Editorials

Disaster in Japan:

a new medical gaze

On the 11 March 2011 disaster struck Japan. A magnitude 9 earthquake followed by a tsunami hit the east coast of Tohoku and Kanto. Thousands of people have been killed, more people have been left homeless, and the headlines around the world now give their attention to the damaged nuclear reactors in Fukushima. This disaster poses particular challenges for Japan and symbolises a more general dilemma for health professionals observing around the world.

In Japan, relief efforts have focused on rescuing trapped or stranded people, evacuating those in unsafe areas, and providing basic shelter, water, food, and medicines. Despite establishing the emergency management committee and activating 120 field units,¹ the government has faced some criticism for not acting more swiftly following the disaster.² The evolving figures are shocking. On 12 April 2011 Reuters reported that 13 843 people were confirmed dead by Japan's National Police Agency, while 14 030 were missing.³ It was reported that 136 481 people remained in shelters, with the majority of the 70 000 people previously living in the 20 kilometre nuclear exclusion zone thought to have left their homes. A request for international aid has been issued. The challenge faced by rescue workers includes poor access to affected areas, flooded hospitals, an older population, and growing fears about the safety of food and water supplies.³ Potassium iodine tablets are being distributed to limit the impact of radiation exposure.⁴

That such a nuclear problem should befall Japan, considered one of the exemplars of 'safe' nuclear power, has prompted many other countries to take note.⁵ In the coming months more details will inevitably emerge regarding the details that led to the nuclear accident. However, despite the understandable concern about the Fukushima nuclear reactors, some have argued that a disproportionate amount of media time has been spent covering the explosion, as opposed to the human tragedy of those killed, injured, and displaced by the earthquake.⁶

STRENGTH OF FAMILY MEDICINE IN FUKUSHIMA

For many involved in general practice, it is

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particularly sad that Fukushima has overnight become known for a disaster when it had been slowly fostering a reputation for very different reasons. Fukushima, a rural and industrial area that has traditionally struggled to attract enough doctors to serve its aging population, now boasts one of the first structured family medicine training programmes in Japan.⁷ As such, it has received a number of international visitors interested to see how a generalist approach fares in one of the most high-tech hospital dominant countries in the world.^{6,8}

In the subsequent days after the first earthquake, trainees in family medicine at Fukushima Medical University, spread around the small communities of the prefecture, were communicating again by teleconference. They have been working hard in the forefront of care at community-based hospitals and clinics. At their regular teleconference sessions, the forum in which they normally meet for teaching sessions, family medicine trainees shared the common challenges faced in the aftermath of the earthquake. These included the difficulties of providing communities and local government with pertinent advice about ionising radiation,

triaging frail older people in order to evacuate them to institutions inland, and maintaining their clinical facilities without enough information, water, electricity, and petrol.

TRAGEDIES IN MODERN CONSCIOUSNESS

For observers around the world, the tragedy left many people who have friends and family in the affected areas desperate for information and keen to help however they can. For those with a less tangible connection to Japan the news of the earthquake perhaps poses a more general dilemma. The distance from Fukushima to the UK is over 9000 kilometres yet the images of the earthquake, the tsunami, and the failed nuclear reactors for the wider international audience are only centimetres away. Within minutes to hours video footage was freely available on YouTube, blogs, Twitter, and rolling news stations. Tragedies around the world are now part of the modern consciousness, such as the recent mud-slides in Brazil, the earthquake in New Zealand, and the upsurge in conflicts in the Middle East. How does one — from a distance and proximity — make sense of such events?

Registrars and medical students at the Family Medicine Resident Forum, Fukushima Medical University, 23 April 2011. The Forum provided the first opportunity to listen to what each attendee had experienced in person (not by teleconference) since 11 March.

Source: Professor Ryuki Kassai

"Medicine is now a truly global profession, whose connections and potential are continually emerging ... Around the world, colleagues in general practice face challenges that can inspire ..."

When Michel Foucault coined the term the 'medical gaze' in the 1960s, it related to the way in which doctors in the 18th century learned in hospitals to see beyond the surface of bodies, to see organs and pathophysiology, and to distance themselves from human suffering.⁹ Now the 'medical gaze', increasingly cultivated in general practice, has a holistic focus¹⁰ with a greater emphasis on patient experience and community orientation in contrast to the 18th century teaching at the Hotel-Dieu; the factors influencing the 'medical gaze' change with time.

As the default exposure to world events increases, it is important that the 'medical gaze' is mindfully international, so that it can better harness this exposure, even if at times solutions and meaningful words will be hard to find. For example, it would be helpful for the international community to construct a database of evidence-based information/references on immediate, short-, and long-term effects of ionising radiation, as well as the impact of other kinds of disasters, looking at interventions and strategies to alleviate their effects, especially from the viewpoint of primary care. Appropriate teaching tools would also be useful. In the UK, it is encouraging that GP trainees are now invited to spend more time overseas with Out of Programme experience.¹¹ A more global view of health may be further facilitated as arguments for an international curriculum gather momentum.¹²

RELIEF EFFORTS AND MEDICAL CARE

Japan will require help in the months and years to come. In practical terms, international aid agencies are best placed to respond initially in the aftermath of natural disasters, but require the support of those who are able to donate time and/or money. As relief efforts continue it is welcome that governments, international agencies, and professional organisations have expressed their solidarity with the people of Japan. Nuclear power deserves to be debated globally and safer sustainable power sources sought. In particular, lessons can be learned for the UK with regards to the

role of primary care if confronted with a similar nuclear tragedy. It is important that political differences about the future direction of Japan's medical system are put to one side as it unites against the challenge posed by the disaster.

Medicine is now a truly global profession,¹³ whose connections and potential are continually emerging. This may mean exposure to news of more disasters, but more importantly it is an opportunity for greater understanding, hope, and solidarity. Around the world, colleagues in general practice face challenges that can inspire acts of great human endeavour despite adversity.

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Provenance

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Competing interests

Patrick Hutt visited the Fukushima family medicine training programme in 2008, staying as a guest of Professor Kassai and his colleagues. Ryuki Kassai established the vocational training scheme in general practice in Fukushima and is a citizen of Fukushima.

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