FROM THE EDITORS' DESK

Comparative International Medical Education

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Sitting forward, smiling, listening, nodding, speaking, pausing, and gradually, becoming animated. Engaged learning looks the same in almost every culture within the health professions. Having taught in Sri Lanka and China, and now in Tokyo as a visiting professor, how learners feel about their education is often readily apparent.

In Sri Lanka, 50 pediatric students crowd into a room built for 20, climbing over each other, laughing and waving—with rapt attention in class. Internet searches and e-learning efficacy ceased temporarily when rolling electrical brownouts occurred. In China, medical students follow their Neurology professor, waiting for questions about their patient, watching as the nurse holds his examination tray with a stethoscope, reflex hammer, monofilaments and a penlight. In Japan, students prepare for pre-clinical OSCEs, practicing examination maneuvers on each other. The occasional minor ground tremor doesn't slow them down, as long as the table contents are unmoved. All of these students are searching for meaning in their work, and are looking for opportunities to engage deeply in their professional self-development.

Educational systems and infrastructure, influenced strongly by culture, often determine each system's strengths and limitations. While Sri Lanka and China's medical systems are based on the British model, Japan's model derives from Germany and Russia—often with a single professor per department personally responsible for all research and teaching activities. In each, observational clerkships dominate, with little or no direct attention to teaching and assessment of clinical reasoning during medical school.

Different challenges arise within each system. In most Asian countries, students enter medical school after high school, and medical schools become responsible for fostering the students' maturation as an adult, as well as their growth as a physician. Issues surrounding professionalism become more acute, as young people struggle with who they want to become (versus who their families want them to become). In most of Asia, medical school admissions are based mainly on math and science scores, leading to enrollment of some bright medical students

who may need more basic training in communication skills. While the North American medical educational system may be based on participatory clerkships, learner performance feedback is often non-supportive for struggling students. In every system, there are not enough dedicated medical educators.

In this issue of *JGIM*, several articles examine some of the challenges confronting medical education in North America, while others suggest solutions. Levine and colleagues¹ explore how residents reporting burnout are perceived by their patients. Over 50% of their residents were classified as suffering from burnout, yet, patients rated these physicians highly on empathic communication. This dissociation may indicate that well-trained physicians can overcome their personal issues when interacting with patients, but it is troubling that quality care may come at the cost of resident physician well-being.

Curricular innovations abound. Karani and colleagues² illustrate how to help medical students improve their counseling of hospitalized patients, matching their discussion to patient health literacy. In *Exercises in Clinical Reasoning*, Synder and colleagues³ walk readers through approaches to help learners manage their cognitive load when dealing with clinical complexity.

Improving medical training is an effort undertaken by educators in every country. Working together, educators can draw on the best of each cultural tradition to improve our learners' experiences and outcomes. As I have learned to say in Japan, *yoroshiku onegaishimas* ("I look forward to working with you").

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