

Reflections on being the first Japanese Fellow of the Joint Faculty of Intensive Care Medicine

Yukiko Goto

"Where do you come from?"

"Perth."

"Wow, you come from Paris."

"Paris? In France? No. Perth. P-E-R-T-H. Western Australia."

My English — especially my pronunciation — was terrible when I first arrived in Australia to take up a training position in intensive care. People laughed, but I accepted this — smiles and laughter are "the gates to happiness". However, when it came to passing the primary and fellowship examinations, it was no fun to be handicapped by my limited English prowess.

I graduated from a medical university in Japan and trained as an anaesthetist. In 2001, after working in an intensive care unit for about 3 years in Japan, I moved to Australia to take up intensive care training. I have now been back in Japan for more than 6 months after completing the training course and achieving the Fellowship qualification of the Australasian Joint Faculty of Intensive Care Medicine (JFICM).

Japan is a small and colourful country. While safeguarding old cultures, Japanese people are enthusiastic about new and cutting edge technologies. You see this meeting of the old and the new everywhere and in all fields of endeavour. I am proud of the unique Japanese culture and the beauty of the country and would recommend that everyone visit Japan to experience them.

On the other hand, this unique Japanese character can also cause difficulties, and the system of intensive care medicine is not immune. If there are 10 ICUs, there will be 10 different systems. The ICU where I currently work is "semi-closed"; we write treatment plans, but teams from the parent units add to these without reference to the ICU team. More than 90% of the patients I care for have had elective surgery, including cardiovascular surgery. We admit no patients from the emergency department because they have their own ICU. Post-surgical patients enjoy the highest priority for admission to the ICU. Therefore, medical patients who require ventilation or inotropes are treated on general wards by parent unit doctors and nurses. Patients may be discharged from the ICU to general wards while still receiving full ventilatory and inotropic support, to make room for new post-surgical patients.

The ICU where I worked before going to Australia was "closed", similar to Australian ICUs. However, most Japanese ICUs are "open"; anaesthetists may look after ICU patients while on call and deal with emergency situations

and bed management, while doctors from the parent units assess and order treatment for their patients. The most important problem is that no authority completely understands the current situation of intensive care medicine in Japan. There are no accurate data on the number of doctors working in the specialty of intensive care medicine, and there is no central database identifying which ICUs are open and which closed.

The various treatments and therapeutic approaches used for critically ill patients in Japan would be fascinating subjects for the Western professional. There are quite a few "Japan-only" medicines and procedures. These include the protease inhibitor nafamostat mesilate used as an anticoagulant for continuous renal replacement therapy, or administered with imipenem by the intrapancreatic route for acute pancreatitis; use of human atrial natriuretic peptide as a diuretic and vasodilator; measurement of β -glucan to detect fungal infection; use of the neutrophil elastase inhibitor sivelestat for acute lung injury; and antithrombin III for disseminated intravascular coagulation; and many more. There are good theoretical reasons for each of these therapies or approaches, but the evidence levels are too low to justify their use elsewhere. What is worse is that many of these medications are very expensive.

When using these Japan-only therapies, I was occasionally not confident whether I was doing the right thing. Major English-language journals and textbooks do not mention many medications and procedures that are used every day in Japan. Also, there was no organised course in Japan at which I could learn world-standard intensive care medicine. These were the main reasons I decided to go to Australia for intensive care training.

In my view, a high-quality examination results in high-quality training. I found that the JFICM Fellowship examinations were one of the most important goals of the training I undertook in Australia. Of course, these examinations caused me much anguish and soul-searching. It was obvious to me that I would gain confidence once I had passed. I had to go through the examination process to achieve my initial goal of learning world-standard intensive care medicine. It also helped me develop a personal sense of achievement. More importantly, I had the experience of watching and learning how to organise a medical education system as well as teaching techniques. These were real treasures to me. Young doctors in Australia, you are in a gold mine!

Without question, Australia has a much better system of intensive care medicine than Japan. A well-established ICU system improves not only the quality of patient care, but also the lives of doctors and nurses. Moreover, good management of intensive care resources is cost effective and also makes it possible to contribute to the progress of intensive care medicine worldwide through large-scale randomised controlled trials. Australian intensive care is certainly one of the best models in the world. I also admire the doctors and nurses in Australia, and enjoyed listening to their life stories. In comparison, most Japanese doctors and nurses have simple lives. They follow a narrow career path. They work hard for their patients, hospital and society, and their sense of responsibility is often at the expense of their personal lives. This attitude is seen not only in consultants, but also in junior doctors and nursing staff.

“No bed in ICU”. In Australia, this happens even when there are physical beds, but no nurse is available to look after a new patient at a one-to-one ratio. This surprised me greatly when I first arrived in Australia. Most Japanese ICUs do not have one-to-one ratio nursing; if necessary, one nurse looks after three ventilated patients. One might argue that having fewer nurses is dangerous and potentially contributes to adverse medical incidents. This is absolutely reasonable, but I would argue that being outside of an ICU if you need to be in one is also not safe! In Japan, ICU doctors help nurses when they are busy, and off-duty doctors, especially junior doctors, stay back to help out if necessary. This is taken for granted. Parent unit doctors may also “stick around” and take care of their patients over-

night, if they are worried. Junior doctors are keen to stay after hours to see “something happen”. It is not that the attitude and work ethic in Japan is better or worse than in Australia, but there does seem to be a different mind-set, based on the social and working environment. I must say I sometimes missed this attitude among younger doctors in Australia, who seem very keen to leave the hospital at the end of the shift.

A problem in the Japanese intensive care community is that few people know how intensive care medicine is practised outside Japan. As an Australian-trained intensivist, there are many things I can do to rectify this, starting with talking about my experiences of Australian intensive care medicine and showing how a trained intensivist handles situations in the workplace (ie, leading by example). I hope to make a good impression on doctors in Japan — especially younger doctors who are interested in intensive care medicine as a career.

Finally, I would like to especially thank Dr Vernon van Heerden and Dr Walter Thompson of Sir Charles Gairdner Hospital, Perth, who accepted me for training from Japan, and Professor George Shorten of Ireland who introduced me to the hospital. My career has benefited greatly from their assistance and my experiences in Australia.

Author details

Yukiko Goto, Staff Intensivist

Intensive Care Unit, Osaka University Hospital, Osaka, Japan.

Correspondence: gyukiko@mbe.ocn.ne.jp. □