Japan Chapter

ACP American College of Physicians Leading Internal Medicine, Improving Lives | Japan Chapter

Governor's Newsletter for All ACP Members

November 2015 Governor: Fumiaki Ueno MD, MACP

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Governor's Message

Join us! We will bring you up to be global internists.

Fumiaki Ueno, Governor of ACP Japan Chapter

ACP (American College of Physicians) is the largest organization for medical science in the world with more than 140,000 members. This year, ACP is celebrating 100th anniversary of its founding in 1915. During the past one hundred years, ACP has been leading internal medicine and improving lives of people worldwide.

Japan Chapter was established 12 years ago, as the first Chapter outside of American Continent. Over 1,000 members of Japan Chapter today consist of not only American Board of Internal Medicine (ABIM) certified or eligible physicians, but also internal medicine specialists certified by Japanese Society of Internal Medicine as well as residents training in medicine and medical students. Japan Chapter has evolved to be among the largest and most active international Chapters. We should recognize enormous efforts of the founding Governor, Dr. Kiyoshi Kurokawa, immediate past Governor, Dr. Shotai Kobayashi, and contribution of many other officers of the Chapter. It is my privilege to succeed the Governor of Japan Chapter. With my delight, I will make every effort for further development of Japan Chapter. As members of ACP, we should be proud of our activities to improve medical science, clinical practice, and human life.

Why ACP is not named "Society" or "Association", but "College"? Traditionally, British medical organizations were named "College", such as Royal College of Physicians or Royal College of Surgeons. Newer American medical organizations apparently followed such denominations. However, it is not merely a matter of denomination. I can think of two important reasons to call "College". Firstly, "College" is not for anyone who wishes to join, but it selects qualified members. We must show credentials to join ACP. Secondly, major mission of "College" is education. Educational resources of ACP are without doubt the best in the world quantitatively and qualitatively. As members of ACP, we can enjoy benefits to obtain resources, such as Annals of Internal Medicine, ACP JournalWise, DynaMed Plus, practice guidelines, MKSAP, and many books, etc. at no or significantly reduced expenses. More than 200 useful educational sessions are held in ACP Internal Medicine Meeting every year, and this is appraised as the best educational meeting in the field of internal medicine. ACP provides those resources to improve knowledges and skills of physicians in order to contribute to human society.

In recent aging society in Japan, needs for health care have changed dramatically. Aged patients usually have multiple comorbidities, and life expectancy is somewhat limited. Until recent past, many of internists in Japan were very knowledgeable and skillful at certain very specialized field, but not good at caring of remaining part of the patients. In patients with multiple comorbidities, very specialized knowledges and skills limited to certain organ system are frequently useless, or sometimes dangerous. What we need today are physicians who have wide and deep knowledges in internal medicine. We must share information with global internists to accomplish health care with high quality. ACP Japan Chapter would be delighted to assist members to attain highest international standard.

The history of ACP Japan Chapter founding

Shotai Kobayashi

Immediate Past Governor of ACP Japan Chapter,
Professor emeritus of Shimane University

I became FACP from a board certified member of the Japanese Society of Internal Medicine (JSIM). I supposed that it became possible by the effort of Dr. Kiyoshi Kurokawa former president of JSIM. He was president of JSIM and negotiated with the leaders of the ACP patiently to treat board certified member of JSIM as the same of board certified member of internal medicine in USA. We have already founded Fellows Society of JSIM board certified member (FSJSIM), so we made Credentials/Membership Committee and recommended many members to FACP.

I surprised very much to see big convocation ceremony at the first time. More than 1000 new fellows, FACP, MACP and so on attended with Regalia (black ceremonial gown). I thought ACP knows well how to make giving pride to fellows. We used this scene for recruiting new members of FSJSIM. Also I surprised that ACP meeting was quite different from that of JSIM. ACP meeting was consisted of many very educative and practical programs in contrast to JSIM meeting had mostly academic research oriented and far from practical educative programs. Attendants of the meeting of both Japan and USA are mostly practitioner or doctors in hospitals. The meeting hall is only big one in JSIM meeting but ACP has more than hundreds educational programs per day including practical simulations of dermatology, orthopedics and ophthalmology in many small to middle sized hall. I felt just “Scales from the eye”.

Professionalism also had been through in ACP, such as co-sponsored evening seminar with pharmaceutical companies were separated clearly and they were held only in the hotel.

Concerning of the exhibition, there ware many exhibitions of medical education including the large booth of the ACP itself and the booth from the training hospitals especially the local hospital in contrast to exhibition of Japanese meeting mostly consisted with pharmaceutical and medical device manufacturers. ACP Japan chapter introduced this idea and now more than 15 hospitals exhibit in annual meeting.

FACP in Japan was increasing every year with spread in the review, and reached to 300 members at 2000. After Dr. Kurokawa was decided next president of Congress of International Society of Internal Medicine (CISIM) in Kyoto, we attended this meeting at Cancun in 2000 for holding preparation. At that time, Dr. Kurokawa negotiated to found ACP Japan chapter with ACP leaders. Although ACP leaders had not idea to expand international chapter outside of Americas at this time, next president of ACP changed mind to expand. And Japan chapter establishment has been approved in 2003.

Dr. Kurokawa became the first governor of Japan chapter and served as a term of office eight years exceptionally. After that I served governor for 4 years. Member increased more than 1000 that it is next to Canada and incorporation of ACP Japan chapter was also successful thanks to the supporting of the members. This growth of Japan chapter has been attracting attention in ACP headquarters.

Now educational policy of ACP is necessary also in Japan because increase of importance of training of general physician. Young doctor with a motivation and the foresight also being gathered to ACP Japan chapter. ACP Japan branch as a society to nurture a general physician to be the leader in future of comprehensive medical care. It can be said that to enhance the existence value of ACP Japan chapter.

Under this idea, we started the program to participate in the United States resident education. More than 12 young doctors experienced 4 weeks of residency training in Olive View Medical Center of UCLA thanks to the cooperation of Dr. Wali who is governor of south California chapter during 3 years.

ACP Japan Chapter in order to spread in the future of comprehensive medical education in Japan, it is necessary to continue the level up of the expansion and its own program of further activities.

RECEIVING THE AMERICAN COLLEGE OF PHYSICIANS CHAPTER CENTENNIAL LEGACY AWARD

Kiyoshi Kurokawa MD MACP

The 2015 annual meeting of the American College of Physicians (ACP) (1) was held over four days, from April 29th- May 3rd at the Boston Convention Center (2).

This year was the one hundredth anniversary of the establishment of the ACP, founded in 1915. An exhibition and written work was published on its history, which can be viewed online (3). For the one hundredth anniversary, the "Chapter Centennial Legacy Award" was established and I was honored to be selected as the recipient of the award.

One hundred years ago, the Meiji Period had just ended in Japan and the United States was rising as a new power, a land created by immigrants who brought Western modernity with them. By following the history of internal medicine, the study of public health, medical care and medical science in post-Meiji Restoration Japan, many interesting developments are brought to light. One can observe that the social changes and the people who carried them out formed the history upon which our present now stands.

After spending fourteen years in the U.S., starting in 1969 (4), I was invited to return temporarily to Japan by one of my esteemed mentors, Professor Etsuo Ogata of the University of Tokyo in 1983. However, what was meant to be a temporary stay became a permanent one. When seeing the education and practice of medicine and universities in Japan in contrast to the rapidly evolving medical education, clinical training and practices in medical schools and academic medical centers in the U.S. and Europe, I became concerned with the university-centric way in which medicine was being taught in Japan, as well as how medical school and academic medical centers were run here in Japan. In the U.S., drastic changes were being made to the healthcare system and medical schools were undergoing significant reforms. For example, Harvard Medical School had just started the "New Pathway" program. Even in Japanese universities, several new keywords started to appear, such as "bedside teaching" to "bedside learning" to "clinical clerkship." Many researchers in various fields started to participate in American academic associations and the keyword, "Impact Factor" was starting to become widespread.

In 1989, as I assumed my post as Professor and Chair of Internal Medicine (Medicine I) at the University of Tokyo, I was also asked to hold various positions, such as member of the board of directors and chairman of the Japanese Society of Internal Medicine, the Japanese Society of Nephrology, the International Society of Internal Medicine, and the International Society of Nephrology. Through the responsibilities that came with these positions, I became heavily involved in reforms regarding the board certification of physicians, the Japanese Medical Specialist System, medical education and training in universities and their affiliated hospitals. This extended beyond the academic realm and included working with various committees of the Ministry of Education, Culture, Sports, Science and Technology as well as the Ministry of Health,

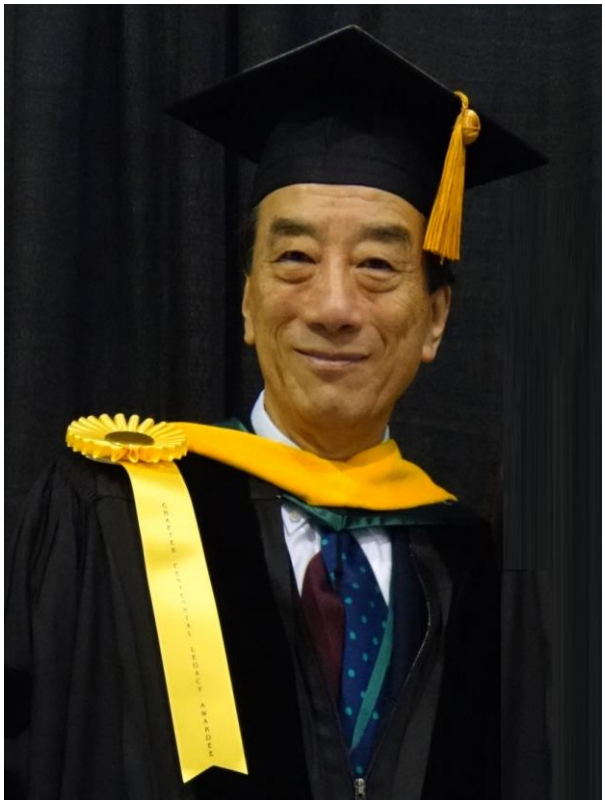
Labour and Welfare. One of my main concerns was the crisis in the medical education and residency training in the face of changing world affairs, ie, from international to global. In 1996, I assumed Dean of Tokai University School of Medicine. Afterwards, I became involved in science, technology and innovation policies through my senior position in the Science Council of Japan, member of Council of Science and Technology Policy of the Government as well as being science advisor to the Prime Minister. Through these experiences, I had many opportunities to meet incredible people of the world which helped me to further expand the scope of my work (5).

New ideas and greater openness do not easily arise in discussions amongst people who still view the pinnacle of Japan to be the old institutions of the hierarchical, "vertical society" of medicine (and other disciplines) that dates back to the time of Tokyo Imperial University. As the world has shifted from simply being "international" to being "global," I was naturally concerned with the medical education and clinical training of physicians in Japanese university medical school at large and its medical centers.

Young people in future generations should be allowed to expand their training and work on a "horizontal" dimension, rather than on just a "vertical" dimension, and for this purpose, the presence of physicians who have undergone clinical training in the U.S., albeit few, are very valuable in Japan. One way of conducting reform is from within, but I surmised that a more suitable option would be from the outside, by coordinating training with the American College of Physicians (ACP). I raised this idea whenever I had the chance, as a member of ACP, to meet with the ACP leadership. I visited the ACP headquarters in Philadelphia, where I discussed the possibility of establishing a Japan Chapter and made comparisons between the Japanese Society of Internal Medicine and certified physicians and medical specialists.

In 2002, the International Congress of Internal Medicine, of which I was Chairman, was held in Kyoto (6). This was to be one part of the one hundredth anniversary of the establishment of The Japanese Society of Internal Medicine and we were honored by the attendance of His Majesty the Emperor and Her Majesty the Empress, with many leading international physicians participating in the congress. As Chairman, I was glad to have Joseph E. Johnson III of the ACP, as well as other leading members of ACP, to participate in the congress, who shared their valuable insights on the reforms of the education and training of physicians in the U.S. with the various accompanying challenges. With many supporting individuals, in 2003, the Japan Chapter of the ACP was established as the first chapter outside of North and South Americas (7). I was appointed as founding Governor of the Chapter and with the support of The Japanese Society of Internal Medicine began our activities with a particular focus on young physicians. Our work at the Japan Chapter received awards from the ACP and was recognized highly by ACP leadership owing to many passionate members. I am incredibly grateful to Dr. Fumiaki Ueno, as Vice-Governor, who took over most of my duties involving the chapter and headquarters as I became increasingly busy through the beginning of 21st Century. Dr. Ueno is one of the few who have undergone residency training in the U.S. in internal medicine and its subspecialty of gastroenterology. Owing to his medical background and his wide network in US, ACP Japan Chapter could expand the scale of our activities even further. Dr Ueno recently assumed the third Governor of Japan Chapter.

My successor, second Governor, was Dr. Shotai Kobayashi, who plays a central role in the Japanese Society of Internal Medicine, and the Society of Internal Medicine Specialists. As the second Governor of the Japan Chapter, he made some very important decisions. Since four years ago, after



becoming an independent entity from The Japanese Society of Internal Medicine, the ACP Japan Chapter has held its annual academic conference (8) at the University of Kyoto. With a program rich in content and quality developed by Prof Shunichi Fukuhara, it has been praised very highly and has attracted many medical students and residents, creating a new tradition. It is wonderful to see such a clear focus to medical educational programs for young physicians.

The award ceremony of the Chapter Centennial Legacy Award (9) was held during the Convocation on April 30th as part of the ACP one hundredth anniversary. Twenty-five representatives of other chapters also attended the ceremony. I had the honor of receiving the award but the truth was, I received the award on behalf of all of our Chapter members, medical students, residents, staff and all of the people who have supported the establishment of the first chapter outside of the Americas and put their tireless efforts into helping nurture Japanese physicians who will go on to play important roles in the world. If I wrote all of the names of people I am grateful to, the list would be endless but I would like to thank each and every person who has helped us along the way, from the bottom of my heart.

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Message from Immediate Past President of ACP

David A. Fleming, M.D., MA, MACP

Immediate Past President, American College of Physicians

For the month of May 2015 my wife, Karen, and I had the amazing opportunity and honor of representing the American College of Physicians at several venues throughout the Pacific. One of the most enjoyable and successful meetings that we attended was the Japan ACP Chapter that occurred May 30-31, 2015 in the historic Clock Tower Centennial Hall on the campus at the Kyoto University. My official role was as immediate past president of ACP but it was also an opportunity to reunite with old friends like your new ACP Governor, Dr. Fumiaki Ueno. I have known Fumiaki for many years since we both served as members of the ACP Governor's Class of 2011. Though not officially a Governor at that time, Fumiaki represented your Chapter well at every one of our Board of Governors meetings and was an able representative. He is also a kind and generous man. We became good friends. He will be a great Governor.

Dr. Bob Centor, Immediate Past Chair of the Board of Regents was also in Kyoto for the meeting as a presenter and it was the first time Bob and I had been together since Boston during Internal Medicine 2015 this past April, where we handed off the ACP leadership batons to our successors. It was good to see Bob and his lovely wife Freda again and to share in our new discoveries of Japan. While in Kyoto I also enjoyed getting to know and work closely with Dr. Yugo Shibagaki, chair of the annual meeting; and Dr. Shunichi Fukuhara, vice governor of the Japan Chapter. It was Shunichi's wife, Naoko, who honored Karen and I with a traditional tea ceremony in an amazing 17th Century Japanese home with beautiful surrounding garden. Our trip to Japan was very special and it was experiences like this that allowed Karen and I to fully experience both the modern and the traditionally old in your fair country, while also enjoying the full depth of everything the Japan Chapter has to offer in professional learning and collegiality.

The meeting itself was a full two days of learning and professional development. A highlight was being able to listen in on the resident "Doctor's Dilemma" session and I got to moderate the presentation session of the poster contest winners. There were 78 posters and they were all great! The writing and presentation skills of our young learners and colleagues never ceases to amaze me. I have found in my world travels that our learners are incredibly bright, eager to learn, and good thinkers - Japan is no exception. They are the future of our organization and interacting with them is always the best part of my visit!

ACP is now a Century old—100 years of growth and development for a professional organization that has increasingly influenced health and health policy in the U.S.A. and that now has a substantive international presence. The Japan Chapter is very much a part of that history. Established in 2002, the Japan Chapter is the oldest in the Pacific and one of the most active in the world. Like all chapters there are ongoing challenges of gaining and sustaining membership, finances, and consistently offering a substantive annual chapter meeting. This is true for every chapter and every professional organization I have visited this past year. But the Japan

Chapter has found a way to maintain the professional glue that holds it together, though strong service to membership, collegiality, strong leadership, and obviously strong engagement with learners and trainees. The ACP Japan Chapter is in good hands with both solid leadership and excellent relationship with its members. It has been an honor for me to be with you and I wish you best in what will be bright and fruitful days for your chapter. I also look forward to returning one day so Karen and I can take more time to explore, experience and learn more about your beautiful country, its people, and traditions.

Studying sore throats – a 35 year odyssey

Robert M. Centor, MD, MACP

Immediate Past-Chair ACP Board of Regents

In 1980 I joined the new Division of General Internal Medicine at the Medical College of Virginia in Richmond, Virginia. I had several duties, including supervising residents in a walk-in clinic.

One day a resident asked me what to do for a patient who had a sore throat. Despite having just finished my internal medicine residency and having passed my board certification examination, I had no idea what to recommend. We quickly made a treatment decision, but the question stimulated my curiosity.

First, I read the existing literature on diagnosing streptococcal pharyngitis. I then developed the idea that a combination of signs and symptoms might help predict pharyngitis. Then I approached the microbiology lab to see if we could do cultures. In those days in the United States, we could develop the project without consent. The microbiology laboratory did the cultures at no cost.

Once we had the data, I had to get advice from the statisticians. I should have asked them for help at the beginning, but I was very young and naïve. Fortunately, I had collected the data in a reasonable fashion. The statistician recommended a statistical analysis of which I was unaware. So I spent time learning how to analyze data.

In retrospect, the project worked much better than perhaps it should have worked. We published our results, and then I began to learn more about streptococcal pharyngitis. Over the years, my sophistication with the topic increased, allowing me to do better studies and make a greater contribution.

So how do you get started? The key factors are that you first ask a good question. Once you have the question, you must research the current literature. You have to develop a hypothesis (mine was that we could stratify the probability of strep pharyngitis using clinical features) and then figure out how to collect data.

I know of no easy path to success. Most successful researchers that I know are persistent and driven to succeed.

The Best Abstract Award (Student section)

Haruka Watanabe

Undergraduate student (5th grade), Ehime University School of Medicine

Acknowledgment

It is a great honor for me to receive this award in ACP Japan Chapter Annual Meeting 2015.

I appreciate the support from many people. Dr. Naoto Kobayashi, a professor of medical education center of Ehime University, gave me a technical advice for this study. And Dr. Takashi Fujiwara had taught us how to read medical article critically for over 3 years. Furthermore, I would like to thank all of my classmates who organize our project with me. I could never accomplish this study without them.

EBM Learning Course in Ehime University

My presentation title is "A year-round evidence based medicine (EBM) learning course organized by medical students in Ehime University." We founded EBM learning course 4 years ago. This is not one of the school curriculums, but so called "after-school activity."

The global standard medical school curriculum (the Global Standards for Quality Improvement in Basic Medical Education by World Federation for Medical Education) says medical school must teach EBM throughout the curriculum. However, there are few opportunities to learn how to read medical article critically (critical appraisal skill) in our school curriculum.

EBM and critical appraisal skill is not synonymous, but learning critical appraisal skill is the first step of using EBM. Therefore we organized the study meeting course. It is mixture of journal club and lecture of statistics which is needed to read the article.

We held the course for 2 years, but it was not clear how well participants understand the course. Thus I evaluated participants' understandings of the course in the study.

Poster and Oral presentation in ACP Japan

Although it was very tough to write a poster and make a presentation in English, it was a precious experience to present my study in ACP Japan conference. Doctors who attended ACP Japan conference were familiar with EBM. Therefore I could exchange many ideas and opinions with audience. In addition, comments from Dr. David A. Fleming and Dr. Kiyoshi Kurokawa encouraged me very much. Furthermore, it was my pleasure that Dr. Rboer M. Centor mentioned my study in his lecture of medical education.

After the conference

By getting many comments from doctors, I thought our study meeting was not unnecessary in clinical medicine. The hardest part of student organized study meeting is "continuing", but we are going to make an effort to continue this study course. I would like to appreciate once again to have such a great opportunity.

The EBM study meeting (April 2015). We are continuing the course in 2015.

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A year-round EBM learning course organized by medical students in Ehime University

○Haruka Watanabe[1)], Takashi Fujiwara[2)], Naoto Kobayashi[3)]

1) Undergraduate student, Ehime University School of Medicine, 2) Department of Otolaryngology Head and Neck Surgery, Kurashiki Central Hospital, 3) Medical Education Center, Ehime University School of Medicine

Introduction

Evidence based medicine (EBM) has been defined as "the integration of the best research evidence with our clinical expertise and our patient's unique values and circumstances"*, and it is one of the essential skill in clinical medicine.

In Japanese medical school, there are some statistics classes during our 6-year curriculum, but there are few opportunities to learn EBM. This situation makes it difficult to use EBM when we become doctors.

Therefore we, medical students ourselves, organized a year-round EBM learning course in Ehime University in 2012.

*Sharon E. Straus, et al, "Evidence-based medicine. How to practice and teach it." 4e

Course planning

Learning course in the previous years

2012 (1st year)

#	Date	Journal	Title	Class
1	2012/10/11	BMJ 2010	Efficacy of 23-valent pneumococcal vaccine in preventing pneumonia and improving survival in nursing home residents: double blind, randomised and placebo controlled trial	RCT
2	2012/10/25	BMJ 2011	Intraoperative use of tranexamic acid to reduce transfusion rate in patients undergoing radical retropubic prostatectomy: double blind, randomised, placebo controlled trial	RCT
3	2012/11/8	Lancet 2012	Efficacy of immunoglobulin plus prednisolone for prevention of coronary artery abnormalities in Kawasaki disease (RAISE study): a randomised, open-label, blinded-endpoint trial	RCT
4	2012/11/29	BMJ 2008	Elbow extension test to rule out elbow fracture: multicentre, prospective validation and observational study of diagnostic accuracy in adults and children	RCT
5	2012/12/10	CMAJ 2011	Prospective validation of the ABCD2 score for patients in the emergency department with transient ischemic attack	RCT
6	2013/1/17	BMJ 2010	Efficacy of 23-valent pneumococcal vaccine in preventing pneumonia and improving survival in nursing home residents: double blind, randomised and placebo controlled trial	RCT
7	2013/1/19	NEJM 2001	Early goal-directed therapy in the treatment of severe sepsis and septic shock	RCT
8	2013/1/24	BMJ 2011	Effect of intensive glucose lowering treatment on all cause mortality, cardiovascular death, and microvascular events in type2 diabetes: meta-analysis of randomised controlled trials	RCT
9	2013/3/21	Internal Medicine 2010	Effect of neutrophil elastase inhibitor (sivelestat sodium) in the treatment of acute lung injury (ALI) and acute respiratory distress syndrome (ARDS): a systematic review and meta-analysis	SR, meta-analysis

2013 (2nd year)

CAST study

JIKEI Heart Study

Problems in the 1st & 2nd years

- Chose articles randomly. → Too many RCTs
- No clear curriculum or goals for participants to learn in each lecture

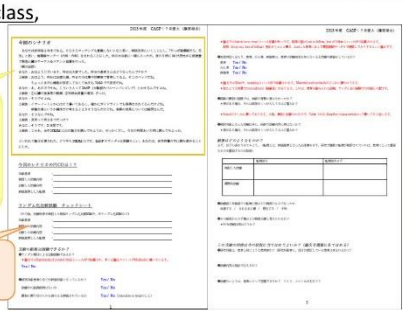
Participants' knowledge acquisition was unclear.

Scenario-based EBM learning course

Until the class,

Simulated scenario: The story which explain why we read the article

Questions related to the article



Participants should …

- Read the simulated scenario
- Fill this worksheet by reading the article

Study meeting

Lecture (5—10min.)
Explain some statistical technical terms related to the article

Read an article (50-80min.)

- Read critically
- Discussed whether participants would appraise the article to the simulated situation

2014 (3rd year)

#	Date	Journal	Title	Class	Goals
1	2014/4/8	NEJM 2012	Intraaortic balloon support for myocardial infarction with cardiogenic shock	RCT	Orientation of the course
2	2014/4/22	NEJM 1999	Preliminary report: effect of encainide and flecainide on mortality in a randomized trial of arrhythmia suppression after myocardial infarction. The Cardiac Arrhythmia Suppression Trial (CAST) Investigators.	RCT	PICO
3	2014/5/13	BMJ 2010	Efficacy of 23-valent pneumococcal vaccine in preventing pneumonia and improving survival in nursing home residents: double blind, randomized and placebo controlled trial	RCT	Randomization, Withdraw, Blind, Baseline
4	2014/5/27	AM J Prev Med 2005	Prevention of upper respiratory tract infections by gargling: a randomized trial	RCT	Randomization, Withdraw, Blind, Baseline
5	2014/6/13	Plos One 2012	Lower versus Higher Oxygen Concentration for Delivery Room Stabilization of Preterm Neonates: Systematic Review.	SR	Basics of meta analysis
6	2014/7/8	BMJ 2013	The effect of fall prevention exercise programmes on fall induced injuries in community dwelling older adults: systematic review and meta-analysis of randomised controlled trials.	SR Meta analysis	Meta analysis, Funnel plot, Forest plot, Heterogeneity
7	2014/7/29		Understanding and practicing of sensitivity, specificity, and so on		Sensitivity, specificity, Likelihood ratio, Bayes' theorem
8	2014/10/2	Tropical Medicine and International	Effectiveness of citronella preparations in preventing mosquito bites: systematic review of controlled laboratory experimental studies	SR	Could discuss about the systematic review
9	2014/10/23	NEJM 2008	Treatment of Hypertension in Patients 80 Years of Age or Older. A Randomized Controlled Trial	RCT	Could discuss about the RCT
10	2014/11/13	JAMA Intern Med 2014	Meditation programs for psychological stress and well-being: a systematic review and meta-analysis.	SR Meta analysis	Could discuss about the meta analysis and systematic review
11	2014/12/4	NEJM 2011	Reduced lung-cancer mortality with low-dose computed tomographic screening	RCT	Could discuss about the RCT. Understanding of the background. Compare to current guidelines
12	2015/1/21	NEJM 2013	Family presence during cardiopulmonary resuscitation	RCT	Could discuss about the RCT. Understanding of the background. Compare to current guidelines

- Set clear goals
- Showed keywords participants would acquire

Objectives of our study

- Observe participants' knowledge acquisition
- Evaluate our EBM course planning to improve the course in 2015

Method : Rubric type questionnaire

The way we observe participants' knowledge acquisition

Score: 1-5 (Q23: 1-3)

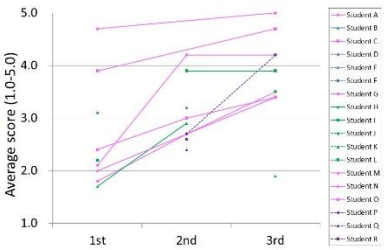
Q1: motivation
Q2,3: experience

Q4-23: How participants understand the keywords related to EBM

- Made an original questionnaire by using rubric
- The rubric contains 23 questions
  - 1 question (Q1): about participants' motivation
  - 2 questions (Q2, 3): about participants' experience
  - 20 questions (Q4-): how deep participants know the keywords related to EBM
- Conducted surveys at 3 intervals
  - Observed knowledge acquisition by calculating rubric scores
  - We used 19 questions to calculate the average score, because Q1-3 are not about knowledge acquisition, and Q23 use different scale.

Results

1) Participants' score increase: the average of the 19 questions

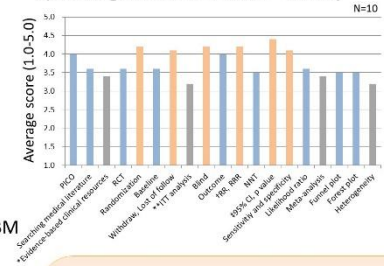


- Conducted surveys at 3 intervals
- 18 students (Student A〜R) answered.
- We calculated 6 students (participants who answered both the 1st and the 3rd survey) score increase.

Mean score increase of the 1st and the 3rd survey (Student A, C, G, M, N, O)

1.17 out of -4.00 to +4.00
(95%CI : 0.72-1.65)

2) Average scores of the 3rd survey



Calculated the average score of the 3rd survey by each keywords

- Keywords which got high (>4.0) score
  - Randomization, Withdraw, Blind, RR & RRR, 95% CI & p value, Sensitivity & Specificity
- Keywords which got low (<3.5) score
  - Evidence- based clinical resources (UpToDate, Dynamed), ITT analysis, Meta-analysis, Heterogeneity

Conclusion

- Our course improved participants' knowledge acquisition.
- We found that participants understood technical terms related to RCT well, but seemed to have difficulty with terms related to meta analysis.

Future vision

Since our year round EBM course improved participants' knowledge acquisition, we would like to continue the course in 2015. In the 2015 course, we will deal with not only RCTs but also meta analysis and other topics and will get a wide knowledge of EBM.

COI disclosure: I have no financial relationship to disclose.

“Special gift”

Yusuke Saishoji, MD
Okinawa Chubu Hospital PGY-3 primary care course

It is a special honor for me to get the 2015 ACP Japan Chapter Annual Meeting Best Abstract Award. There is no doubt that it was a very exciting experience for me.
On May 3, 2015, my beloved grandmother died. It was more difficult than imagined to proceed with preparation in such state. However, I recalled the saying of my grandmother, “I’m proud of you, Yusuke.” and it was encouraging me to prepare not to be ashamed to my grandmother. Perhaps, this award is even the last gift that grandmother gave me.

(Photo: my brother, father, grandmother, writer from left)

Abstract submission has been recommended by my teaching physician. I’m not familiar with English and I was away from reading the literature of English. However, to read a number of English literature for my preparation, I was able to realize that much interesting knowledge is scattered with papers. And I got a big stimulus to see what the height of awareness of medical and education of people who are participating in the annual meeting. There is no feeling even now that I had been elected to the Best Abstract Award but I appreciated the teaching physician and residents who support me everyday.

(Photo: residents of Okinawa Chubu Hospital)

At the annual meeting, many participants have a strong passion for education and medicine. And also, each sessions was ingenious, these were very interesting. It is true feelings that I wanted to know from all means early that have been made this such a great Society. I’m not familiar with English still now, but I want to update the new knowledge every day. I think the latest knowledge are those obtained from the literature, which is every day publish. Also, in order to provide the best treatment for patients in front of me, continuing to take advantage of the English as a kind of tool might be the duty of the physician. I also fell again that I have to strive to learn English to perform the day-to-day practice.
In closing, I’d like to be appreciated the officers of ACP japan which gave me such a valuable experience and Dr.Kiyoshi Kinjo, Dr.Shin Yamashiro who separate me long time in tough schedule, my friends in residency program who had cooperation in various forms all of the support, Chika, who encourage and support me always, my family that is willing to support the little son always, and special thanks for my grandmother watching me in heaven.

Migratory pulmonary cavities caused by recurrent lung infarction due to Takayasu's arteritis.

○Yusuke Saishoji MD, Shin Yamashiro MD, Kiyoshi Kinjo MD
Okinawa Chubu Hospital

Introduction

Takayasu's arteritis (TA) is a chronic systemic inflammatory disease that mainly affects medium to large size arteries such as aorta and its major branches. It may sometime involve pulmonary arteries.

Nakamura T. Intern Med. 2006;45(11):725-8. Epub 2006 Jul 3.

Case

A 30-year-old woman

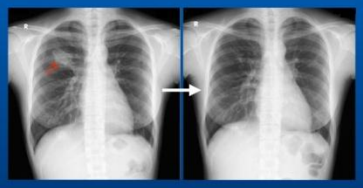
[Chief complaint]
cough and fever

[History present illness]
One month prior to admission, continuous dry cough began. 10 days before, she spiked temperature up to 39℃. She was given oral antibiotics but cough became so severe that she vomited. She lost 7 kg during 6 months. She had noted dyspnea on exertion as well.
No chest pain or edema.

[Past medical history]
#1.Pulmonary embolism (PE)
3 years ago; she presented with severe cough and hemoptysis. CT scan showed left lower lobe PE; transbronchial biopsy of the area was consistent with PE.She had no PE risks at the time and all coagulopathy workup was negative.She took warfarin for 6 months.

#2.Lung abscess
One year ago; her annual health check chest X ray was abnormal. 22 mm cavitary nodule was present in the left lower lobe. Transbronchial biopsy showed inflammation. Culture showed scant growth of Actinomyces. Clindamycin was given for 6 weeks and cavity improved.

2 months later, a new mass appeared in the right upper lobe. Repeat tests were non diagnostic but the mass disappeared spontaneously 3 months later.



[medications]
Codeine, Salbutamol, Acetaminophen
Allergy None

[social history]
Alcohol: social drinker
Tobacco: 1/4 pack/day (20-22y.o.)

[family history]
emphysema (grandmother)
lung cancer, asthma (grandfather)

Physical examination

[Vital signs]
Blood pressure 117/98 mmHg, Heart rate 77/min, Respiratory rate 18/min, Temperature 36.2℃, SpO2 94% (ambient air)

[Physical examination]
HEENT: not anemic, not icteric, throat not injected
no oral ulcers
Lung: clear bilaterally
Heart: regular, no murmur
Abdomen: non tender, normal bowel sound
Extremity: no edema
Skin and joint: normal
Neuro: non focal

Laboratory data

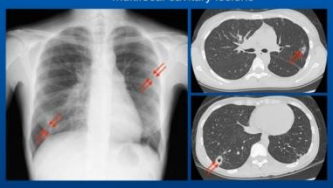
- Electrolytes, renal and liver function tests: normal
- WBC 13.400/μL (Neut 76.6%, Lymph 19%)
- ESR 78mm/hr, CRP 7.90
- Albumin 3.6g/dL
- U/A : normal

Laboratory data

- ANA, ds DNA antibody, P-ANCA, C-ANCA negative, Sm antibody, SS-A/Ro antibody, SS-B/La antibody, QuantiFERON all negative
- Protein S 123%, Protein C 108%, ATⅢ 123%, Anticardiolipin antibody and Anticardiolipin β2 GP antibody negative, homocysteine15.6 (5.1-11.7)
- HIV negative

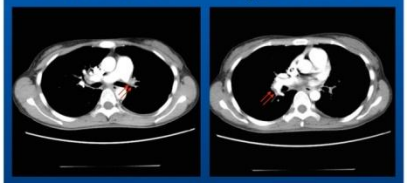
Chest Xray/CT on admission

multifocal cavitary lesions



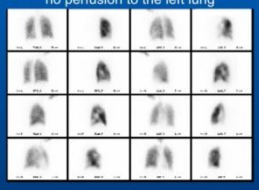
Contrast-enhanced CT on admission

Left PA was not visible. Right PA was thickened.



Ventilation/Perfusion scan

no perfusion to the left lung



Pulmonary Angiogram

total occlusion of left PA

Discussion

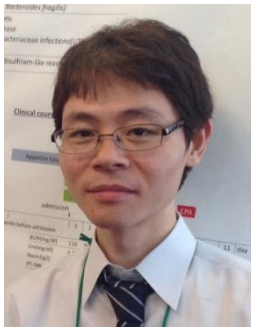
- Thickening of pulmonary arteries with enhancement raised the possibility of vasculitis.
- Literature review suggested that lung infarction can cause cavitary nodule and mass.
- Given her young age and large vessel involvement, we suspected Takayasu's arteritis.

Libby LS. MI.Medicine (Baltimore). 1985 Sep;64(5):342-8.
Eva Castañer, MD. The Pulmonary Vasculature 2012, 33,6:567–579

Conclusion

- Takayasu's arteritis may affect pulmonary arteries and present as recurrent lung infarctions.
- Careful review of previous history and imaging studies helped establish the correct diagnosis.

Upon receiving the Best Poster Award at the American College of Physicians (ACP) Japan Chapter 2015 Annual Meeting



Nobuhiro Kodama, MD

Department of General Internal Medicine, Fukuoka Tokushukai Medical Center

"Attention needs to be paid to the fact that cefmetazole sometimes prolongs prothrombin time (PT)."
This was taught by a general internal medicine educator approximately 10 years ago at this hospital during bedside rounds. He also taught us about the mechanisms shown in this poster. Based on what I learnt during these rounds, I established a style that took PT carefully into account whenever cefmetazole was administered, regardless of whether or not warfarin was being administered. However, I did not pursue this very far and only had a very small amount of second-hand knowledge on prolongation of PT by cefmetazole.
As time passed by, I became a chief at the general internal medicine department, a position to conduct bedside rounds and taught residents to be careful of side effects every time cases using cefmetazole were observed. However, a patient being treated by a resident died from what appeared to be cefmetazole side effects. As my own knowledge was only second-hand, I felt that the ramifications of what had happened were not fully understood by residents and interns. Furthermore, the side effects of cefmetazole, an antibiotic that is frequently used without a high level of caution, were unknowingly developed and most improved spontaneously. Thus, I hypothesized that even if adverse events were to occur, they would only be recognized in an extremely small number of cases. The motive of this presentation was to confidently communicate knowledge regarding side effects on a mastered level.
For the presentation, I conducted search of the articles investigating PT prolongation by cefmetazole. During this search, I found myself following the findings of the medical educator who had first taught me about the mechanism during rounds and it was deeply impressive. I am still far from reaching the level of him but I consider myself to be extremely fortunate to have been able to receive instruction from a medical educator of his caliber in my days as a resident.
Many physicians spoke to me at the poster exhibition. As this could form an opportunity for physicians to change their style of medical care such as the opportunity that I was given 10 years ago when I first came across this mechanism, I was delighted to think that this could aid in reducing the number of patients who suffer from the side effects.
I have previously heard that "The purpose of participating in meeting is not to learn but to gain opportunities for learning." Since I was notified at the end of April that my abstract received the Best Poster Award, I made many discoveries from preparation of the presentation to its conclusion. The most prominent things that I noted were my inefficient use of time each day and how I have avoided communicating in English and writing reports. Another issue was the fact that on the day, I was very tense and anxious so I wasn't able to really enjoy the meeting, which is one of the main objectives of participating in meeting.

These various discoveries that I made are even more valuable than the Best Poster Award and I hope to work through these issues one by one into the future. Thank you very much.

Scene of rounds

Cefmetazole induced hypoprothrombinemia

○Nobuhiro Kodama, Shuichi Matsumoto, Sunao Matsubayashi
Department of general internal medicine, Fukuoka Tokushukai Medical Center

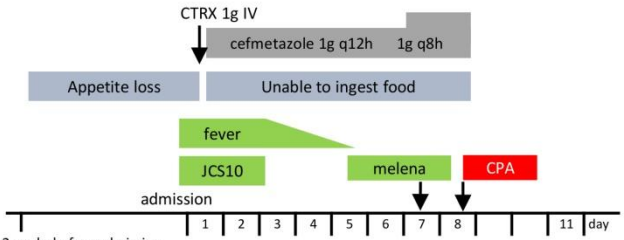
Introduction

Cefmetazole; Cephamycin group	
Spectrum	aerobic gram-negative rod(e.g. *E.coli)* anaerobic bacteria(e.g. *Bacteroides fragilis)*
Indication	intra abdominal infections pelvic inflammatory disease ESBL-producing Enterobacteriaceae infections(UTIs) surgical prophylaxis
Adverse reaction	Hypoprothrombinemia, disulfiram-like reactions

Case presentation

chief complaint: fever, unconsciousness
History of present illness:
A total dependency 93-year-old woman who living in nursing home were transported to our hospital because of a 2 weeks history of appetite loss and one day history of fever and unconsciousness. She was received ceftriaxsone 1g IV before transport.
Past medical history: tuberculosis, hypertension, dementia
Medication: benidipine, sulpiride, azosemide, trihexyphenidyl hydrochloride, memantine, etizolam, Yokukansan
Physical examination:
BP 137/70mmHg, pulse 106/min regular, respiratory rate 28/min, temperature 37.6℃, consciousness JCS 10, CVA knocking pain negative
Laboratory test
WBC 10570/μl, Hb 11.6g/dl, Plt 20.8X10^4/μl, BUN 116.4mg/dl, Cre 2.88mg/dl, Na 159mEq/l, K 3.3mEq/l, Cl 114mEq/l, glu 188mg/dl
PT-INR 1.07, APTT 25.7sec
Urinalysis WBC>100/HPF, Gram stain; gram negative rod

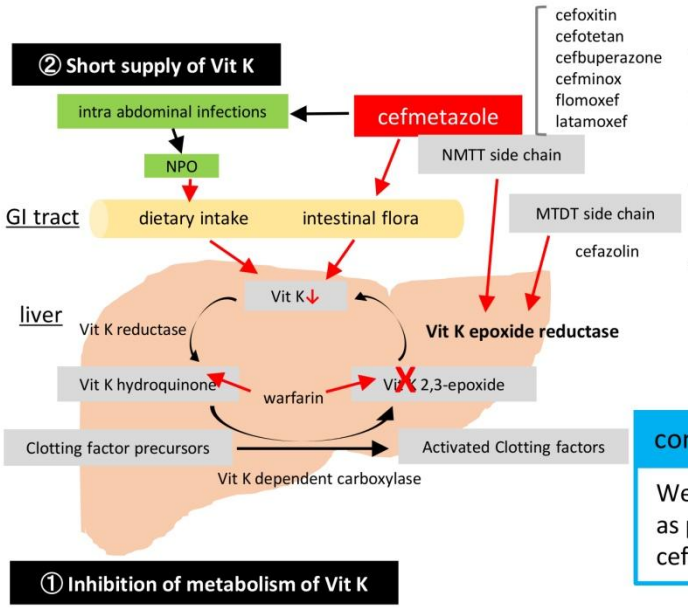
Clinical course



BUN(mg/dl)	116	99.2	45.2	29.8	20.7	19
Cre(mg/dl)	2.88	2.39	1.54	1.28	1.20	1.27
Na(mEq/l)	159	155	155	142	135	139
PT-INR	1.07					2.51

Discussion

1.Antibiotics(cefmetazole)induced hypoprothrombinemia: Mechanism



③ Low Vit K stores elderly patients, renal disease, malnutrition

2. Cefmetazole induced hypoprothrombinemia: Case series

Ref.	year	country	age	sex	Underlying disease	Duration Antibiotics (days)	Poor food intake (days)	PT(sec) [control PT]	bleeding
1	1989	USA	57	M	Appendectomy	4	8	17[11]	+
2	1997	USA	63	M	Amputation, ESRD	6	NA	91.2[11.5]	-
3	1984	JPN	86	F	Penumonia	5	11	45[NA]	+
			70	F	Sepsis	15	27	22.9[N/A]	+
			81	F	UTI	20	9	36.9[N/A]	+
4	2012	JPN	58	M	Sigmoidectomy	2	10	42%	+
5	1984	JPN	71	F	Uremia	4	NA	NA	+
			72	F	Uremia	10	NA	NA	+
					average	8.3			

NA: Not available

The average time from initiation of antibiotic therapy to diagnosis of hypoprothrombinemia (n=17) 5.7days(range, 2-15days) (6)
Vitamin K should be given 5-10mg one to three times weekly(7)

conclusion

We should monitor PT-INR or give 5-10mg of vitamin K as prophylaxis every a few days when we use cefmetazole in elderly patients.

reference

1. J Antimicrob Chemother. 1989; 23 Suppl D:47-54.
2. Jann Pharmacother. 1997; Sep; 31(2):180
3. J Antimicrob Chemother. 1984; 14 Suppl B:325-30.
4. JJSP. 2012.19(4):519-522
5. Tousekikaishi. 1984.17(3):165-171
6. Antimicrob Agents Chemother. 1987; 31(2):281-5
7. Rev Infect Dis. 1990; 12(6):1109-26.

IM2015 Report

Kenji Maeda, MD, FACP
Secretary, ACP Japan chapter

The year 2015 was a very special one because ACP celebrated its 100th anniversary this year. So it was a moving experience to participate in the IM 2015 in the old historic city of Boston.
The key word in the IM 2015 was "HVC" – high value care, not that hepatitis virus. I think it's a very important thing too to Japanese internists.
I already wrote a report about the sessions I heard in Boston in the previous Newsletter (Japanese language edition) so I won't translate it fully here. (I will only put a list of the lectures I attended.)
I hope those who had some interests in my previous reports will participate in the future annual sessions (Internal Medicine 20xx).

To follow is a list of the lectures I attended:

Thursday April 30th

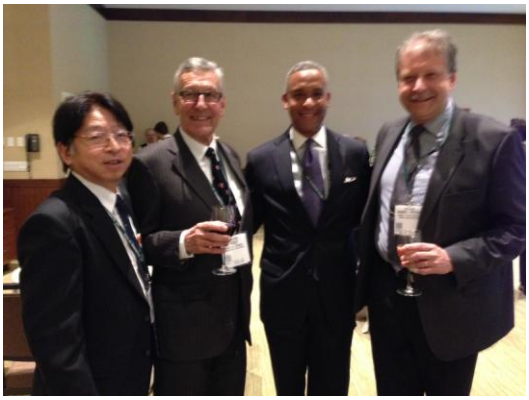
●The Expanding World of Fatty Liver Disease
(Dr. COL Stephen A. Harrison, FACP)
●Hepatitis C: New Patients, New Treatments
(Dr. Raymond T. Chung, MD)
●Opening ceremony
(The keynote speaker was Dr. Thomas A. Daschle)
●Lung Cancer Screening
(Drs. Gregory C. Kane, FACP, Patrick Nana-Sinkam, MD, and Rita F. Redberg, FACC, FAHA)
●Update in General Internal Medicine
(Dr. Stephanie Ann Call, MSPH, FACP)
●Atrial Fibrillation 2015
(Dr. Peter Zimetbaum, MD)

Friday May 1st

●The Year's Most Compelling Papers
(Dr. Alan W. Dow, MSHA, FACP)
●Functional Gastrointestinal Disorders and Food: You Are What You Eat
(Dr. Brian E. Lacey, MD, PhD)
●Thieves' Market – Fascinating Cases
(Dr. David R. Scrase, FACP)
●Clinical Pearls: General Internal Medicine and Infectious Diseases
（Drs. Scott C. Litin, MACP, John B. Bundrick, FACP, and Mary Jo Kasten, FACP, FIDSA）
●Update in Cardiology
(Dr. Peter Zimetbaum, MD)
●Vector-Borne Infections: Not Just For Travelers
(Dr. Stephen J. Gluckman, FACP, FIDSA)

Saturday May 2nd

●Implementing New CKD Guidelines into Practice
(Dr. Lesley A. Inker, MS)
●Clinical Triad: Anticoagulants Update – What the Internist Needs to Know
(Drs. Marc J. Kahn MBA, FACP, Victor A. Ferrari, Alice D. Ma MD, and Marc S. Zumberg FACP)
●Clostridium difficile: From the Simple to the Complicated
(Dr. Colleen R. Kelly, FACG)
●Update in Infectious Diseases
(Dr. John G. Bartlett, MACP)
●Update in Pulmonary Medicine
(Dr. Jess Mandel FACP)
●Internal Medicine Meeting 2015 Highlights and Doctor's Dilemma: The Final



(From the right, Dr Hans-Peter Kohler（Secretary General ISIM（International Society of Internal Medicine））、Dr Wayne J. Riley MACP（President of ACP）、Dr Rolf A. Streuli MACP, FRCP（Honorary President ISIM ）

What is it like to be a FACP?

Haruhiko Banno, MD, PhD, FACP

Department of Neurology, Nagoya University

Massachusetts General Hospital

This year, Internal Medicine 2015 (IM2015) was held in Boston as the 100th anniversary meeting of the American College of Physicians (ACP). I have been studying clinical research in Boston since 2013 and it was a great opportunity for me to participate in the Japan Chapter Reception of IM2015. I was promoted to a Fellow of the American College of Physicians (FACP) just before I came to the US. This was also my first chance to know what the ACP is in the US and what is it like to be a FACP.

Seven years ago, I was wondering if I should be a member of the ACP or not. It was a time when I passed the board exam to be a Fellow of the Japanese Society of Internal Medicine (FJSIM). It was when I was very busy, both with clinical and research work, and when I had to recertify for continuous medical education (CME) credits for several Japanese board certificates. They were becoming heavy burdens for me. The ACP was new for me at that time and I was unsure if I should become an ACP member on top of Japanese board certifications. If I could give myself some advice, I would have definitely recommended becoming a member of the ACP and applying for the promotion to be a FACP in due course. I would like to explain why, as follows:

Why do I recommend being an ACP member? First, I believe US medicine will remain strong in the world. Indeed we can search and find information for almost everything through the Internet. However, clinical practice varies by country by country partly due to differences in clinical cultures. This discrepancy is particularly evident in new therapeutics, which need approvals by the regulatory agencies of their country. Due to the late start of Phase 3 clinical trials followed by delayed drug approval in Japan, accessibility to new drugs is one of the biggest problems that now confront Japanese people. I have been working on investigator-initiated clinical trials for 10 years in Japan and I came to the US to learn about the American clinical trial environment for future international cooperative clinical trials. Indeed, the American clinical environment is very unique and is not suitable to apply directly to other countries. However, Americans can retain their strength as long as they try to incorporate international values through acceptance and competition of various thoughts, as they did historically, because immigrants founded the country and they had to discuss their common values. Let me add something about education by the ACP: ACP members can access fascinating web resources through the ACP, both to have a strong CME and to learn about current international advances in the medical field. Moreover, annual meetings of the ACP Japan chapter are high quality and very educational.

Second, an ACP member is a future candidate to become a FACP. Fellow status means a lot, especially for Japanese medical doctors who want to survive in the US. Communication skills and a convincing career trajectory are indispensable to be highly valued in the competitive American society. Even though unbiased evaluation of a medical doctor is very difficult, international journal publications and becoming a FACP are at least worthwhile to a Japanese doctor that enters the American medical environment.

Third, I would like to point out that doctors in the ACP Japan chapter are wonderful. In the Japan Chapter reception and its party in Boston, it was a great pleasure that I could speak to former governors of Japan Chapter, Drs. Kiyoshi Kurokawa and Shotai Kobayashi, whom I have respected for many years. I also had a chance to get to know the current governor, Dr. Fumiaki Ueno, and Drs. Shunichi Fukuhara, Yuko Takeda, Kenji Maeda, Yukari Shirasugi, Soichiro Ando, Nobuhito Hirawa, Takeshi Yanagawa, Noriko Yamamoto, Koichi Onaru, Mamiko Ohara, and Koichiro Yuji. I would also like to thank Drs.

Hiromitsu Kusafuka, and Kenji Ina who recommended me to be promoted to a FACP.

I was able to talk with so many respectable doctors on this occasion that deeply inspired me to contribute positively to medicine from now on.

Japan Chapter Party at IM2015 (By courtesy of Dr. Yukari Shirasugi)

My dream, my obsession

"France is where I'd like to go, but France is so far away."

Sakutaro Hagiwara

(Japanese writer, 1886-1942)

Tetsuya Makiishi, MD, FACP.

Chief, Division of Nephrology and Dialysis
Saiseikai Shiga Hospital
Social Welfare Organization Saiseikai Group, Imperial Foundation, Inc.

About 20 years ago, when I was participating in clinical clerkships, it was rare to have an opportunity to be directly instructed by a physician or surgeon who had had clinical experience in the US. I believe that Dr. K was the only such surgeon in Shiga prefecture at that time. After graduating from a medical college in Japan, Dr. K completed his clinical residency training in the US, and had become a board-certified surgeon in the US just before he started his academic career at my own medical college in Japan. On the first day of my surgical rotation, I was inspired by him. His way of teaching was quite different from the ordinary Japanese style and was really an eye-opener for me. Soon, I came to think that I would like to experience clinical residency in the US in the near future. I was young and passionate, and was admittedly short-sighted. I began to prepare for it on my own, dreaming of undertaking a residency program in the US, without considered reflection. I believed that I could make it if only I could pass the United States Medical Licensing Examination (USMLE), Step 1 and Step 2.

However, the world is not that easy. It took me several years to pass the USMLE Step 1 and Step 2, both of which I passed with only low scores and I found myself stuck between a rock and a hard place, facing a newly introduced practical exam, a Clinical Skills Assessment (CSA). Time flies: while preparing for the USMLE, I had to make several inevitable life decisions. After completing a residency program in Japan, I joined a medical office in Japan, as did the majority of clinical residents in Japan at that time. I got married and became a father of three children. As I grew older, my dream of having residency training in the US became so separated from me that I could no longer see the light of it. By the time 10 years had passed since I first met Dr. K, I was working as a mid-career nephrologist at a teaching hospital in Japan, having risen to the position of attending physician. I felt I had to face reality and had no choice but to lock my dream at the bottom of my heart.

I found it interesting to teach the many excellent, ambitious clinical residents I was working with. In activities such as reading circles, we read several famous medical textbooks written in English, such as "Bate's Guide to Physical Examination and History Taking," and "The ICU Book," while remembering my old days of struggling with preparations for the USMLE. However, I have to admit that the way I taught them at that time was rather ad hoc, and was mostly motivated by my own self-satisfaction.

It was at such time when I happened to learn of the ACP Japan Chapter. While reading an article on the web that told of their activities, my "old dream" of having residency training in the US re-emerged. On the same day, I decided to join the ACP. Since then, through activities as an ACP member I've had many opportunities to learn of "global

standards" in medical education and in general medical knowledge as well. I participated in the ACP Internal Medicine Conference 2013, held in San Francisco, to feel the atmosphere of American-style medical education. I also learned a lot through activities as a member of the "Young Physicians Committee" (YPC), of the ACP Japan Chapter. Moreover, these activities offered me an opportunity to get acquainted with many Japanese physicians, all of whom are excellent clinicians and educators, and most of whom had had clinical experience in the US. One of them is Prof. Yano, of Tsukuba University, who is now my mentor. Through these activities, I gained more insight into medical education. All this said, you might think I had become a good educator; however, the answer was "No." Truth be told, at the time I was holding feelings of inferiority that originated from the fact that I could not experience US residency training, which made my way of teaching a little diffident.

In November 2014, I participated in a clinical observation program organized by the ACP, and spent an entire month at the Olive View-UCLA Medical Center. Six months earlier, I had decided to apply for this program after careful consideration. When I first heard about it, I thought that the program could only be a wish for me, because being away from the hospital for a month is thought to be nearly impossible for most physicians in Japan, regardless of the reason. I was afraid it would bother my colleagues and my patients. On the other hand, I thought it might be the last chance for me to experience the US medical education system. I finally made up my mind, and as if jumping off the stage at Kiyomizu, I told my colleagues about it, and thankfully enough, I was allowed and even encouraged to participate in the program.

Through my experiences as a member of a ward team at this highly ranked educational hospital in the US, I learned much about the differences between the US and Japanese medical education systems. Talking and discussing with other team members, who were very excellent and kind to this middle aged, poor English-speaking physician from Japan, I came to understand the culture that makes their residency program truly excellent. Every day at lunchtime, I talked with clinical residents and fellows about American culture, and life in general. Under the blue sky of southern California, I found that the feeling of inferiority I had been bearing in my mind was meaningless, and that the important thing is what you learn from your experiences, not what you experience. Taking part in this clinical observation program and interacting with distinguished physicians, residents, medical students, and house staff for a month at the Olive View-UCLA medical center was the best thing I have ever done throughout my career.

Thankfully, soon after the year 2015 had started, I received an email from ACP headquarters, which informed me of my promotion to the position of Fellow of the ACP. While taking part in the convocation, held on a sunny day in Boston during the conference held on 100th anniversary of the ACP, and swearing the pledge of the ACP, I felt that my obsession about having residency training in the US had finally vanished, that I had changed, without realizing it, from the days when it was my dream.

Now, I am now eager to help clinical residents learn global standards in medicine, hopefully with some aroma of the excellent American medical education system. I am convinced that I can do it.

I am grateful to all those involved in helping me get thorough each step of the process to become an FACP, including clinical residents and my patients in the past, present, and future.

Unforgettable experience and profound impressions on attending the Internal Medicine Meeting 2015 of the American College of Physicians

Yasuyoshi Takei, MD, PhD, FACP

Department of Cardiology, Tokyo Medical University

The Internal Medicine (IM) Meeting 2015 of the American College of Physicians (ACP) was held at Boston, Massachusetts from April 29 to May 2, 2015. The IM 2015 was a 100th memorial meeting highlighted by many historical events. I had a great opportunity to write a report regarding my attendance to the IM 2015 and convocation ceremony as a new fellow of the ACP in the Governor's newsletter of the ACP Japan Chapter.

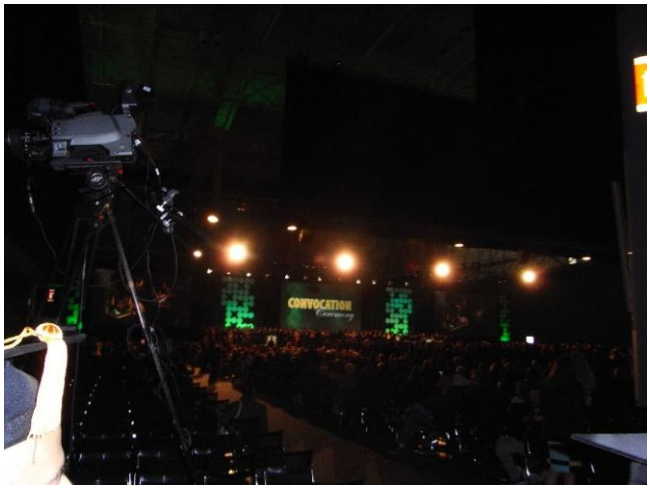
This was my second time to attend the IM meeting. My first time to attend the meeting was during my fellowship in New York Presbyterian Hospital affiliated with Columbia University of Physicians and Surgeons. It was surprising and very interesting for me to observe that the Clinical Skill Center Activities, which involved many practical educational sessions such as various physical examinations using audio systems or different echo-guided paracentesis techniques using simulators, were held for medical students, residents and attendees. These practical seminars were different from major conferences in Japan, and were very useful and meaningful for general internal medicine practice in patient care. In addition, Internet wireless connection in the whole conference center facilitated the easy access to the associated references while listening to the lectures. I felt that the systematic leaning programs such as the newest guideline for valvular heart diseases or treatment for atrial fibrillation using new oral anti-coagulation therapies (NOACs) in the IM meeting were well developed not only for cardiologists but also for all of internists. Recently, the importance of learning general internal medicine has been emphasized in Japan because of the strong trend in being subspecialty medical doctors. This results in the lack of ability of young physicians to thoroughly examine patients. Consequently, I feel that the various learning issues in ACP have important messages particularly for young Japanese physicians.

I would also like to describe the impressive and elegant ACP convocation ceremony. New masters and new fellows attended the convocation ceremony wearing their traditional regalia, hoods, and hat with tassel depending on their university or institute. Before the start of the convocation ceremony, I was very much impressed to see many new fellows from all over the world taking their pictures in front of the entrance of the ceremony hall. This is a dramatic scene for me realizing the prestige and honor of becoming an FACP. When the convocation ceremony started, the new fellows were led to enter the venue by Dr. Shotai Kobayashi and Dr. Fumiaki Ueno. We sat in seats separated by state or chapter in front of the board members and guests. With much applause, their families, friends, and colleagues welcomed us around the seats. One thing especially worth mentioning was that Dr. Kiyoshi Kurokawa was commended the chapter centennial legacy award. After the complimentary speeches, awarding, and

the oath, we stood up when we were called by state or chapter. When I was inducted as a new ACP fellow, I strongly felt the untiring effort to provide the best treatment for all patients and to continue learning and being engaged in various important medical issues for the rest of my life.

It was my honor to meet the ACP faculties and world famous medical doctors at the International Reception and at the Japan Chapter Reception. I was also fortunate to meet Dr. Masatoshi Kawana who thoughtfully wrote my recommendation letter. In addition, it was a great honor for me to have a special dinner with all of the Japan Chapter faculties. I would like to express my deep appreciation to all of these exceptional doctors supporting various activities.

Finally, I strongly hope that I will be able to share my "once-in-a-lifetime" experience and profound impressions to the members of the ACP Japan Chapter. The ACP fellowship will definitely build and advance you career to a higher position. I would like to highly recommend you to become an ACP member and to apply for a fellowship in the future. I strongly encourage you to attend the IM meeting and the annual meeting of the ACP Japan Chapter to acquire not only the best medical knowledge but also the best "Role Model" for your lifelong medical career.



An introduction of medical students' activities in Japan "TEAM KANSAI"

Akane Ito

Kansai medical university, 6th year medical student

Hello, I'm Akane Ito, director of the medical student study group called "TEAM KANSAI". TEAM KANSAI consists of motivated medical students from 12 universities located at the Kansai (region around Osaka). We hold a conference once a month to present interesting cases, and learn and share opinions from each other.

Every autumn, we hold an annual study seminar trip at a temple, and we invite noted physicians to have lectures for the participants. We could say that the TEAM KANSAI is the largest student organization in Japan, because more than 800 members are registered at out Facebook page, where event information is announced. Because I would like to contribute for the ACP by utilizing TEAM KANSAI community, I have decided to represent the student committee of ACP.

The topics that we had presented this year are from various fields, such as diabetes, pharmacokinetics, method of clinical reasoning, medical economics, case studies,emergency medicine in rural area, training experience at the University of Hawaii, how hematologist use antibacterial, and so on. In each presentation, we provide some time to discuss within the group. We think that the peer teaching beyond the grade and universities are essential in the process of learning.

Participants are not necessary from the Kansai region only. In fact, students from Tottori University, Shimane University, Kagawa University, Hiroshima University, Fujita Health University and more are attending our sessions. Since our members are from all parts of Japan, we have more chance to expand our community and exchange useful information.

Because our members have wide range of interests, some of them participate in exchange program overseas and even hold a workshop at different student organization. By participating TEAM KANSAI, we believe that we can help build a good relationship amongst student from different universities. That may help one to keep good relations with others even when they start working along with higher motivation. Team Kansai always welcomes those who want to join us at any time. Please do not hesitate to like our Facebook page by searching "TEAM KANSAI", if you are interested.

In addition, we hold an all-nighter event called "Shukubo camp" every year. "Shukubo camp" is our original event, and we invite 20 doctors and 100 students. In 2015, the camp was held at a beautiful temple located in Kyoto called "Toji", a UNESCO World Heritage site. The theme of that year was "Think about 'Choosing Wisely'". We are always thinking what is the most important value to become a appropriate medical intern and physician. Then, we have to have confidence in every "selection" on every

day practice based on evidence.

We thought that "Choosing wisely campaign" (http://www.choosingwisely.org/) matched really well with the theme, so we have decided to refer to the idea. Based on ideas from the campaign, we are able to understand that there are many statements about reducing the excessive testing and over diagnosis based on EBM. At the same time, the campaign states that "one must think and select for the patient's 'best' interest", and we thought that is exactly what we needed to learn. Nowadays, medical information is flooding all over the place. We had planned this "Shukubo camp" so that all participants may find something new and start acting towards their ideal future.

Furthermore, it is our goal for participants to deeply consider about what really is the ideal physician to them.

TEAM Kansai is the study group to focus not only on learning but also providing a chance to connect with others. We will continue to provide this opportunity for students to learn beyond the grades and different university in the future.

Young Physicians Committee, ACP Japan Chapter

Noboru Hagino, MD

Division of Hematology and Rheumatology
Teikyo University Chiba Medical Center
Chair of Young Physicians Committee

The Young Physicians Committee (YPC) of the American College of Physicians (ACP) Japan Chapter has aimed to increase young physicians' knowledge which is necessary for their career development. The career paths for the young internists have increased their diversity more than ever before. They need to increase their clinical knowledge and skills, must catch up the advances in medicine, conduct their own research, and are sometimes requested to have perfect "work-life balance" as well in these days.
There is no single, clear solution for this difficult situation, although the members of YPC have offered the opportunities for the young physicians to talk and share the difficulties with the others, which may ease the burden of them and lessen their anxiety.

In ACP Japan Chapter Annual Meeting 2015, we held a session entitled "How To Be an Effective Middle Manager – Leadership in Medicine", in which we focused on leadership and administration as a middle manager through brief lectures and case discussions. The concept of "leadership" has been viewed somewhat unimportant in Japanese "traditional" medical world, which is a pyramid-style organizational structure with the professor sitting at the top, and the professor is the only person who should display his or her leadership. But that old concept of "paternalistic leadership" is no more applicable. ACP has emphasized the notion of leadership recently, and they launched the ACP Leadership Academy, which has provided the members with training and resources.
Our session consisted of small group case discussion and a lecture about leadership by a guest speaker: Dr. Ryota Konishi at Kanto Rosai Hospital.

The essential part of the example case for senior young physicians are as follows.
"You are a chief physician of general internal medicine at a certain general hospital, who have taken over the position from the former "charismatic" physician. Your daily activity takes a huge amount of energy, including the ward round, ambulatory clinic, NST meeting, and so on. In addition, you must play a coordinating role between other division of the hospital and your division, resolve the conflicts between your residents."
The example cases are made for medical students and physicians-in-training as well, and the participants discussed on the questions provided in the case, shared their experience and difficulties with other participants.

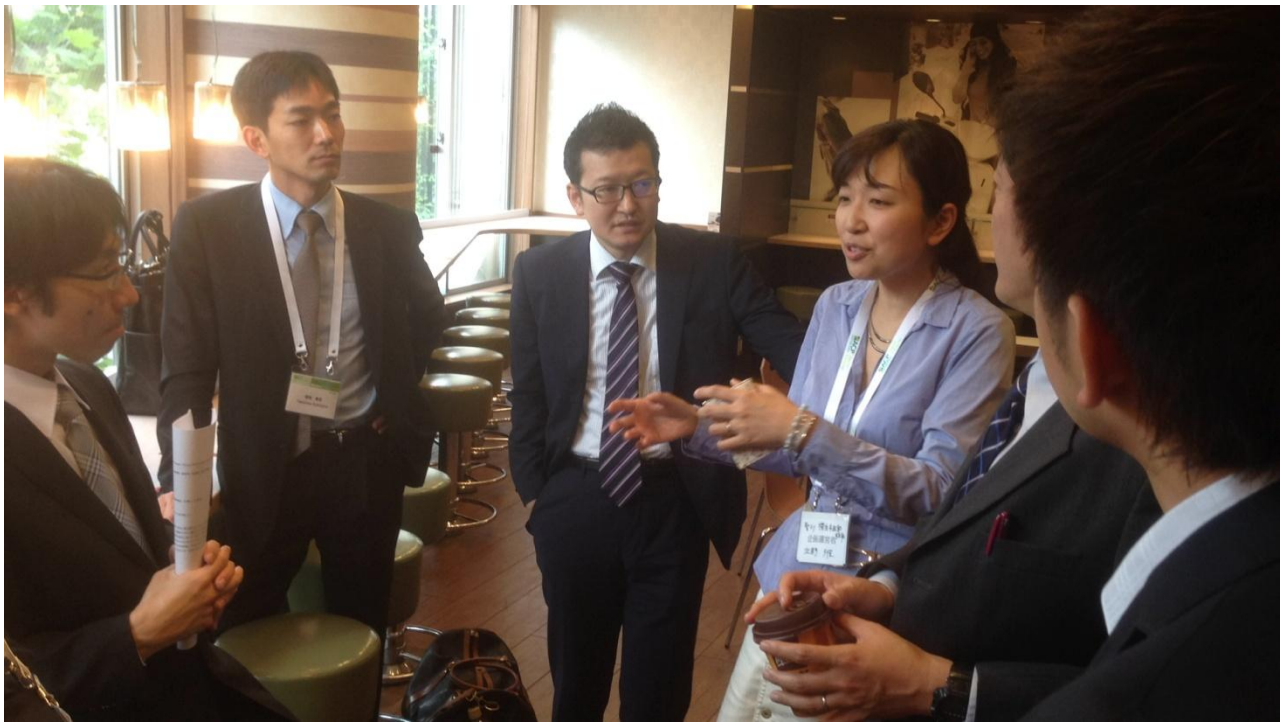
Dr. Konishi emphasized in his lecture that there has been no single theory of leadership which can be applied to all situations. He referred to several leadership theories, "Servant Leadership" by Greenleaf, and "Managing" by Mintzberg for example.
In a survey after the session, many positive feedbacks are obtained.

We will continue to provide educational and mentoring opportunities and support career and membership advancement to young physicians and to enhance the professional development and quality of life for young physicians, as well as foster their involvement in ACP activities.

Our “near-future” project includes:

1. E-medicine updates – Evernote, Workflowy, SNS and more.
2. Medical Teaching 101
3. Fukushima-logy – what we know, what we don’t know.

Your suggestion for our YPC activity will be highly appreciated.



Pre-session discussion at Hyakumanben, Kyoto.

International Exchange Program

Harumi Gomi, MD, FACP

Chair, International Exchange Program Committee
American College of Physicians Japan Chapter
Mito Kyodo General Hospital, University of Tsukuba

This letter is a follow up information on our committee's educationally highly valuable exchange program for the ACP members and associate members in Japan.

International Exchange Program (IEP) Committee, American College of Physicians (ACP), Japan Chapter was founded initially as ad hoc committee in 2011. Since 2012, clinical observership at Olive View Medical Center, University of California, Los Angels has been initiated and developed. ACP Japan Chapter Governor and Former IEP Committee Chair Dr. Shotai Kobayashi, and the California Governor Dr. Soma Wali had made significant efforts to make this happen. In this valuable exchange program, ACP members and/or associate members are eligible to apply. Below is the website for the application details (in Japanese).
http://www.acpjapan.org/info/adhocboshu2015_1.html

At Olive View Hospital, a maximum of twelve observers can be accepted each year.

If you or your colleagues are interested in making the best of this opportunity, please contact the ACP Japan Chapter, International Exchange Program Committee. The Committee will try our best to support the applicants for their request and wishes.

Since 2012, there have been five observers in Year 2012-13, five in Year 2013-14, and two in Year 2014-15.

Below is the list of all clinical observers at Olive View Medical Center, University of California, Los Angeles, USA

Program Director of the Clinical Observership:
Dr. Soma Wali
Professor, Director
Department of Medicine
Olive View Medical Center, University of California Los Angels, USA

Candidate No.	Last name	First name	日本語名	Specialty		Date	Year
2012-13				General Medicine Wards	Consultation service		
1	Uemura	Takeshi	植村健司	Internal Medicine	No	September	2012
2	Shimamura	Shonosuke	嶋村昌之介	Internal Medicine	Infectious Diseases	February	2013
3	Minobe	Shoko	美濃部祥子	Internal Medicine	Hematology/Oncology	February	2013
4	Isohisa	Ai	磯久愛	Internal Medicine	Rheumatology	May	2013
5	Cho	Narihiro	張成浩	Internal Medicine	No	May	2013
2013-14							
1	Tsuda	Moe	津田萌	Internal Medicine	Hematology/Oncology	January	2014
2	Muranaka	Emily	村中総美里	Internal Medicine	Infectious Diseases	May	2014
3	Soma	Shinko	相馬真子	Internal Medicine	Cardiology	May	2014
4	Sato	Ryota	佐藤良太	Internal Medicine	Critical care	June	2014
5	Tanaka	Takamasa	田中孝正	Internal Medicine	Hematology/Oncology	June	2014
2014-15							
1	Kuriyama	Akira	栗山明	Internal Medicine	Critical care	November	2014
2	Makiishi	Tetsuya	牧石徹也	Internal Medicine	Nephrology	November	2014

Here we are pleased to share the essay of the clinical observers Drs. Akira Kuriyama and Tetsuya Makiishi. Dr. Makiishi has been appointed as a member of the International Exchange Program Committee, ACP Japan Chapter since 2014.

Clinical observership experience in Olive View Medical Center

Akira Kuriyama, MD, MPH

Department of General Medicine, Kurashiki Central Hospital

I am hereby reporting on my observership experience in Olive View UCLA- Medical Center (OVMC) in November 2014, which was kindly hosted by the California and Japan Chapters of American College of Physicians.

I had two main motives for this observership. First, I wanted to learn about how the medical intensive care units (ICUs) in the US are being managed. Most ICUs in Japan are currently driven by anesthesiologists. As an intensivist and formerly a general internist, I aspired to learn something about "medical" ICUs that are managed by physicians in other nations. Second, I wanted to learn about the training and educational system in the United States in the areas of general medicine. Teaching younger physicians have been my passion, and seeing different styles of teaching in the US is invaluable to me.

I spent my first two weeks in the ICU where patients with medical and/or postoperative surgical patients were being managed. There, I saw a system where some teams of PGY-1 and 3 residents assessed the patients' conditions and came up with the goals for the day. This goal was further discussed with the attendings during the round, which the entire morning was dedicated for. The attending physicians sometimes paused for a moment to mention some latest evidence on some drugs, or to explain the physiology and theory of some phenomenon using some formulas. I had the chances to meet three attendings, who sometimes talked about the trials and errors that they had made, in contrast to the knowledge described in textbooks or recent researches. I felt somewhat relieved to know that the physicians in the US confronted and struggled with some of the same problems that I had been facing in Japan, and that they do similar trials and errors to utilize evidence based medicine in an individual patient. At the same time, I felt close to them for their clinical pearls which they made during their struggles. I was also motivated to learn more so that I could create mine. One of their surprising practice customs were that, unless two pressors are given, they do not place arterial lines on patients! This was a shock to me as an arterial line is being placed immediately in Japan once a patient receives a pressor even at a stable low dose. Another example of culture shock was the way fluid was managed more liberally in the US than in Japan.

I was able to see some differences in teaching style in the US through the way young physicians interacted with attending physicians. Active discussions were held in the rounds of general medicine and infectious diseases, and in the Morning Reports which the chief residents facilitated every morning. The residents were able to equally discuss with the attendings and senior doctors from other departments. The attendings mostly had trusts in the residents' assessment and empowered them with their management. And overall, they both were able to "naturally" communicate with each other. Looking back at the Japanese residency and education, I am convinced that we need to learn from them on the following points; 1) to share the agenda on a common table, which will facilitate the constructive and smooth discussions; 2) to learn the words and create the atmosphere that will keep the discussion going; and 3) to learn that the discussion and education are interactive entities, for which we recognize others as equal and first listen to them. We must not rely solely on old-fashioned 'traditions', or some leaders' statements or opinions in our care; all professionals must seek for and share a common direction through discussions.

Japanese attendings and residents should get used to calmly and naturally discuss things. This might be part of "professionalism" and could be the clue to promote the learning of young physicians.

I am also convinced that the essential elements necessary in the case conferences is the presence of experienced attending physicians, in addition to interactive discussions. In fact, it was the attending physicians and their 'real' experiences, knowledge and clinical pearls that made the conferences exciting and fruitful. Back in Japan, we cannot afford to frequently hold case conferences, and junior attending physicians with similar experience levels tend to gather at these meetings, which may not always be an effective educational opportunity for other young physicians. It is difficult to allow the attending physicians to participate in such conferences in Japan, but I still believe that it is necessary to unite and involve all the physicians in the hospitals to accommodate such a system that will facilitate the young physicians' learning.

Although limited by time, I was able to successfully complete the two purposes that led me to OVMC. One thing is at least clear: I am inspired to improve the education system for younger physicians as well as my self-education. I also learned more than I have described above, and stimulated to learn more.

As I was enlightened through this program, I hope that this program will go on so that younger physicians will get an opportunity to be stimulated.

Lastly, and most importantly, I would like to thank the California and Japan Chapters of the American College of Physicians for giving me such an enlightening opportunity. I am grateful to Mr. Norman Belisle and physicians involved in the OVMC for extending their greatest hospitality. And finally, I would like to thank my best 'roommate', Dr. Tetsuya Makiishi, for having the trip together for a month.

Report of the clinical observership program at the Olive View-UCLA Medical Center

Tetsuya Makiishi, MD, FACP

Vice Chief, Division of Nephrology and Dialysis, Otsu Red Cross Hospital

Taking part in this international exchange program provided by ACP Japan Chapter's International Exchange Committee, and interacting with distinguished physicians, residents, medical students, and house staff for a month at the Olive View-UCLA medical center was the best thing I have ever done throughout my career. The experience helped deepen my understanding of the internal residency training system provided by the United States' top-ranked educational hospital, which will definitely improve my ability to teach future residents. The experience also helped me gain more insight into professionalism as a physician.

As an attending physician who is struggling to teach residents in Japan, I expected that the program would help me to learn about the differences in the residency training system provided by teaching hospitals in the United States and Japan. It was important for me to find out how bedside teaching is performed, cases are discussed, and feedback is given to residents or medical students. It was also important to find out how the medical team, consisting of an attending physician, fellows, residents, and medical students, works in a coordinated fashion, and how the quality of education is guaranteed. I have learned that, and more. I was able to learn from high-quality interactive case conferences held every morning, noon lectures focused on clinically-relevant topics and a regular journal club provided by attending physicians, as well as everyday

experience among a ward team.

I also found that every physician I met at the hospital really believed in developing residents and fellows. I would like to share a story of one of the attending physicians at the hospital, as an example. My impression of her, when I first met her in her office, was that she was a calm, mild, and gentle woman. So I was little surprised to hear her criticize her fellows harshly at the clinical conference when they were unable to answer her stream of questions. After the conference, one of the fellows said to me, "Yes, she's quite demanding and expects our best efforts, but she's also a great listener. She always says, "My door is always open." And in her case, it's true." They also shared energy, passion, and dedication to their patients. I found that the combination of all those things, in other words the culture, make their residency program truly excellent.

They have also been spent considerable effort to maintain the quality of their program. I spent November at the hospital, which was an interview month, so we often saw medical students wearing suits walking down the corridors looking nervous. I was a little surprised to hear from Mr. Norman, the secretary of the department of internal medicine at the hospital, that only 30 of the approximately 1,500 applicants per year are selected for their program through the matching system. What was much more surprising to me was that they spend four months interviewing the 500 applicants who pass the paper sift. It was also interesting to know that residents, as well as attending physicians, are involved in interviewing to keep the selection system more efficient and transparent.

It is true that there are some challenges for a Japanese physician spending a month on the program, where the situation is totally

different from Japanese hospitals. These challenges include the language barrier and cultural differences. No one spoke Japanese at all. Regarding cultural differences, however, I quickly learned to cope with the new situation. Overall, I found it an incredibly rewarding experience. Seeing is believing. In conclusion, this program is the place to be for any physician, no matter how much clinical experience they have, who wants to expand their horizons.

I am grateful to all of the people who were involved in helping me get through this program. I also would like to thank Dr. Kuriyama who spent a month with me as my roommate, and Mr. Norman. Through him I learned a lot about the culture of the United States, and life in general. I will always cherish those memories.

Editor’s Postscript

ACP celebrated its 100th anniversary this year. We pay tribute to the tradition and the remarkable development of ACP.

In this memorial moment, Dr Kiyoshi Kurokawa, who founded Japan Chapter, received the Chapter Centennial Legacy Award. This Award honors one influential chapter member who served the chapter and made significant impact on the chapter's viability.

In this issue, you can see the history of Japan Chapter before and after its foundation from essays of Dr Kurokawa and Dr Kobayashi and also see how actively young members play a remarkable role in Japan Chapter and senior physicians grow to be mentors.

Japan Chapter received Chapter Excellence Award 2015. The goal of this Award is to recognize chapters that are meeting the standards of chapter management. Our chapter activity is highly evaluated.

We, PR Committee, preserve our history leaders have established and will record how young members are making history.

We are pleased to acknowledge the contribution of Dr Fleming and Dr Centor in this issue. Both ACP leaders visited Japan Chapter Meeting in Kyoto as guest speakers and gave us special lectures and comments. （SA）

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