2026 NUSOM Summer Program: Bridging Community Meidcine and Innovation in Japan

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Life is as fluid as the tide, always moving, receding, and returning. A ripple may disappear from the surface, but the water continues to carry its movement forward. Throughout my time in Japan, I found myself thinking about what remains after a moment has passed, what remains of a person when memories fade, what remains of a culture as centuries pass, and what medicine must preserve as technology and society continue to change.

Our program began at Nagoya University, where I had the opportunity to visit the Department of Urology with two Japanese medical students, Shunsuke and Yosuke. There, we met Dr. Akamatsu, a urologist who balances clinical practice with research. Having trained in Canada, he described several differences between urologic practice in Japan and in Western countries. He explained that urology in Japan historically developed from dermatology, in part because physicians treated patients with sexually transmitted infections such as syphilis. One difference that stood out to me was the role Japanese urologists play in caring for patients with cancer. In Japan, urologists may direct both the oncologic and surgical management of patients with urologic cancers. In the United States, systemic cancer treatment is more commonly directed by medical oncologists, with urologists becoming most involved when surgery is required. The Japanese model allows urologists to follow patients across more stages of their illness and to personally manage many of the complications arising from treatment. As someone interested in urology, this conversation reminded me that specialties are not fixed entities. Their responsibilities are shaped by a country's history, healthcare system, and population needs.

That evening, the sushi exchange party allowed us to meet the other participants outside the formality of the hospital. These early conversations became the foundation for relationships that deepened throughout the week. Medical exchange did not occur only during lectures or clinical visits. It also happened over shared meals, through jokes, and in conversations about our families, interests, and lives outside medicine.

The following morning, we visited Nagoya University's Medical xR Center. I practiced laparoscopic surgery while Dr. Nakanishi guided me through a simulated appendectomy, and I used interactive models to practice microsurgical techniques. Although the technology was impressive, one of the most meaningful moments involved something much simpler: suturing alongside Japanese medical students. They showed me the hand-suturing techniques they had learned, while I demonstrated techniques commonly used in my own training. We compared our approaches, corrected one another, and learned together. That interaction represented genuine cultural and professional exchange. Neither group entered the room possessing all the knowledge. Innovation came not only from the machines around us but from our willingness to share what we had been taught. I left understanding that medical progress does not always begin with inventing something new. Sometimes, it begins by placing different ways of thinking beside one another and remaining open to changing our own practice.

Our visit to the National Center for Geriatrics and Gerontology expanded my understanding of innovation further. The center brought diagnostic evaluation, rehabilitation, physical therapy, pharmaceutical care, cognitive health, and geriatric medicine together in one location. Rather than asking older adults to navigate multiple disconnected systems, care was organized around the complexity of their lives.
In the United States, older patients are often expected to move among specialists, pharmacies, rehabilitation facilities, and social services that may communicate poorly with one another. At the center, I saw how the structure of a healthcare system can itself be therapeutic. True innovation is not limited to advanced equipment. It can also be a system that reduces fragmentation and allows clinicians to see an older adult as one person rather than as a collection of diagnoses.

This lesson became more personal during our home visits in Mino City. One of the patients we met was living with Alzheimer's dementia. She had lived an entire life, yet much of that life was no longer available to her through memory. Her presence made me wonder: where is a life held when a person can

no longer recount it? Perhaps a life remains in the people someone has touched, in the routines that continue to offer comfort, and in the spaces that have witnessed their experiences. As someone who has also seen Alzheimer's affect a relative, I know that family members begin carrying memories that their loved one can no longer access. Lucid moments become especially precious, but the value of spending time together does not depend only on whether the person will later remember it. For the family, it becomes another memory to hold. For the person with dementia, it remains a moment in which they can experience comfort, affection, safety, or joy.

Meeting this patient taught me something that a lecture on the pathophysiology of dementia could not. Dementia is not only the accumulation of plaques, the degeneration of neurons, or the loss of cognitive function. It is the lived experience of a person who continues to deserve dignity even when their story becomes difficult to communicate. Understanding who a patient was before an illness is therefore not separate from clinical care. It is part of the care itself. Seeing patients inside their homes also revealed information that could never be fully captured in a hospital room. We could observe the environment in which patients moved, ate, rested, interacted with family, and encountered limitations. Home visits transformed questions about "social history" into something visible. A staircase, a family photograph, a favorite chair, or the location of a bathroom could influence a care plan as meaningfully as a laboratory result.

At Kagayaki Clinic, Dr. Ichihashi introduced us to the concept of *ikigai*, the people, activities, purposes, and sources of meaning that make life worth living. We created a mind map incorporating a patient's disease, treatment, physical environment, social circumstances, and *ikigai*. This exercise challenged the assumption that restoring physical function should always be the final goal of rehabilitation. Function matters, but we must also ask what the patient hopes to do with that function. Is the goal to walk a certain distance, or is it to reach the garden they love? Is the goal to improve hand strength, or is it to prepare food for their family again? As physicians, we frequently design interventions intended to return patients to a medical definition of "baseline." Yet patients do not experience life through measurements alone. A meaningful care plan should help them remain connected to what gives their life purpose. This is especially important when caring for older adults, because clinicians may unintentionally prioritize longevity or function without first understanding what the patient considers worth preserving.

Our experience at CamCam Swallow offered another example of preserving identity through care. We learned how dysphagia-friendly meals could be prepared to remain recognizable, appealing, and similar to the meals eaten by everyone else. Dysphagia management is often discussed in terms of aspiration risk, nutritional content, calories, and texture modification. All of those are important, but food is also culture, pleasure, memory, and community. In both Mexican and Japanese cultures, eating together can be central to family and social life. Whether people gather around a table, in a café, or at a *horigotatsu*, meals create belonging. When a patient with dysphagia is given food that looks entirely different from everyone else's, the person may be physically present at the table while still being separated from the shared experience. CamCam Swallow demonstrated that safety and dignity do not have to oppose one another. Clinical care can protect patients while still allowing them to experience familiarity, pleasure, and connection.

The cultural experiences surrounding our clinical activities reinforced this theme of preservation. Wearing a yukata, walking through Mino City, and observing the Ukai cormorant-fishing ceremony allowed us to encounter traditions that have been carried forward across generations. Ukai was not simply a performance for visitors. It represented knowledge and ritual preserved through families and communities over centuries. My first experience in an onsen also required me to move beyond my own cultural expectations. Being completely nude around others initially felt uncomfortable because nudity is often treated as private or taboo in the environment in which I was raised. Some of my Japanese classmates, however, had visited public baths since childhood and understood the experience as ordinary and communal. The discomfort forced me to recognize that what feels "natural" is often simply what has become familiar to us. Cultural humility begins when we stop treating our own habits as universal.

Our final academic session, led by Dr. Desai, focused on infectious and zoonotic diseases. His lecture connected human health to animals, technology, climate change, deforestation, and the environment. Human advancement has allowed us to treat diseases more effectively, but it has also altered ecosystems in ways that facilitate the emergence and movement of infectious diseases. The lesson complemented

everything we had observed during the week, health cannot be understood in isolation. Patients are connected to families, communities, cultures, animals, and environments. Medical solutions must therefore account for relationships that extend beyond the individual body.

The program also led me to reflect on how identity shapes cultural exchange. As a gay man, I am sometimes cautious about disclosing my identity while traveling because attitudes toward LGBTQ+ people differ across cultures. During a conversation about relationships, I shared with my Japanese classmates that I had a same-sex partner. One classmate had previously assumed that my partner was a woman. He immediately apologized and explained that LGBTQ+ identities are not always discussed openly in Japan. More importantly, he acknowledged his assumption and said that he wanted to become more conscious of it. I had initially withheld this part of myself to avoid creating an uncomfortable conversation. Instead, sharing it created an opportunity for honesty and learning. Cultural exchange requires more than observing another country from a comfortable distance. It sometimes requires allowing ourselves to be seen. That conversation reminded me that openness can challenge assumptions gently, and that humility includes being willing both to correct others and to be corrected ourselves.

As I reflect on this program, I recognize that we remember people partly through the memories and stories others carry about them. People leave impressions that shape how we think, care, and move through the world. The students and physicians I met in Japan may not remember every conversation we shared, and I may eventually forget many of the details of the week. However, the experience has already influenced the way I understand medicine. Ten years from now, I hope this program remains visible in the questions I ask my patients. I hope I ask not only what illness they have, but what they hope to preserve. I hope I consider the home, family, culture, and community surrounding a diagnosis. I hope I use technology without allowing it to replace human presence. Above all, I hope I remember that caring for someone means recognizing the person who exists beyond their symptoms, even when they can no longer tell me their entire story.







