

Governor's Newsletter for All ACP Members

March 2014

Governor: Shotai Kobayashi MD, MACP

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Emerging healthcare needs and the future Role of Internal Medicine

- Grand design for Internal Medicine's future in a hyper-geriatric Society
- How can Internal Medicine be committed to primary care?

**2014
5/31
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ACP Japan Chapter
Annual Meeting
2014

Kyoto University
Clock Tower
Centennial Hall

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■ Governor's Message



Next year will be the final year of my governor's term because I am governor of class 2015. Full independence from the Japanese Society of Internal Medicine (JSIM) was the great mission over the past two years for ACP Japan Chapter. Fortunately, we completed independent financial and management operations including annual meeting. Attendees of our annual meeting increased last year even though it was held at different time and place with JSIM meeting. The contents of our annual meeting aimed to education for general physician same as the ACP might match the needs of medical students and young physicians. ACP is organized with general internists who have the board of US general internal medicine. Therefore, primary purpose of ACP is education for general physician. In contrast, board of directors of JSIM is traditionally organized with mainly university professors, ie subspecialty specialist. JSIM is in the trend of academic focus and less enthusiastic in education of general physician. It may be a main cause of insufficient education of general medicine in Japan.

In this issue, we post 2 interesting essays from US ACP members. The first one described by Dr. Deshpande who is now working as staff physician, US Embassy Tokyo Health Unit. He taught many short visit Japanese medical students in Hawaii University and also working as clinical educator in medical school in Japan. He knows Japanese medical education system very well as far deep in "Ikyoku". He described "As has been described from sociology and anthropology literature in Japan, individual identity is often tied to work relationships, rather than family, friends, or self." This system has both the positive and negative aspects and now it is moving in trend to American style. He also pointed out weak point of education for clinical research in Japan. I think his comment is getting target. ACP Japan Chapter should improve these points and to grow good general internist as a goal of our society.

The second essay is written by my old friend Dr. Loge. About 10 years ago, I visited him in Montana with Professor Paauw, Chief director of WWAMI program, in international observational training program of rural medical education for Japanese young doctors and students (Good Practice) planned by Shimane University Hospital. He became my good friend after that and has served Governor of ACP Washington state Chapter later. Barrett Hospital Dillon is located in middle of the mountain area far from Seattle. I saw only cows and elks as far as the eye could see around hospital. His daughter was medical student in University Washington at that time, and after residency she came back his hospital. I remember well that he told me about it with a big smile. I believe his daughter was fascinated by his passion for Cowboy Country Medicine.

Shotai Kobayashi, MD, MACP
Governor, ACP Japan Chapter

■ Feature Article

A US Perspective on Japanese Medical Education: Excellence in clinical care, with room for improvement

Gautam A. Deshpande, MD

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Staff Physician, US Embassy Tokyo Health Unit
Senior Researcher, Center for Clinical Epidemiology,
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Member, American College of Physicians



Mature civilized cultures can assess both the good and bad in their systems in equal measure, celebrating the good, and sincerely and passionately working to overcome the bad. These comments, invited by the ACP Japan leadership, are submitted with the deepest respect for the wonderful accomplishments that the Japanese health system has achieved. In this brief essay, I will outline both the positive and negative aspects of Japanese medical education from the perspective of an American clinician and medical educator who has lived and worked in Japan for the last 5 years. A Japanese colleague in medical education, who interacts very often with international educators, recently confided to me that--deep down--he really doesn't like invited foreigners "dropping in on Japan and telling Japanese educators how to teach students." While this is an understandable sentiment, and one that would be universally echoed abroad, it runs counter to the idea that countries should—and indeed must—contribute to each other in a positive and constructive way. We are all working to benefit patients--and as I get older, anticipating that I may one day be a gaijin patient in a Japanese hospital, I am struck by the fact that medical education must be a borderless endeavor. I ask readers to view my comments in this light.

I. A Focus of the Fundamentals

Dedication to Learning, Dedication to Excellence

As a clinical educator at the University of Hawaii, I began working closely with Japanese medical students in 2007. The University, having close ties with a number of Japanese institutions, hosts 24 students for a 1-week Clinical Reasoning Workshop in Honolulu every year. Albeit a self-selected group, they impressed me year after year with their motivation and passion for learning. Younger than their US counterparts by 2-4 years and immeasurably less cynical, they gave the impression of empty bowls, hungry to be filled with knowledge. Compared to Japanese students of the same level, I find US students a bit more challenging to educate; as any parent knows, independence of thought also brings a stubbornness of will. While I find that all medical students are generally bright and exceptionally motivated, Japanese students continue to strike me with their sunny positivity and energy-filled attitudes towards daily learning and growth. While this is

in line with the Confucian tradition of scholarship, I speculate that the typical Japanese student, compared to their US counterpart, has substantially lower rates of student loan debt, more family support, and lower stress through the training process, leading them to see education as a gift, rather than a burden or entitlement. As an educator, this is a refreshing and invigorating context in which to teach the art and science of medicine.

Though perhaps a bit more fatigued and cynical than students, Japanese residents exhibit the same passion for learning. They are singularly committed to the hard work and long hours needed to achieve medical excellence. This shows in their generally excellent funds of knowledge, especially as applied to memorized facts such as clinical criteria (e.g., Duke criteria for endocarditis or EULAR guidelines for Sjogren`s) and practice algorithms (e.g., step-by-step lab work-up of suspected renal tubular acidosis). I laugh to think that I know several Japanese residents who have read Harrison's Principles of Internal Medicine from cover-to-cover, while I know of no US trainees who have managed this tremendous feat. While it is debatable whether reading a textbook equates to better clinical care, I think we can agree that it reflects the passionate pursuit of clinical excellence. In comparison, I find US residents generally less focused on learning; there is a common complaint that academics takes too much time in the modern teaching hospital, with US residents increasingly focused on getting out of the hospital "on time." Indeed, we US educators have been complicit in allowing this attitude to foster, as we relent to increasingly bizarre demands on work hour restrictions and napping protocols at the expense of education and patient care. The Japanese system currently remains, perhaps blissfully, free of these limits; this educator hopes sensible restrictions that protect occupational health may be instituted in the future, without shackling education and residents' critical sense of responsibility to their patients.

Team Oriented Training

The team-oriented structure of the Japanese clinical training system further encourages dedication to the profession, while stimulating continuous improvement. As has been described from sociology and anthropology literature in Japan, individual identity is often tied to work relationships, rather than family, friends, or self. This is an enormous benefit to clinical hospital education, translating into tight-knit training groups. Often delineated along departmental lines, these groups of trainees and supervisors learn together, weep together, play together, and progress together—providing an outstanding measure of interpersonal support that has long been absent from the American training structure. While American training prides itself on encouraging early independence, it does so by pushing trainees to "do it alone" remarkably early in the clinical training process. In fact, the Japanese training system may be better adapted to fostering later independence through a strong sense of support from "near peers" and supervisors. My own research among Japanese residents suggests that this "ward-mentor" support structure is an important factor in increasing resident quality of life (interestingly, a recent study suggested that co-sleeping toddlers more often develop into confident children, ostensibly through provision of a safe and supported environment). While it is not uncommon to see senior faculty often absent from the team structure, this may strengthen senpai-kohai relationships between "near peers". Compared to other training systems that disdain age-based hierarchical structures, senior trainees ("senpai") often provide admirable teaching and mental support to their junior peers ("kohai"). Lack of resident duty-hours and a cultural obligation to the team further promote senpai

accessibility and availability. Similarly, the presence of a kohai allows senior trainees to feel rewarded through teaching and being needed, whilst sharpening their own knowledge and teaching skills.

Training of technical skills (clinical and basic science)

The skill and experience that young trainees receive in technical skills – both invasive and non-invasive bedside procedures—is perhaps the most remarkable aspect of the Japanese training system. Japanese residents appear remarkably more adept than their US colleagues at independent performance of procedures such as thoracenteses, spinal taps, and wound suturing. Of particular note, Japan has done far more than the US to promote appropriate use of helpful bedside technology, such as resident-performed ultrasound. This is particularly important as it potentially leads to more efficient and effective care. By contrast, procedural skills in the US have been parceled out over years and decades to increasingly specialized groups of medical and co-medical staff, effectively disempowering hospital-based residents from ability to perform timely care. It is not uncommon for a US resident to wait days for a simple cardiac echo or abdominal ultrasound. In contrast, I have now come to expect that a Japanese resident will have at least done a rapid bedside ultrasound (abdominal and/or chest) prior to further treatment and workup. The US would do well to adopt Japan’s teaching paradigm in which “patient-centered technology” is put into the hands of those on the front lines of patient care.

II. Where to Improve and Where Do We Go from Here?

As much joy as it gives me to work with Japanese medical students and residents, I know that those that proactively seek to work with me (or Dr. Tierney or Dr. Dhaliwal or Dr. Moody or Dr. Salcedo or Dr. Branch) are a self-selecting group of the most fearless, the most passionate, and the most progressive trainees in the country. On the rare occasion that I am asked to work with an entire medical school class, I am reminded that the majority of Japanese medical students are very, very young, and not very interested in being students. I see much sleeping, I see much truancy, and I see much confusion over sense of self, and identity as a future physician. I believe this is largely due to the fact that a typical Japanese student will only have 2 years, rather than 6 years, of medical school.

The 2 Year Japanese Medical School Experience

Many countries share Japan’s 6-year undergraduate model of medical education including England, Germany, and Australia. However, it is generally agreed upon that training can only be considered successful if at least 4 of these years (~10,000 hours/year) are devoted to the serious study of science and medicine. Unfortunately, social history has encouraged students in Japan to treat their medical studies (and future careers) as a distant second priority, with first priority going to club activities and sports. While these are undoubtedly important activities in building interpersonal and team skills, they come at the price of building maturity as a physician. Maturity as a physician comes almost exclusively from the intense study of patients and their experiences of illness, as well as self-exploration of future professional goals, both inside and outside of clinical medicine. Japanese students often come to focus on these aspects of their education only in the 5th year of medical school, far too late to be of practical use.

The clinical and interpersonal skills required for patient-centered doctoring require Meaningful Clinical Interaction, which is comprised of (a) time steeped in the health sciences, (b) intense human (rather than mechanistic) experience with patients, and (c) constant introspection. Incidentally, the very busy junior resident in Japan has time for none of these, as they struggle to learn the “nuts and bolts” of acute care and hospital mechanics. For this reason, the clinical (“senior”) years of medical school are crucial for learning the human elements of doctoring. International trends in both undergraduate and postgraduate medical training point to initiating Meaningful Clinical Interactions earlier and earlier in the med school curriculum (several schools in both the US and Europe now begin meaningful clinical interaction in the very first year of medical school). While engaging in these clinical interactions, medical students in the US are also typically involved in other types of Socially Meaningful Interactions—public health projects, basic and clinical research, and provision of health care to the disenfranchised.

In stark contrast, typical Japanese medical curricula focus on short clinical rotations with limited patient interaction. Perhaps even more deleterious, many clinical requirements stop early in the 6th year, to provide study time for university and national exams. Providing neither the necessary time in the clinical environment nor an adequate depth of experience with patients, this curricular structure likely leads to a “learned helplessness,” in which trainees consider themselves inexperienced and helpless students rather than working doctors, even after graduation.

Implementing a post-graduate medical entry program in which motivated and mature undergraduate students from a variety of fields and backgrounds can enter into the medical arena (currently ~10% in Japan) is ideal for several reasons. First, it provides an opportunity for students to explore a variety of career fields prior to matriculating to medicine. This is vital for ensuring that the nation’s future doctors are truly committed to healthcare (and perhaps would not be better suited to another field). Second, it allows undergraduates to experience and then shed the indulgences of youth—extracurricular activities, alcohol, and personal relationships. Graduate studies can then be spent focusing on the health sciences, including the important task of developing differential diagnosis, history-taking, and physical exam skills. Finally, graduate medical entry allows only the most competitive students—those who succeed based on scientific achievement and motivation—to matriculate to medical school, rather than just the very smart high schooler (who may be the next Steve Jobs, but not a very good clinician.)

Study of the Clinical Sciences

Implementation of a postgraduate system entails fundamental structural changes that may be difficult to implement quickly. However, a good start might be sensible restrictions on club activities after the second year of medical school, increased opportunities for meaningful clinical interactions starting in the second year, and a promotion of graduation research projects in the clinical sciences. Increased time engaged in the serious study of clinical sciences will also help tackle one of Japan’s biggest academic shortcomings: lack of high-quality clinical research. In order to truly compete on the world stage, it is important to take Japan’s many achievements in the bench sciences and translate them to the clinical fields, constantly evaluating their effectiveness in the actual patient arena. In many ways, medical school is the perfect time to address this need, as senior students have both time and new-found motivation to excel in the clinical sciences. One way to encourage clinical research is to promote use of evidence-based medicine (EBM) in both classroom

and clinical teaching activities. As students and junior residents round with clinical teams, team-leaders would do well to ask younger members if they know the latest literature, and if not, to evaluate it in mini-homework projects. At the University of Hawaii, where I often interact with visiting Japanese physician-observers, these EBM-based projects encourage a sense of academic inclusion, even when clinical participation is limited by hospital rules. As medical student participation in clinical activities is similarly limited in Japan due to government/institutional regulations and societal expectations, including students in EBM, clinical outcomes/effectiveness research (and even hospital quality and patient safety projects) is an excellent way to promote and expand Meaningful Clinical Interactions.

A Crisis of Confidence: Fostering Clinical Reasoning

Clinical reasoning is perhaps the most fundamental skill that we can teach the next generation of physicians; it is somewhat lacking among young trainees in Japan. You may ask, if Japanese trainees have an excellent fund of knowledge, why are basic clinical reasoning skills lacking? This stems not from lack of knowledge, but rather is part of the “learned helplessness” of young trainees, and includes a lack of confidence in independent critical thinking skills. In medicine, critical thinking skills roughly translates into the catch-all phrase, “clinical reasoning.” Whether young trainees are truly ill-prepared for clinical reasoning, or whether they are simply never exposed to the opportunities to foster these abilities is up for debate. Correction of this deficit should take first priority during the early clinical years of training, not the smallest reason for which is patient safety.

As a practicing generalist, I think the most dangerous manifestation of lack of clinical reasoning is inability to make a comprehensive and realistic differential diagnoses at the point of care. In Japan’s specialty-driven clinical environment, this promotes “anchoring,” a common clinical error in which the clinician obsessively focuses on a narrow spectrum of disease, missing the actual diagnosis. A famous saying is, “When you’re a hammer, everything looks like a nail.” Well, in medicine, when you’re an interventional cardiologist responsible for general care, the danger is that everything looks like a heart attack. Ironically, due to the lack of generalists (hospitalists, ambulatory medicine internists, and family practitioners) in Japan, it is incumbent on every specialist to be aware of a wider spectrum of disease than their field would normally obligate. Attending physicians have an obligation to teach broad-based critical thinking to young trainees, roughly 30% of whom will leave hospital-based specialty practice in their mid-40s, to set up independent primary care practices in the community.

Promotion of confidence in critical thinking skills pays dividends both inside and outside of the hospital. Recent literature suggests that up to 10% of physicians will be called on an emergency basis to practice their profession outside of their normal work place. This might be on the highway, walking down the street, or an airplane to Hawaii. In my short 4 years in Japan, I’ve encountered two medical emergencies on the streets in Tokyo (a heat-related syncope and an acute stroke), which required quick medical attention. I’ve heard from colleagues of at least two cases in which a bystander, later identified as a medical student or young resident, simply walked past the patient, allowing another provider to assist. To be clear, I don’t think this is a problem of ethics. Rather, this is a crisis of confidence and ability, a manifestation of “learned helplessness.” Being a physician is more than knowing what lab or scan to order while within the safe confines of the hospital or clinic. With the help of attendings and peers, younger trainees deserve to be given the ability to

quickly assess a situation, think through relevant needs, and then act on their rationale. While this type of training can start in the classroom, it is better brought to fruition in the guided clinical environment.

Conclusions

Ultimately, the burden (and reward) of medical education improvement must fall on the shoulders of hospital attendings and experienced clinical teachers in Japan. For adult learners in the clinical context, this is most effectively and efficiently done at the patient's bedside. Bedside teaching should be aggressively incentivized in the Japanese medical education system, recognizing excellence in teaching similar to excellence in basic science research. The dearth of bedside teaching is a problem not only in Japan, but in many other health systems, including the United States. As I look back across the Pacific to the US, it is easy to see that America has failed to sustain the uniform excellence in healthcare that made it an icon to the world for the past 60 years. While social, political, and economic factors are the main drivers, it is difficult for me to ignore that this slide corresponds with the decline of bedside teaching, as doctors increasingly leave teaching "to someone else," bowing to the numerous competing demands and pursuits of modern life.

Luckily, Japan appears to be on an opposite trajectory. Japanese healthcare has continued to grow in excellence, a trend which corresponds to the steady and growing interest in medical education reform including increased clinical and bedside teaching, and increased breadth of generalist training in early residency. Undoubtedly, Japan has a long way to go in bringing clinical teachers to the bedside, but this perhaps means that Japan's health system, as good as it is, has not yet reached its full potential. Japan's future needs in medical education dovetail amazingly well with the country's proven skills. For the last 7 decades, Japan has distinguished itself by marrying the new to the old, appreciating the synergy of pushing social and technological advancements while protecting historical traditions. This applies to the future of medical education in Japan, as well. Higher peaks of excellence are within reach, and will be achieved if Japan continues to demand educational reform and innovation, coupling this with the grand traditions of bedside medical teaching and safe clinical care for all.

■ Feature Article

Medicine in Cowboy Country Montana

Ronald V. Loge MD MACP

Specializes in Geriatric Medicine/Internal Medicine

Barrett Hospital/Healthcr Cln

Dillon, Montana USA

Out here in Montana, we just call them boots. And the same is true for hats -- just hats. The lexicon of the rural North American West reflects the culture, so in these parts there are no cowboy boots, no cowboy hats, just boots and hats. And, an experienced cowboy may just as likely be called a "good hand" as a cowboy.



Anna Loge MD, Ronald Loge MD MACP, Doug Danielle
[3rd year medical student (the University of Washington)]

Just as environment of the rural American West shapes the culture, and the culture molds the people, so it is also that the environment, culture and the people all to help to define rural medicine. A certain cultural competence is required to care for these westerners, our friends and neighbors. To illustrate this concept the following vignettes give snippets of a cowboy's medical life.

When a ranch worker develops hypertension in his younger years, his doctor can't necessarily assume that he will always be compliant taking his antihypertensive medication, especially during the late winter when he is out in the barn helping with birthing and tending to newborn calves all day and all night. When he quits smoking after his first myocardial infarction, one must anticipate a switch to chewing tobacco. When that same cowboy gets a wound infection after accidentally shooting his thumb with this pistol loaded with birdshot while trying to scare a bull out of the willow thicket, one is not surprised that he waits three days before coming in to get it examined. He has to look after the cattle first. There are priorities!

And, finally, in later years when he develops a post-obstructive pneumonia and is found to have a large pulmonary mass with liver metastases, his doctor knows him so well from this continuum of care that they can discuss this fatal diagnosis based on mutual trust and understanding. The cowboy's willingness to face this malady without extensive consultations and futile treatments all comes from his life experiences and his doctor's clear understanding of how the patient perceives life and death. Continuity clarifies care.

Medical students I teach in my office often marvel at these sorts of clinical narratives that they hear. The students learn to observe, practice and reflect on what I call the Major C's of rural primary care: Continuity, Community and Comprehensive Caring. Through the students' eyes, I have been able to reflect upon these key characteristics of this unique career that has sustained my passion for rural primary care for more than three decades.

Students come from the University of Washington School of Medicine as part of the medical school's regional approach to training known as WWAMI (acronym for the states involved in the educational consortium:

Washington, Wyoming, Alaska, Montana and Idaho). The students travel 600 miles from their educational base in Seattle to have their six-week educational experience in our rural ranching community of five thousand people in Southwestern Montana to get a real taste in general primary care internal medicine. They are eager and hungry to learn clinical internal medicine; to satisfy their hunger I feed them large servings of direct patient care.

What they find here in rural Montana is hard to find in their otherwise excellent urban and university-based sites. Here they will experience the entire breadth of internal medicine. As they join me in the morning our day may start in the endoscopy suite doing a biopsy of the scalloped mucosa of the duodenum of a patient who has had malabsorption. The day may end with a house call to a patient dying of metastatic prostate cancer who has been my patient for the last 30 years. Interspersed during the day the student will see patients with me who may be in for general wellness examinations, common maladies and infections, complex diabetes management or new atrial fibrillation. We may encounter a patient with a persistent cough and new crackles on examination or a patient with new but atypical chest pain whom we will study with an exercise stress echocardiogram the next morning. In the same day the student will learn to evaluate a clinic patient with an incidental macrocytic anemia who came in because of frequent falls. This is all in a day's work. Indeed, this is a full day of learning for the student and for the attending.

The majority of these typical day-to-day patients are those who would have been seen mostly in subspecialty clinics elsewhere. Here, as in many areas of rural America, there are no subspecialists within an easy commute -- in our case they are 100 to 150 miles away. Thus, it is necessary for a rural practitioner not only to have medical knowledge with breadth and depth but also to have procedural, diagnostic and management skills to care for these people at home. We expect to manage the majority of our patients' problems and they expect that of us. Of course, referral to specialists comes about when we exceed our diagnostic or technological capabilities, but even then, we look ahead to manage these patients' care over time after their specialty consultation.

Often these demands make a career in rural medicine seem daunting to our trainees. In great numbers they are enticed to careers that focus on technology and to careers that are predominantly procedural which promise a high income. Those types of medical careers, however, typically lack the important precepts of Community, Continuity and Comprehensive Caring. Along with altruism, these career attributes are those to which most students seek before entering medical school, but without suitable medical educational venues that demonstrate those values, students often have little choice but to select the type of medicine to which they've been exposed. Students who have had learning experiences in rural communities often say that they believe that every medical student in every medical school should have an opportunity to learn in this kind of setting.

Today in clinic my current third year internal medicine student saw one of my patients who has obesity, myasthenia gravis, hypertension, obstructive sleep apnea and diabetes. I first met this man a year ago when he arrived at our emergency department with pneumonia in the midst of a snowstorm. Because of this infection, he was in myasthenic crisis. The storm made for impassable roads, and airflight to evacuate him to a regional critical care center was impossible. And so, it was left to us to manage his illness. He recovered and has since been a loyal patient.

Today this patient was concerned about several months of increasing fatigue. As we tried to sort out the

cause of his fatigue, the student was somewhat surprised that we could consider each of his major problems in a single office visit. From the student's experience in an urban setting he would have expected to see this patient's care divided amongst a diabetologist, a cardiologist, a pulmonologist, and a neurologist with no guarantee that each of the specialists would have communicated with the other specialists. Nor would they have necessarily appreciated the interrelationship of these major medical problems as related to fatigue. Each would likely have addressed the presenting symptom from his or her own focused professional perspective.

This example illustrates that the approach of comprehensive caring in the setting of high quality rural primary care not only encompasses care of the whole patient based on a thorough past experience with him or her, but also that this care is much less costly. Compare the single office visit to deal with these problems to the five disparate visits and the costly specialty diagnostics thus generated.

We rural primary care physicians are an odd breed -- "an anachronistic way to practice medicine," some may say. I would disagree and rather affirm, instead, that this is how medicine should be practiced. It serves our patients best.

The personal and professional lives of rural doctors are intertwined with the community. We know our patients also as our neighbors, childrens' teachers or friends, clergy, trout fishing buddies, backcountry skiing partners, homebuilder and plumber, bread baker or gardening guru. The community sees us not as just a one-dimensional doctor but as their neighbor and school board member, book club reader, fellow church choir member and birdwatcher. This enmeshment of lives and activities in a small town and community enhances the richness of our time outside of our profession and results in a better understanding of the lives of others. The private and professional boundaries are sometimes blurred but rarely in a negative way. One learns when and how to take off and put on the professional and the private hats.

In these times I know of many premedical students and medical students, eager for careers in medicine, who have been discouraged from choosing this life's work by a doctor whom they know or even by physician parents. I believe that this is a reflection of the unhappiness generated by the doctor's own career environment. When asked if I would choose this career path again, the answer is an emphatic "yes!" I can think of no other career so professionally and personally satisfying than being a rural medical practitioner. In what other profession other than medicine can one find the daily intellectual challenges, stimulation and growth and, at the same time, help so many people live healthier and better lives?

When former students return to join our practice or choose medical careers in other rural communities, it is evident that they also value the Major C's of rural medicine. My daughter made that choice. After student years at the University Of Washington School Of Medicine, internship in Boston, and further residency training and primary care internal medicine at the University of Washington, she chose to return to Dillon to practice rural internal medicine and to live in a community which she considered was the best place to raise her children. Opportunities abound for those seek them -- in rural areas, too. Her choice is the greatest affirmation to me of the value of rural primary care medicine for the physician.

■ Report

Lectures & Workshop for Students and Residents by ACPJC

November 9, 2013 (Sat) 13:00-15:00 at Hotel Tatsumiya in Fukushima

Shuichi Fukuhara, MD, FACP

1. Purpose

The purposes of this seminar are (1) to provide students and residents who are interested in clinical research with lectures and workshop and (2) to motivate them to try making presentations at ACP Japan Chapter Annual meeting 2015. This workshop was co-hosted by Scientific Program Committee (SPC) and Committee for Associate and Medical Student Enrichment (CAMSE).

2. Strategy

We blended “flip teaching” with this workshop. Specifically, attendees watched web-based lectures on clinical research (“What is clinical research?” and “How to formulate research question”) in advance. On the workshop day, after several short-lectures, attendees participated in group work, presented summary of each group’s work, and obtained feedback from experts.

3. Contributors

They contributed the workshop as lecturer or facilitator:

Hiroshi Nishigori (Associate professor at Kyoto University)

Shunichi Fukuhara (ACP Japan Chapter Vice Governor, Professor of Kyoto University)

Kenneth E. Nollet (Professor at Fukushima Medical University)

Miho Sekiguchi (Professor at Fukushima Medical University)

Takuya Nikaido (Lecturer at Fukushima Medical University)

Kinshi Kato (Assistant professor at Fukushima Medical University)

Hiroki Nishiwaki (Assistant professor at Showa University Fujigaoka Hospital)

Yuki Kataoka (Kyoto University)

Noriaki Kurita (Kyoto University): Program Chair

4. Attendees

28 participated in the workshop; 8 medical students, 8 young physicians (PGY 1 to 5), 12 physicians (PGY 6 or more) although this workshop was targeted for medical students and young physicians, significant proportion were physicians older than the target.

5. Program

13:00 : **Introduction**

Fukuhara S

Orientation

Kurita N

13:05 : **Clues to find clinical question (CQ)**

Nishigori H

13:25 : **Converting CQ into RQ for quantitative research**

Fukuhara S

13:40 : **Effective presentation at scientific meetings**

Kenneth E Nollet

13:55 : **Group work**

Kurita N, Kataoka Y

14:25 : **Presentation and feedback** (everyone)

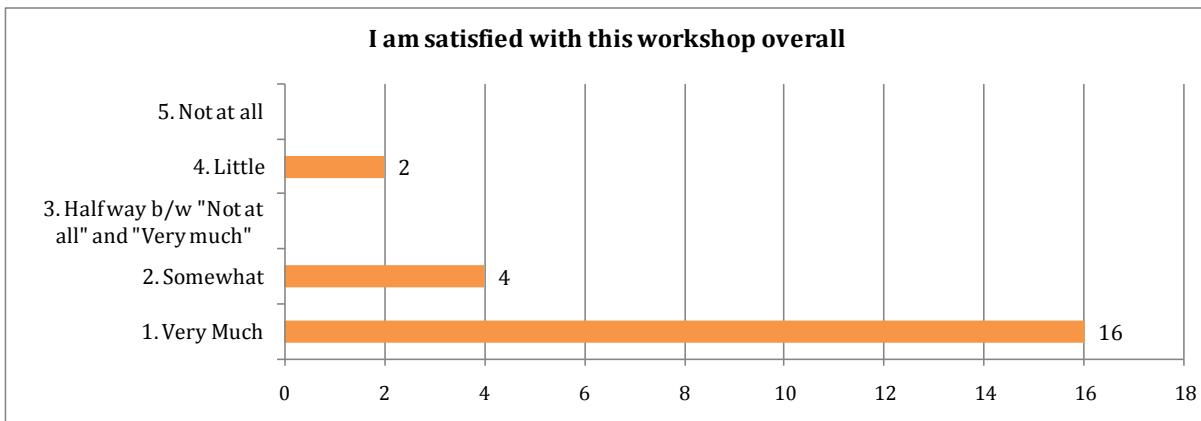
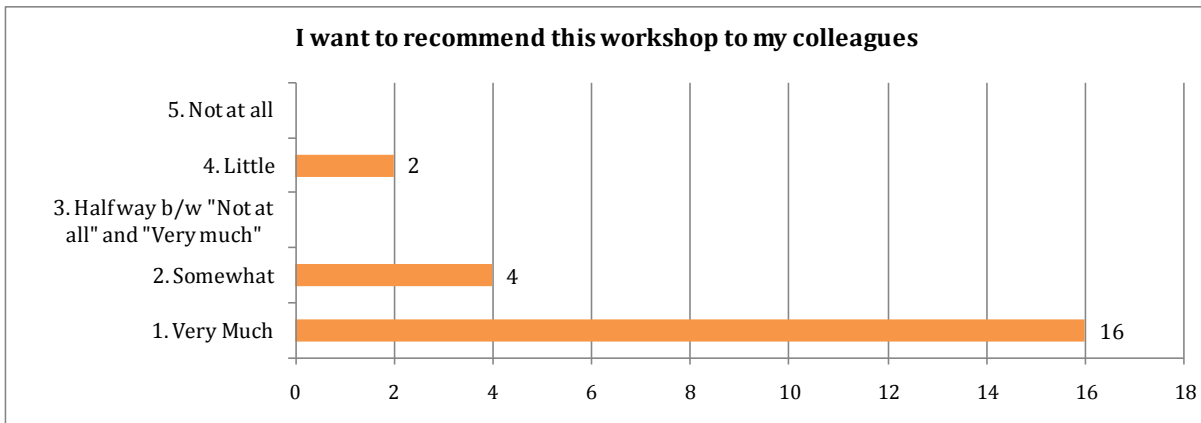
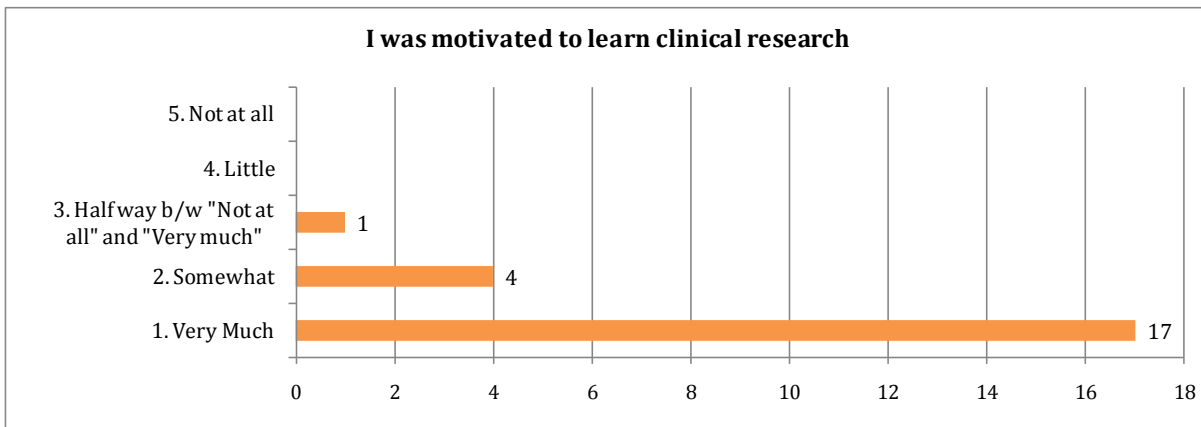
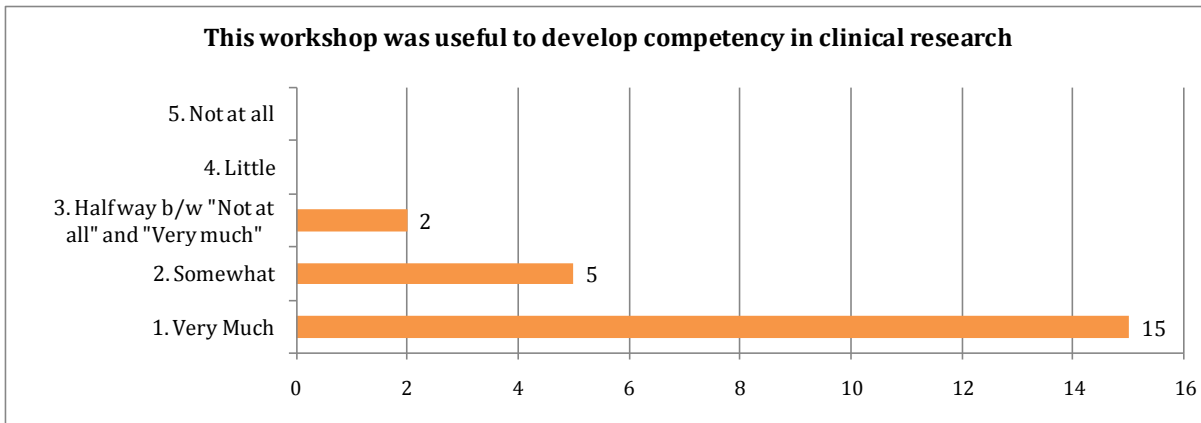
14:50 : **Guidance** (aBus, ACP Japan Chapter), questionnaire

15:00 : **Closing**

6. Feedback from attendee

Overall, about 90% of attendee were satisfied with this workshop.

With respect to the whole workshop (response rate 22/28)



7. Pictures of the workshop



Noriaki Kurita, Program Chair



Kenneth E Nollet



Hiroshi Nishigori



Group work with facilitator (Miho Sekiguchi)



Participants meet the Professor (Shunichi Fukuhara) at party

■ Report

Olive View Medical Center Visit Report

Moe Tsuda, MD

Department of Breast Surgery,

Kyoto University Hospital, Japan

I would like to share with you the wonderful one-month experience I had at the Olive View Medical Center (OVMC) in January 2014.

OVMC, a 377-bed general hospital in Los Angeles, has a close relationship with the University of California, Los Angeles and provides a strong training and educational environment for young physicians. Case conferences and lectures are held daily and are highly educational.

I spent 3 weeks in the Division of Hematology/Oncology and 1 week in the Division of Palliative Care. The Division of Hematology/Oncology provides comprehensive care for patients with hematological disorders or solid carcinoma. It is therefore very different from the Japanese system of organ-based treatment subdivisions. The Division of Palliative Care is also a new concept in Japan. I was very interested in learning the roles of these divisions, the inter-division collaborations, and the training system operating in each division.

In the Division of Hematology/Oncology, I shadowed a fellow every day and attended various conferences and rounds, which made for an eventful schedule. I was particularly impressed by the environment there, which encourages active and educational discussion involving everybody. Daily rounds included discussing therapeutic strategies, supporting evidence, generally accepted views, and mechanisms in basic medicine. Fellows frequently held discussions among themselves and exchanged information on the literature, indicating they were enjoying their work.

The Division of Palliative Care focuses on pain relief, family meetings, and post-discharge planning. I witnessed the significant roles of health professionals other than physicians, as well as problems in the medical care insurance system. I also experienced different views on life and death between the USA and Japan.

My one-month stay was very enjoyable and passed by quickly. I would like to express my sincere appreciation and gratitude to everybody at OVMC and at ACP Japan for this opportunity to gain valuable experience.

■ Editor's Postscript

In this issue, we have two feature articles well worth reading. The first article was contributed by Dr. Deshpande, a clinical educator at the University of Hawaii, depicting Japanese medical education from a viewpoint of western-educated clinician, as well as a 'gaijin' living more than five years in Japan. His words analyzing our medical education touch a sore spot. However, his sincere and respectful attitude toward Japanese medical students and residents makes us listen to his words. I hope many physicians read this article and discuss what they can do to improve the medical education.

The second article by Dr. Loge, describes primary care in the rural area of the US. Although this appears to be an unfamiliar theme to us, this is not the case. We have many problems in medical infrastructures, including shortage of physicians, in the rural area of Japan. To my surprise, students from the University of Washington School of Medicine spend six weeks at a small town of 5,000 people in Southwestern Montana, to experience general primary care. He mentions some of these students later join his practice, or choose medical careers in other rural area, the fact that greatly encourages us in tackling problems we have in our own rural area of Japan.

Besides these feature articles, we have two reports of activities for members of ACP: "Lectures & Workshop for Students and Residents" and International Exchange Program. Please enjoy the reports and we welcome your participation in the future. (MI)

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