between the murmur and the problem of the heart. I was much more motivated as well...'* (J4)

*'I think the main difference is the fact that in England medical students spend lots of time in hospitals. We spend three years in hospitals in clinical practice and they try to introduce clinical practice as early as year 1. [...] While in Japan, like from the discussions I had from one of the medical students, they spend like one year or a maximum of two years [in hospitals during medical school]. So I think that is the main difference. But then, I presume if Japanese students do spend so much time just studying and learning, they have more basic knowledge.'* (B5)

**Cultural competence** (outcome noted in 15/15 of Japanese and 6/6 of British medical students' responses)

The geographical location of Japan being in the Far East, both British and Japanese students were able to observe many general cultural differences, for example, the multiple nationalities in the UK and the hospitality and morality characteristics of people in Japan. From their international elective experiences, students acquired greater cultural competence and ability to relate in different ways to patients from different cultures.

*'It was so exciting, because so many people of so many ethnicities from so many countries are living*



*in the UK. [...] It broadened my outlook on other things as well.'* (J8)

*'Generally, I think the Japanese people are more hospitable. [...] We felt very special when we came [to Japanese hospitals]. [...] They were very like, 'Oh, thanks for coming!' and they were extremely friendly, so making friends was easy and made the experience really good.'* (B3)

**Personal development** (outcome noted in 15/15 of Japanese and 6/6 of British medical students' responses)

Most students faced some kind of difficulty in the course of their international electives, and some difficulties were challenging. However, both positive and negative experiences helped students develop personally.

*'I wasn't told what to do or when, although I thought I would be given something like a work schedule. Worse, I got very little support when in the hospital. So I had to find out what I should learn by myself. [...] It was very hard, but through this experience I learned how to survive and how to be self-directed.'* (J9)

Discussion

In this exploratory qualitative study, we clarified nine major learning outcomes of international electives through bidirectional communication between medical students from two developed countries. On examining all the results, we realised that cultures and systems appear to be the two key factors affecting learning outcomes of international electives. Students learned about healthcare systems and about medical education because the systems in the two countries differed. They learned about management of diseases rarely seen at home, clinical ethics, the work ethic, doctor–patient relationships, and cultural competence because of cultural differences they observed including epidemiology. Therefore seven of the nine outcomes of international electives could be termed culture- or system-dependent (Table 3).

We also found that participation in international electives was associated with several outcomes related to medical professionalism. By observing another country's healthcare

system, students learned about principles of social justice, commitment to improving access to care, and commitment to a just distribution of finite resources – all items mentioned as components of Medical Professionalism in the New Millennium, a physician's charter (Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine, 2002), which is one of the most well-known and accepted models of medical professionalism in the world (Blank 2004). By observing the work ethic in another country, students learned about the principle of primacy of patient welfare in the physician's charter. By observing doctor–patient relationships in another social context, students learned about patient autonomy and commitment to maintaining appropriate relations with patients. By observing other approaches to medical education, they learned about the commitment to professional competence described in the physician's charter.

Although the elements of medical professionalism are well-described in the literature, many medical schools still struggle to teach professionalism effectively (Wagner et al. 2007). By allowing students to encounter different models of medical practice, for example, for British students to see the Japanese model which has differences as well as similarities to the Western one (Takahashi 2008), international electives could play an important role in the development of curricula, provided that the learning outcomes of professionalism as a curricular item are clearly defined. Conversely, by studying these students' opportunities to learn professionalism in international electives, we realised more clearly than before that differences as well as similarities in medical professionalism exist among countries (Takahashi 2008). These differences should be taken into account when examining medical professionalism from an international perspective.

The effects of international electives are not limited to what the students learn about – how students learn is also significant. We found that students learned most outcomes, particularly those related to professionalism, not only by observing the differences but also by reflecting on what they learned or experienced in their own countries. For example, students learned about the characteristics of ideal healthcare systems not only by observing a different healthcare system model but also by reflecting on that of their own country. As most learning outcomes were achieved through reflection and the visiting elective programme necessarily prompted the participants to have such reflections, reflection is more than a hidden asset: it is a crucial learning process that produces important outcomes (Balandin et al. 2007). (And let it be noted that the evaluation of international electives through studies such as this one promotes such reflection by students and faculty.)

This study had two major limitations. One was that international electives were examined in only two countries, both developed. As the literature on international electives for medical students from developing countries is very limited (Balandin et al. 2007; Thompson et al. 2003), further research should focus on this area to address learning outcomes in a wider global context. Studies on international electives are also needed to shed light on the brain drain as a notable issue with suspected negative outcomes for developing countries

Table 3. Culture- or system-dependent/independent learning outcomes.		
	Culture- or system-dependent	Culture- or system-independent
Learning outcomes	Management of diseases rarely seen at home Clinical ethics Healthcare system Doctor–patient relationships Work ethic Medical education Cultural competence	History taking and physical examination with clinical reasoning Personal development

(Gupta and Farmer 2005). Certain outcomes of this study (e.g., comparisons between healthcare systems and between medical education systems, sensitivity to cultural differences) are nevertheless clearly generalisable to international electives involving developing countries and students from developing countries. A second limitation of this study is that it examined only short-term learning outcomes of international electives. Through follow-up interviews, for example, long-term outcomes should be further studied, with the focus on higher levels of curriculum evaluation (e.g. changes in career choices or benefits to patients) (Morrison 2003; Ramsey et al. 2004).

## Conclusion

In this study, we clarified nine major learning outcomes of international electives. We found that students achieved mainly culture- or system-dependent outcomes as well as professionalism-related outcomes, through reflection in most cases. As what medical students learn in their international electives becomes better known, both faculty members and medical students will, we hope, better understand the desirable outcomes of such programmes and appropriate goal setting will give the programmes a better structure. For example, future international elective programmes will be prepared with careful investigation of medical education curriculum of both home and visited countries and in these, students will be requested to write a reflective diary regarding professionalism-related practice. We confidently expect that, through quality-assured international electives, future doctors will acquire broader perspectives on international health issues and more professional attitudes towards their work.

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