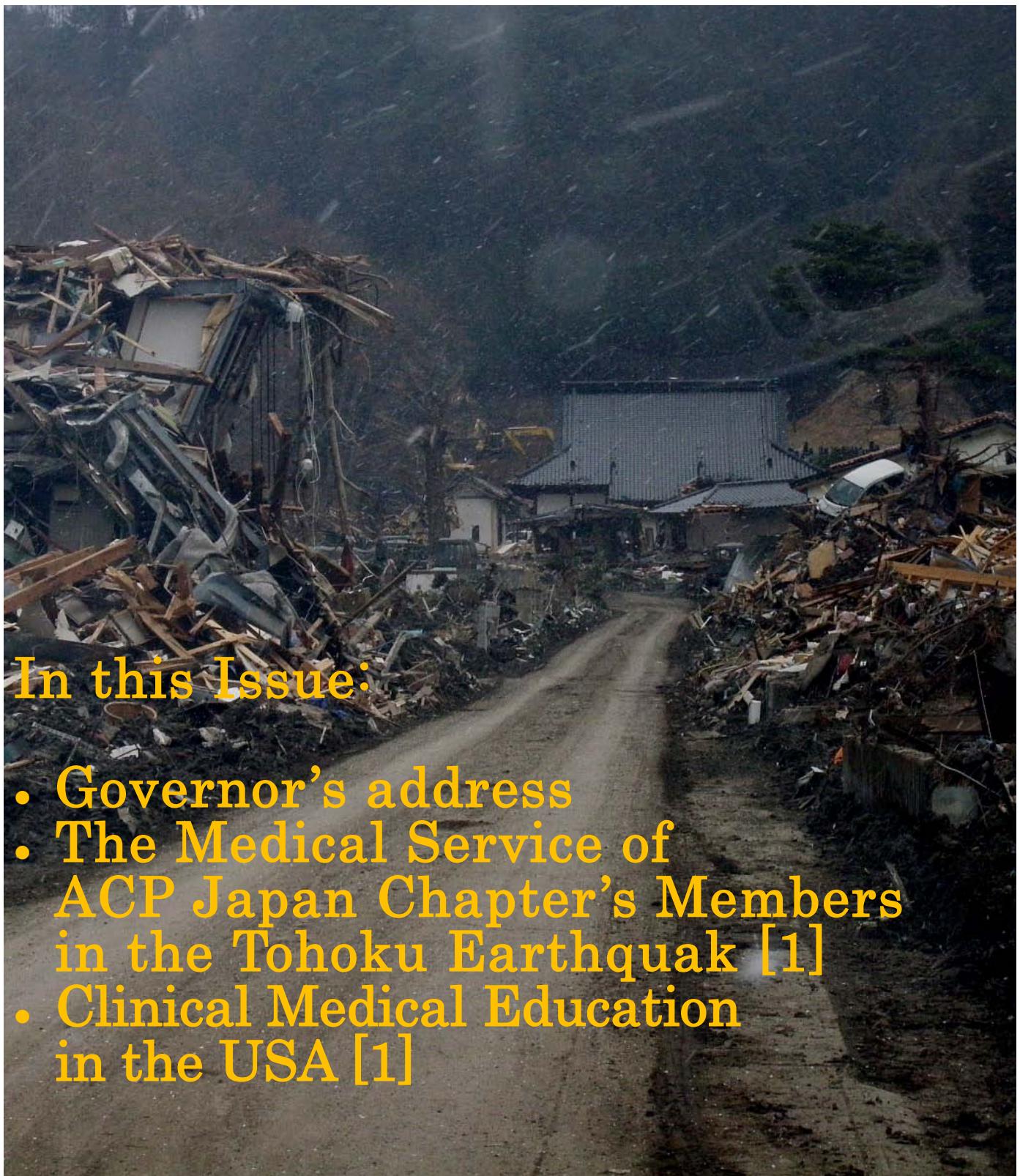


Governor's Newsletter for all ACP members

October 2011

Governor: Shotai Kobayashi MD, MACP



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■ Governor' s Address

Shotai Kobayashi, M.D., MACP
Governor; ACP Japan Chapter



At the first, on behalf of ACP Japan Chapter, I appreciate for kind and heartily message of sympathy from ACP members for the Tohoku Earthquake on March 2011. Fortunately, our members are all safe, but several doctors suffered from this disaster. In addition, meltdown trouble in the Fukushima nuclear plant is serious problem for residents in wide area of Fukushima prefecture. Therefore, we will send real reports from our member living in this area and member who supported as volunteer doctor in Tsunami suffering area.

We will send information about hot news in Japan and interesting issue for international chapters also. If you have a comment or advise on our news, please give us message.

With my best regards,

Governor of ACP Japan Chapter
Shotai Kobayashi, M.D., MACP

■ Special Feature: The Medical Service of ACP Japan Chapter's Members in the Tohoku Earthquake

Part 1: Reports from Members Living in the Disaster Area

1) The Aftermath of the Explosion of the Fukushima Daiichi Nuclear Power Plant –Nearly Beyond Human Strength–

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On March 11, 2011, a catastrophic earthquake and tsunami destroyed the back-up electric generators of four reactors at Tokyo Electric Power's Fukushima Daiichi nuclear power plant. The subsequent explosions damaged four of the plant's six buildings, and the radioactive material formed a plume that contaminated the soil of Fukushima. Consequently, people within 30 km of the nuclear plant were forced to evacuate their homes. My town is 38 km away from this nuclear plant. For all practical purposes, we did not need to evacuate, but as soon as the town's official began to broadcast the evacuation recommendation, the people of my town panicked. Food stores, banks, post offices—most of the town's buildings—were quickly closed, and parents and grandparents began to evacuate with their young children and grandchildren.

The situation in my clinic was not an exception. The day after the broadcast, the young mothers among my staff (clerks and nurses) were absent, without giving any notice. Furthermore, after two weeks, we experienced serious shortages of all daily necessities, particularly food, gasoline, and medical supplies. Thus, our work was hindered. However, evacuees from towns close to the nuclear plant continually visited my clinic in order to obtain medical attention and supplies. More than 150 patients visited us every day. At this point, four of the seven clinics in my town were closed owing to a shortage of manpower, medical supplies, and gasoline as well as the collapse of their facilities. Because of the no-warning emergency evacuation, many evacuated patients did not carry their medical information with them. In spite of our dwindling drug supply and the lack of background information, we managed to treat these patients and prescribe

drugs. In addition, the medical association in my town provided a traveling clinic for people housed in temporary shelters, who could not receive medical attention.

An unfortunate event occurred when the news of this disaster first reached my town. Acting on the rumor that the Japanese government had issued a statement entitling the evacuees to free medical supplies, the evacuees stole all the OTC drugs from the showcases of the local drugstore. Actually, the evacuees were entitled to obtain free medical supplies only from a medical institute. Regrettably, the drugstore could not prevent these ravages; it has not yet received compensation from the government for this loss.

The shortage of gasoline hindered outpatients from regularly visiting my clinic. In order to maintain their health and prevent their condition from deteriorating, my clinic provided a round-trip bus service from their homes to the clinic, with gasoline supplied by several gas stations owned by some of my patients.

Ever since the accident at the nuclear plant occurred, my staff and I have worked hard, physically and mentally. We could not say "give up," because we faced many sick people who lost their home in all meanings. However, frankly, we were also in a state of turmoil. I can hardly remember what we did for the first two weeks after the disaster.

Many events have occurred since the March 11 earthquake and tsunami. We must not forget these past five months. Because of these traumatic experiences, I wish to recommend the following basic precautionary measures: (1) Individuals must carry their personal medical information on their persons, or an official, universal, "secure" system must be created that swiftly provides personal medical information upon a request from a medical institution. (2) Local medical associations need to supervise the stock and coordinate the distribution of medical supplies, and these institutions should be closely connected to and communicate with each other. For whatever reason, we, medical staffs, have to exert all our force to treat sick people. We need to prepare anytime.

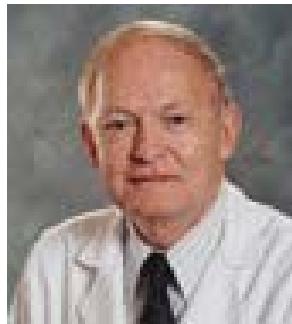
Henceforth, we must face the possibility of long-term radiation exposure, albeit low-level radiation. Medical checkups, especially thyroid examinations in young people (0~18 years old), will begin shortly in Fukushima, and regular checks will be continued for at least the next 30 years. Our responsibility is grave.

Finally, I would like to thank ACP for this opportunity and the entire world for their physical and mental support.

■ Serial Publication: Clinical Medical Education in the USA

1) American style clinical medical education and medical social background in the USA

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Chairman, Department of Medicine and
Program Director, Internal Medicine Residency,
Exempla Saint Joseph Hospital.



Dr. Gibbons

Prior to applying for medical school in the United States, students must complete four (4) years of undergraduate work (college) and may major in any subject. However, those who do not major in the sciences will be required to take additional science classes in order to be eligible to apply to medical schools. The majority of medical schools in the United States are state funded and the remainder are private. There is one national medical school. The tuition for medical schools varies considerably, but in general, state schools are less expensive than private.

All medical schools in the United States require four (4) years of study. The first two years are the basic sciences in which students are primarily studying anatomy, biochemistry, physiology, etc., while the second two years are considered to be primarily clinical (practical work in hospitals and clinics.) In most medical schools, students will begin working in primary care clinics (internal medicine, family practice, pediatrics, etc.) in the first year to gain some practical experience. These clinics are generally one-half day each week throughout the first two years of the basic sciences and sometimes during the third year of medical school.

The third year of medical school (clinical year) is primarily devoted to gaining experience in the major specialties, primarily in the hospital, but also in the clinics. A typical curriculum would include three months of internal medicine, three months of general surgery and surgery subspecialties, two months of pediatrics, two months of family practice, one month of neurology and one month of psychiatry. Medical students during the third year are expected to be able to learn how to take a complete history, perform a full physical examination, make work rounds and teaching rounds on patients, and develop differential diagnoses and plans of treatment. They will also assist in doing some basic procedures in internal medicine, pediatrics, family practice and surgery. Their supervision is carried out by residents in training, as well as supervising/teaching attendings who are full time faculty or volunteer faculty.

In the fourth year of medical school, students are generally required to participate in at least one to three hospital subinternships in one or more of the major specialties (internal medicine, surgery, pediatrics, family practice). Students continue to be under the supervision of residents and faculty members, but are more independent, and are responsible for an increasing number of patients. The remainder of the fourth year is very flexible, and students are allowed to participate in any of the other specialties, such as anesthesia, radiology, surgery and medicine subspecialties, dermatology, etc. During the first six months of the fourth year, students will apply to specialty and subspecialty residency training programs, and interview at those to which they are invited. This may include the university-sponsored residencies or private/university affiliated programs. The academic data for the students is transmitted through a nationwide computer system, titled Electronic Residency Application Service (ERAS.) Interested residency programs only receive the information from those students who are requesting an interview. In

March each year, students are matched to a program through a national computer system, titled The National Residency Matching Program (NRMP.) This match is announced in March prior to the beginning of the new academic year for residencies.

Medical students are required to pass a basic science examination following the completion of the first two years of medical school. The United States Medical Licensing Examination (USMLE-I) can be taken at any time, but is required for graduation. During the clinical years, all students must also pass USMLE-II, which is a clinical based examination. Finally, all students must pass the Clinical Skills Examination (CSE), a practical test with patients or simulated patients, in order to successfully graduate and continue their training in a residency. These

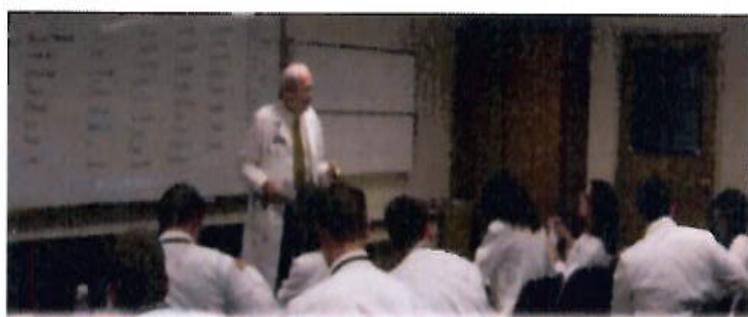
examinations are required for both American and International students, as well as physicians who have completed their training internationally.

Residency programs in the United States have different requirements for training depending upon the specialty (three years for internal medicine, pediatrics, family practice, emergency medicine; four years for ob/gyn; five years for general surgery, etc.) Following the completion of training in internal medicine, physicians may then apply for subspecialty training programs (cardiology, pulmonary, nephrology, etc.). While in these programs, they are generally referred to as ‘fellows.’ These fellowships also vary in the amount of time required for completion. Depending on the subspecialty, the training is generally two to three years, and frequently an additional year for clinical or basic science research. In internal medicine, residents will spend approximately 35–40% of their time in an outpatient setting in general medicine or one of the medicine subspecialties. In addition, one month of emergency medicine and one month of neurology will also be required. The remaining time is spent on the hospital in-patient medicine and subspecialty services, to include the critical care units. Residents are also required to participate in a continuity care, general outpatient clinic for one-half day or two-half days each week throughout the entire three years.

In order to become “board certified” in internal medicine and any of the subspecialties of internal medicine, residents/fellows must successfully pass a one-day examination. These examinations are created and given by the American Board of Internal Medicine (ABIM), and are given in a secure, computer software format.

Internal medicine training in residency programs will have significant variation depending on each program’s curriculum. However, all programs must meet certain requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME), which oversees a Residency Review Committee (RRC) for each specialty. All residencies must include certain types of training and meet a variety of requirements in order to be accredited by the RRC. Although residents function independently in the care of patients, they must be supervised by teaching/attending physicians. Limits on the number of patients for which a resident can care, as well as duty hours and other requirements, are set by the RRC. Most programs will administer an examination (in-service examination) at least once, but generally three times during the three academic years in order to judge the progress of the residents. Supervising and teaching attendings also submit written evaluations, generally on a monthly basis, to the residency program director. The RRC makes periodic visits to programs (generally at three- to five-year intervals) in order to determine if the residency and fellowship programs are meeting the RRC requirements. The maximum accreditation given following any visit is five years.

IM Curriculum



Rotation Details

Overview

Residents at Exempla Saint Joseph Hospital serve on inpatient rotations in General Internal Medicine, Critical Care, and Oncology. All first year residents rotate for one month at Denver Health Medical Center for Emergency Medicine. Elective rotations are available in all specialties, and are offered in each year of training. Residents in the three-year categorical track also practice ambulatory medicine in the Caritas Clinic, a charitable clinic for the underserved, one half day per week throughout the year. All rotations strictly adhere to the guidelines and work hour regulations of the American College of Graduate Medical Education.

The numbers of months allotted to each rotation are different for each post-graduate year, and are summarized below:

Post-graduate year	Wards	ICU	EFIT	MIM	Onc	ED	Float	Caritas	Elective
PGY I (Prelim.)	4-5	1-2	0-1	1	0-1	1	1-2	0	2
PGY I (Categ.)	4-5	1-2	1	0-1	1	1	1	0-1	2
PGY II	3-4	1-2	0-1	0-1	1	0	1	1	5
PGY III	1-2	1-2	1-2	1-2	0-1	0	0-1	1	6

General Medicine Wards

There are four inpatient Ward teams at Exempla Saint Joseph Hospital. Each house staff team consists of one senior resident (PGYII or III) supervising two interns (PGYI), and possibly a third-year medical student (MS III). Residents are responsible for the care of patients from admission to discharge, and are the primary providers for the patients. Residents are supervised by a teaching attending who manages patients and conducts teaching rounds with the housestaff team. Additionally, residents may have an additional managing attending who oversees care of additional patients on the team. Teams take "long call" every fourth night, triaging new admissions to the various Ward teams until 9:00 p.m. Sunday through Thursday, and staying overnight on Friday and Saturday. Overnight admissions during the week are the responsibility of the Night Float team, which transfers the care of these patients to the Ward teams in the morning.

Night Float

There is one Night Float team on service every month, consisting of one supervising resident (PGY II or III), and two interns (PGY I). Residents are responsible for cross-cover management of inpatients on the teaching services, and for new admissions. The team is in the hospital during the week, Sunday through Thursday, from 7:00 p.m. until 7:00 a.m. Supervision of the Night Float team is by the admitting physician for each specific patient. Care of patients admitted overnight is transferred to the Ward teams in the morning.

Exempla Faculty Inpatient Team (EFIT)

One EFIT team is on service each month, consisting of a senior resident (PGY II or III) supervising one intern (PGY I) and frequently a subintern (MS IV). Residents on the EFIT team are responsible for admission and ongoing care of patients from the Caritas Clinic (our resident-run clinic), and "unassigned" patients from the Emergency Department (those patients without a primary care physician or with a primary care physician who does not have privileges at Exempla Saint Joseph Hospital) in rotation with the MiM team (See below). The EFIT service follows these patients in and out of the ICU, and provides medical consultations for other specialties in the hospital. The team is supervised by one of the Internal Medicine Faculty, who serves as both the teaching and managing attending. The EFIT team is in house daily, but has no overnight call. The Night Float team covers cross-cover issues and new admissions overnight.

Midtown Inpatient Medicine (MiM)

One MiM team is on service each month, consisting of a senior resident (PGY II or III) supervising one intern (PGY I) and frequently a subintern (MS IV). The MiM Group is a private hospital-based physician group that

provides inpatient services (admission and consultation) for private physicians in the community. Residents on this team are responsible for admission and management of these patients and unassigned patients from the Emergency Department in rotation with the EFIT team. The MiM team follows patients in and out of the ICU. Residents are supervised by one of the MiM physicians, who serves as both the teaching and managing attending. The MiM team is in house daily without overnight call. The Night Float team covers cross-cover issues and new admissions overnight.

Critical Care Medicine

Three critical care teams are on service each month at Exempla Saint Joseph Hospital, consisting of a senior resident (PGY II or III) supervising one intern (PGY I), and frequently one subintern (MS IV). Residents are the primary caretakers of patients in the Intensive Care Unit, responsible for admission and ongoing management. The teams rotate through ten day shifts, then five night shifts. The day teams alternate short call and long call, with the long call team triaging admissions during the day until 9:00 p.m., and the short call team helping with admissions and patient care until no later than 4:00 p.m. The night call team arrives at 8:00 p.m. and is responsible for new admission and cross-coverage until 7:00 a.m., but stays until 9:15 a.m. to help with morning work, to check-out to the day teams, and to participate in teaching rounds. The long call and night call teams are responsible for all adult Cardiac or Respiratory Arrest (Code Blue) calls in the hospital, and all Rapid Assessment Team (RAT) calls in the hospital. When patients transfer out of the ICU, one of the General Medical Ward teams assumes their care. Critical Care teams are supervised by a managing attending for the day-to-day care of each patient. Additionally, the three teams round at the bedside together every weekday with Pulmonlogy, Cardiology, Infectious Disease, and/or Nephrology Critical Care teaching physicians. During this month the residents do not have responsibilities at the Caritas Clinic.

Oncology Medicine

One Oncology team is on service each month, consisting of one senior resident (PGY II or III) supervising one intern (PGY I), and frequently one subintern (MS IV). Residents are responsible for the care of patients admitted to the hospital with hematologic or oncologic illnesses. Residents are supervised by both Oncologists and Internal Medicine Hospitalists, who help direct the day-to-day care of individual patients, as well as performing bedside teaching rounds daily during weekdays. The Oncology team is in house daily without overnight call. The Night Float team covers cross-cover issues and new admissions.

Caritas Clinic Ambulatory Rotation

Every month there are one or two categorical residents on service at the Caritas Clinic. Residents care for patients in the clinic with specific half-days dedicated to care of acute illness, diseases of the joints, diseases of the skin, and pre-operative evaluation. There are also half-days dedicated to teaching residents about specific ambulatory care topics, ranging from training in treadmill stress-tests to learning about malpractice at Colorado's largest malpractice insurance carrier. Further, residents are given dedicated time to develop and implement a quality-improvement project at the Caritas Clinic to improve the care we provide to our patients.

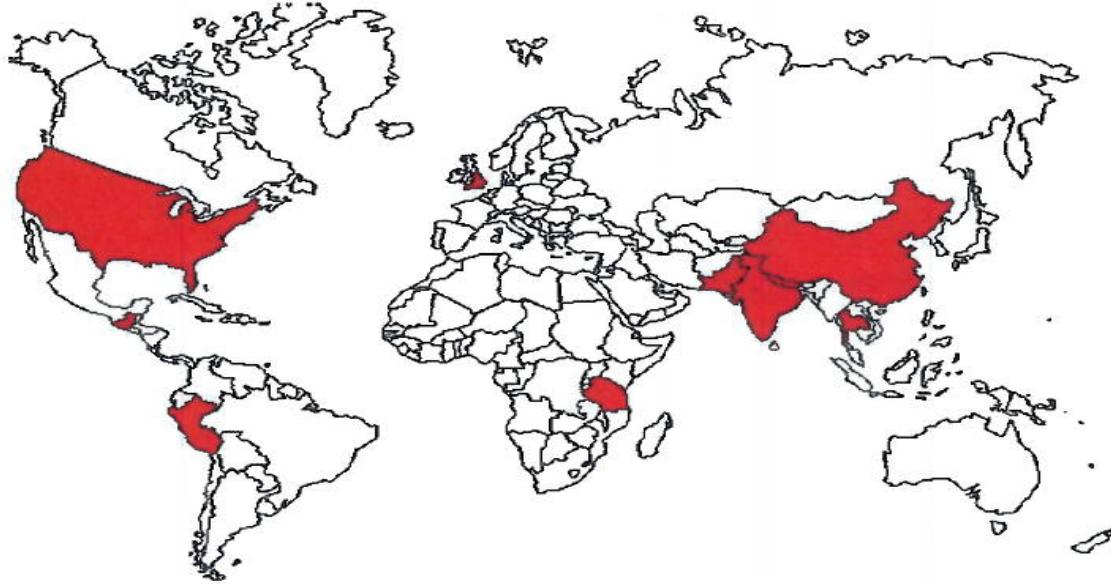
Emergency Medicine

Every intern (PGY I) rotates for one month at Denver Health Medical Center, the premier Emergency Medicine training program in the United States. Residents are responsible for assessing patients as they enter the Emergency Department, formulating and implementing the plan of care, and discharging them appropriately. Residents work on a shift schedule, and are supervised by senior Emergency Medicine resident and attending physicians. Residents do not have responsibilities at the Caritas Clinic this month.

Elective Rotations

Elective months are available to all residents in each year of training. Residents have numerous options for their elective months, allowing them to tailor their training to their interests. Elective rotations are available in all specialties, and are offered at Exempla Saint Joseph Hospital, University of Colorado Health Sciences Center, and local private and HMO offices. Additionally, residents may arrange unique elective months to suit their own educational goals. This includes rural, out-of-state, or international settings. Residents have participated in rotations in Europe, Africa, Asia, Central and South America. They have the option to organize the rotation themselves or participate in the overseas programs affiliated with Exempla Saint Joseph Hospital. Residents have rotated all over the United States, and around the world to China, England, Guatemala, India, Nepal, Pakistan, Peru, Tanzania, and Thailand.

Below is a map indicating, in red, countries in which our residents have traveled for rotations:



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2011-2012 Internal Medicine Residency - Master Rotation Schedule											
Careteam/Rota	8/23-7/22	7/23-6/22	6/23-5/22	5/23-4/22	4/23-3/22	3/23-2/22	2/23-1/22	1/23-12/22	12/23-11/22	11/23-10/22	10/23-9/22
Bassis	Night Float	D Team	ED / DH	MIM	B Team	B Team	Derm CUI/Pvt	C Team	Rheum / CU	Oncology	A Team
Cahill	ICU-3	Rheum	A Team	A Team	International	ED / DH	B Team	MIM	Night Float	D Team	Oncology B Team
Estopinal	C Team	Night Float	D Team	Res / UCSF	ED / DH	C Team	ICU-2	A Team	C Team	TBD	MIM D Team
Finseth	B Team	Office Ortho	Night Float	C Team	C Team	MIM	D Team	ED / DH	ICU-2	A Team	Neuro / CU Night Float
Hawkins	MIM	B Team	ED / DH	Night Float	A Team	A Team	Rheum	ICU-1	B Team	ID	D Team Night Float
Houkai	ICU-3	ED / DH	ID	D Team	MIM	C Team	C Team	Night Float	Cardi	B Team	B Team Oncology
McKenzie	ED / DH	ICU-3	B Team	B Team	Night Float	D Team	MIM	Office Ortho	C Team	C Team	Night Float Rheum
Simpson	ED / DH	C Team	Night Float	A Team	A Team	Derm CUI/Pvt	ID	D Team	MIM	C Team	C Team ICU-2
Smith	Night Float	C Team	ICU-2	C Team	B Team	Rheum	A Team	ED / DH	D Team	Night Float	Derm CUI/Pvt MIM
Warmer	ICU-1	MIM	C Team	Night Float	C Team	ED / DH	Neuro	B Team	A Team	MIM	D Team International
Wert	A Team	A Team	MIM	Anesthesia	D Team	ICU-1	C Team	ED / DH	iPunit	Night Float	C Team
Categorical Rots	8/23-7/22	7/23-6/22	6/23-5/22	5/23-4/22	4/23-3/22	3/23-2/22	2/23-1/22	1/23-12/22	12/23-11/22	11/23-10/22	10/23-9/22
Arriola-Tirella	A Team	EFIT	C Team	ED / OH	ICU-1	GI / CU	Night Float	Cardi / CU	Oncology	ICU-1	C Team EFIT
Benoit	Oncology	A Team	Cards	ICU-2	EFIT	Night Float	Caritas	ED / DH	A Team	ICU-2	A Team Pulm
Feingold	ED / DH	B Team	ICU-1	Rheum	Night Float	B Team	EFIT	Oncology	ICU-1	B Team ID	ID Team
Keown	EFIT	ICU-1	B Team	Oncology	Renal	ED / DH	ICU-1	Palliative	B Team	Night Float	Caritas A Team
Mast	C Team	ICU-2	Rheum	B Team	Office Ortho	Night Float	Oncology	ICU-2	EFIT	Caritas	ED / DH B Team
Nguyen	D Team	Night Float	A Team	ICU-1	PC / Kaiser	Oncology	ED / DH	B Team	Renal	EFIT	ICU-2 Caritas
Slater	B Team	ID / CU	Oncology	EFIT	ED / DH	ICU-2	A Team	EFIT	Night Float	Cardi / CU	B Team ICU-3
Yegappan	Renal	Oncology	EFIT	ID / CU	ICU-2	A Team	Night Float	A Team	ED / DH	A Team	EFIT ICU-1
Yelman	D Team	D Team	ICU-3	Endo / CU	Oncology	EFIT	B Team	Night Float	Renal / CU	ED / DH	ICU-1 C Team
Zee	7/1-7/21	8/1-8/21	9/1-9/21	10/1-10/21	11/1-11/21	12/1-12/21	1/1-1/21	2/1-2/21	3/1-3/21	4/1-4/21	5/1-5/21 6/1-6/21
Berger	B Team	Night Float	Caritas	Office Ortho	Sports Med/ CU	ICU-1	Oncology	Geriat	MIM	Pulm / CU	C Team ICU-1
Johansen	Oncology	Geriat / CU	ICU-1	PC / Private	Caritas	Rheum / GU	Night Float	Cardi	ICU-2	Renal B Team	B Team
Lesic	A Team	Geriat / CU	Oncology	Night Float	PC / Private	ICU-2	Cardi	B Team	Anesthesia	Renal / CU	ICU-2
Limanasky	ICU-3	C Team	Renal	Oncology	C Team	Caritas	International	A Team	Research / CU	Rheum / CU	Night Float Geriat / CU
Lewis	C Team	Oncology	Geriat	ICU-2	Caritas	ID / CU	A Team	Rheum / CU	Night Float	A Team ICU-2	Neuro
Mendoza	D Team	Geriat / CU	ICU2	Caritas	Rheum / CU	B Team	Hospitalist	Night Float	Palliative	MIM	Oncology A Team
Senavsky	Night Float	Derm CUI/Pvt	C Team	ICU-2	Sub Abuse	ED / DH	Geriat / CU	Caritas	ICU-2	D Team	Oncology
Silva	Pathology	D Team	Night Float	Pulm / CU	B Team	MTM	Geriat / CU	ICU-2	Oncology	Caritas A Team	Cardi
Theis	Rheum	Caritas	ICU-3	B Team	Night Float	Research	Research	Renal	A Team	Oncology	Geriat / CU ICU-3
Zee	7/1-7/21	8/1-8/21	9/1-9/21	10/1-10/21	11/1-11/21	12/1-12/21	1/1-1/21	2/1-2/21	3/1-3/21	4/1-4/21	5/1-5/21 6/1-6/21
Barr	EFIT	A Team	Derm CUI/Pvt	ID / CU	ICU-1	Pathology	MIM	Oncology	ENDO	C Team	Caritas IR / Rad Onc
Conklin	ICU-1	Neuro	EFIT	Rheum / CU	MIM	Caritas	ENDO	C Team	ICU-1	ID / CU	EFIT International
Eiser	ICU-2	MIM	Caritas	Endo / CU	Oncology	Cardi	C Team	ICU-1	Pathology	EFIT	Pulm Derm CUI/Pvt
Fransen	MIM	Rheum / CU	Research	A Team	EFIT	Anesthesia	ICU-1	Caritas	G Team	Palliative International	Night Float
Gleason	Palliative	ICU-1	A Team	MIM	Pathology	EFIT	B Team	Derm CUI/Pvt	Caritas	GI Rheum / CU	D Team
Hurley	Caritas	B Team	Rheum / CU	EFIT	Neuro	Oncology	ICU-2	International	Research / CU	Night Float	Renal MIM
Nelson	PC / Private	ICU-2	B Team	Caritas	Neuro / CU	A Team	EFIT	MIM	Derm CUI/Pvt	ICU-1	Women's Hill EFIT
Oshetski	Neuro	ICU-3	MIM	Renal	Pulm / CU	Night Float	Anesthesia	EFIT	Rheum / CU	B Team	ICU-1 Caritas
Pham	ID / CU	EFIT	Anesthesia	ICU-1	A Team	C Team	Office Ortho	Caritas	EFIT	Derm CUI/Pvt	MIM C Team

updated 6/22/2011@ 0849

Code Abbreviations for Master Rotation Schedule

ICU: Intensive Care Unit

A-Team
 B-Team
 C-Team
 D-Team
 MIM
 EFIT

Inpatient General Medicine

ED: Emergency Department

Night Float: Inpatient General Medicine 7:00 pm – 7:00 am

(edited by Public Relations Committee)