Governor’s Newsletter for All ACP Members

Governor: Fumiaki Ueno
MD, MACP

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What’s New

May 2016
Dear Colleagues,

Welcome to the Annual Meeting of the American College of Physicians Japan Chapter 2016! This year, the meeting will be held again in Kyoto, which is among the most exciting cities to visit in the world. The Scientific Program Committee chaired by Dr. Shibagaki has prepared extraordinary attractive sessions with the faculty consisting of renowned physicians from all over Japan and overseas. This Meeting will be a great learning opportunity not only for physicians specializing in internal medicine, but also for those in other specialties, trainees and students. The aim of the meeting is to offer updated knowledge and clinical expertise in internal medicine to improve lives of the human being.

Many non-member physicians, trainees and students attended the Annual Meetings in the past years. Recently, we established a new category of membership, Affiliate Membership. We offer opportunities for those who are not qualified to become regular members of ACP. Members of ACP in any categories will receive benefits of membership. Distinguished educational resources for internists, such as Annals of Internal Medicine, MKSAP, Journalwise, DynaMed Plus, ACP guidelines will be provided for free or at significantly discounted cost. I encourage you to join ACP today.

We look forward to seeing you in Kyoto, and join ACP for your future!
Dear Colleagues

It is my great pleasure to welcome you again to the ACP (American College of Physicians) Japan Chapter Annual Meeting 2016, which will be held at the Kyoto University Clock Tower Centennial Hall in Kyoto, Japan on June 4th and 5th, 2016.

The theme of the Meeting this year is “Raising Generalist Medicine”. The medical board system is now being renovated. The background of this idea of the renovation is the fact that now the majority of our patients in internal medicine is the elderly with multi-morbidity, for whom only the care of the subspecialists is not optimal, and so the most of the IM residents should get the longer and wider experience with general medicine. Well, the idea is very good, however the educational programs not only for the residents but even in the medical schools are still too inclined to subspecialty. In this meeting, we will address this very important issue in the plenary session, where Dr. Thomas Inui from University of Minnesota give a keynote lecture on Renovation of Medical Education in China, followed by the discussion with the primary care physicians, general hospitalists and residents.

In addition, we will offer session like Dr’s Dilemma (Quiz tournament by teams of residents), special session on medical disparity in Japan (by immediate past president of ACP; Dr. Wayne Riley and Dr. Naoki Kondo from University of Tokyo).

Our meeting is made by volunteers from ACP Japan Chapters and does not seek support from industries, so it is the meeting of the clinicians, by the clinicians, and for the clinicians. We offer a lot of educating and rewarding sessions/lectures, a poster session with full of lively discussions.

We are very looking forward to seeing all of you in Kyoto in its best season.
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The “shock” has quite broad meaning in it. Getting a speeding ticket just for 58 km/hr puts you in shock state, eh? The fresh new residents who are supposed to work together with you from this new fiscal year failed in National Medical doctor’s exam. This story makes you shock. Besides if your patients in the ward, in the ER, or in the prehospital setting, crashed into shock, you fall into shock, eh? According to ACLS experienced provider course, OMI, oxygen, monitor, iv would suffice, but in reality you need to do more, like ultrasound, ECG and chest X-ray to figure out the treatable underlying causes. The mnemonics, 「サルも聴診器」 in Japanese would be very useful to deal with patients in shock.

Especially ultrasound is useful to detect the treatable causes, therefore you need to to know how to use it with systematic manner. Checking IVC is more reliable to evaluate volume status than BP. Thorough echocardiography examination usually takes 15 minutes, but you can’t spend sucha long time to the patients in shock. Just checking cardiac contraction, EPSS, cardiac tamponade, RV dilation wouldn’t take long. You better to familiarize the “RUSH” protocol, as well as “CORE” scan.

We love a gadget like ultrasound. Also we need to know to use our brain to differentiate the causes of shock and bradycardia. Then you’ll be more comfortable to see shock patients. You’ll come to know why you need to order ECG in the first place after completion of this session.

This session consists of only 90 minutes, but you’ll gain more confidence in the end. You’ve gotta overcome the RUSH of information in this session. Are you ready to go?
Systematic reviews (SR) and clinical practice guidelines (CPG) play important roles in evidence-based practice. SRs are a summary of available evidence and CPGs provide recommendations for decision-making in clinical practice. The methodology of writing SRs and CPGs is not adequately standardized, and the quality of SRs and CPGs varies widely. Since several grading systems for recommendations exist, health care providers are unsure about the best approach. In 2000, The Grading of Recommendations Assessment, Development and Evaluation (or “GRADE”) Working Group (http://www.gradeworkinggroup.org/) was established which subsequently developed a standardized methodology for writing SRs and CPGs, referred to as the GRADE system. It is outcomes-based and based on grading the quality of evidence and strength of recommendations. The ACP has endorsed, and utilizes the GRADE system.

This workshop is mainly for investigators who will develop SRs and CPGs. At the end of the session, participants will have basic knowledge for writing high quality SRs and CPGs. We will provide a short lecture to explain the concept of the GRADE system, demonstrate the methodology for making a meta-analysis, grading the quality of evidence and ultimately making recommendations based on available evidence to answer a clinical question, and write ideal SRs and CPGs.
How do you intervene in alcohol problems, something frequently observed in daily clinical practice? Alternatively, have you ever experienced difficulty in training medical interns on dealing with alcohol problems? In this session, procedures for intervening in alcohol-related problems will be provided from the perspectives of an internist and a primary care physician. In addition, there will be group work to help participants reflect on the procedures for intervening in alcohol-related problems, based on cases frequently observed in daily clinical practice. Our aim is that by the end of this session each participant will have gained appreciation for the various approaches to alcohol-related problems and have increased awareness of alcohol-related problems in clinical practice.

〈Time table 90 minutes session〉
- 0-5min (5 minutes) Introduction / Ice Breaking
- 5-25min (20 minutes) Lecture：Tips and advice on alcohol problems from the perspective of an internist
- 25-30min (5 minutes) Questionnaire
- 30-50min (20 minutes) Lecture：Tips and advice on alcohol problems from the perspective of a primary care physician
- 50-55min (5 minutes) Questionnaire
- 55-70min (15 minutes) Small group discussion：Study of case examples
- 70-85min (15 minutes) Presentation / feedback
- 85-90min (5 minutes) Closing / Questionnaire
Drinking excessive amounts of alcohol regularly for years is toxic to almost every tissue of the body. Many of the toxic effects of alcohol are due to disturbances of a wide variety of metabolic functions and organ damage. Long-term alcohol use increases the risk of liver disease, pancreatitis, heart disease, peptic ulcers, certain types of cancer, complicated pregnancies, birth defects, and brain damage. Heavy or binge drinking may even result in respiratory depression and death. Alcohol use can also cause mood changes and loss of inhibitions as well as violent or self-destructive behavior.

On the other hand, epidemiological and clinical evidence shows that light-to-moderate drinking is associated with a reduced risk of coronary heart disease (CHD), total and ischemic stroke and total mortality in middle-aged and elderly men and women. The evidence suggests a “J- or U-shaped” relationship between alcohol intake and CHD incidence.

In the past two decades, metabolic syndrome, the combination of obesity, hypertension, dyslipidemia and hyperglycemia, all are also recognized as major cardiovascular risk factors, has given rise to much clinical and research attention, because of its high prevalence in the world. Therefore, it is of interest to evaluate the overall associations of alcohol consumption with the development of the metabolic syndrome. Recently, the protective, detrimental, or “J- or U-shaped” associations have been reported between alcohol consumption and the metabolic syndrome.

The “J- or U-shaped” beneficial effect of alcohol can be explained by several factors, including increases in HDL-cholesterol and the balance between blood coagulation and fibrinolysis. The harmful effects of heavy alcohol consumption are considered due to an increase in plasma triacylglycerol and increased blood pressure. Therefore, this controversy may be due to the complex mechanistic relation between alcohol consumption and each component of metabolic syndrome, and almost all studies have various limitations and problem points. Prospective studies are therefore needed to confirm the association between alcohol consumption and prevalence of metabolic syndrome, and to assess the influence of alcohol drinking patterns and other possible factors, such as smoking, physical activity, socioeconomic status, education, occupation, diet, and exercise. Such information is important because alcohol consumption and the metabolic syndrome are both common, and because physicians and patients would benefit from, but currently lack, specific knowledge about how drinking patterns may influence the risk of the metabolic syndrome and its related diseases, which comprise the leading causes of death in the Western countries.

This program will be focused on the clinical problem associated with excessive alcohol consumption, and discuss the epidemiological evidence for alcohol’s putative vascular protective effects and plausible underlying biological mechanisms. (Naoki Fujita)
Objectives:
Participants will be able
To experience discussions on clinical reasoning on the basis of a presented case.
To exchange thoughts with colleagues in English
To learn how to approach patients
Targeted audience: Anyone who is interested in learning medicine in English.
This session is designated to pay special attention to those whose English skills are at the “novice” level.

Language used in session:
English

Time table 90 minutes session
0-20 min (20 minutes)
Ice breaking, introduction to each other, and large group session
20-70 min (50 minutes)
Case presentation, small discussion, and large group session
70-85 min (15 minutes)
Feedback session, Questionnaire Large group reflection of the session
85-90 min
End of session (5 minutes)
Residents as Teachers is the idea that residents should have teaching skill as attending. According to a data from United States, twenty percent of a resident’s time was spent on teaching activities. So, in western countries, several workshops and training courses for young attending have been held more than twenty years ago. In Japan, residents and interns have a lot of opportunities to teach younger doctors and medical students.

Despite their critical role as teachers, only doctors who have more than seven-year clinical experience can attend formal training session for attending in Japan.

Therefore, we hope to hold a workshop for young attending in this American College of Physician Japan chapter 2016 annual meeting, where many young doctors with ambition will attend. Attending needs a lot of skills. This time, we would like to cover the topic with “case conference”. Various styles of case conference have been hold in various situations. A young attending often moderate a case conference but they seldom learn how to do it in a systematic manner. No matter how worthful case, poor moderator can kill its value. On the contrary, an outstanding moderator will pick up educational topics even in an ordinary case.

In this session, we would like to introduce practical tips and techniques of case conference moderator, which you can apply to your facilities.
In 2001, position papers, “Principles of appropriate antibiotic use for treatment of acute respiratory tract infections in adults” were published by the American College of Physician (ACP), and they had been helpful as guidelines in clinical practice of acute respiratory tract infection. This year, a new guideline, “Appropriate Antibiotic Use for Acute Respiratory Tract Infection in Adults” was published by the ACP. In this session, I will revisit the principles of management of acute respiratory tract infections in adults, including what’s changed, and what hasn’t.
The aim of this session is to provide the real-world answers to overcome the barriers in writing peer-reviewed manuscripts during the residency or fellowship training. Well-written papers are read, remembered, cited. Poorly written papers are not. What are the critical differences between the two? And more importantly, where can residents and fellows fit in the time to write the papers? We will try to discuss these topics in a dialogue format, a narrative conversation between the actual staff member that mentors clinical research project, and his scholar.
Is physical examination so old that we can't use in our medical practice any more?

Even if you learn some specific physical sign, you may realize that none of your colleagues know it, and none of them won't know the real meaning. Or, you may see a doctor who treat his patient based on laboratory abnormalities In spite of taking careful physical examinations.

Nowadays, we utilize many medical equipments, but how many of us can utilize physical exams properly? I want to emphasize that we have to realize the meaning and necessity of taking physical examination, and pass it down to the next generation. And I believe "bedside teaching"is the best way to study physical examination, for learning from a textbook is not enough.

In this presentation, I want to tell how we learn and teach physical examination. I hope this will be your revolutionary program !!
Most young doctors who want to become internists would think to become a General internist at first. I myself also thought so.

There is no doubt that old internists were generalists in the beginning. However, by the establishment of the sub-specialty area and rapid progress of knowledge and technology, foundation of "Internists as Generalists" have continued fluctuation.

On the other hand, the argument that "What is a Generalist" "What is Generalism" has been continued among other generalists (primary care, family medicine, general medicine, etc.). The outcome of such discussion has been specifically reflected in the post graduate training and continued professional development.

Now, by the aging society and the complexity of medical care, generalists are required from society. And general internists (e.g. "Hospitalists") has been attracting attention from many people. If general internists want to build a strong position in the society, it is essential to deeply understand "Generalism".

In this session, I will present current meaning of "Generalism" for internists from the perspective of hospital based generalist and want to discuss with audience.
Palliative care is an interdisciplinary team approach aiming at improving quality of life (QOL) of patients with serious illnesses and their families, with an expertise in symptom management, psychosocial care and facilitation of decision making throughout the disease trajectory. Over the past decades, there has been a growing body of evidence to support the role of palliative care in improving symptom control, QOL, quality of care, illness understanding, patient/family satisfaction, bereavement process, and cost of care, especially in the field of cancer care.

Hospitalized patients with advanced cancer or other serious illnesses often have multiple comorbid diagnoses (e.g., cerebrovascular disease, chronic obstructive pulmonary disease, heart failure, chronic kidney disease, liver cirrhosis) and medical complications (infection, electrolyte abnormalities, organ failure). Progression of underlying diseases coupled with these conditions can contribute to significant physical and psychosocial symptom distress resulting in a decreased QOL toward the end of life (EOL). To provide individualized care when faced with these challenges, physicians need to tailor decisions to the individual patient/family based on multiple factors. These may include patient/family factors (e.g., prognosis, performance status, comorbidities, disease understanding/acceptance, EOL preferences, decision making style, social factors, logistics, and family/social support), disease/treatment factors (e.g., curability, aggressiveness of disease, response to current treatment), and clinician factors (e.g., the level of training, personal experience, discomfort talking about death, perception about “good death”, inpatient/local health care resources including palliative care specialist).

In this session, we will discuss the essential skillset for primary care physicians to provide optimal palliative care based on current evidence, including symptom management, prognostication, interdisciplinary team approach, timely EOL discussions, and comfort care.
One picture is worth 1,024 words. Snap Diagnosis is back again as version 4! From the aspect of learning, physical examination may be divided into 2 components. One is what you need day-to-day practice to master, such as auscultation or percussion. The others are rare diseases or findings which we cannot practice because it is difficult to encounter. You need to have an attitude of watchful waiting. An “be prepared” stance will always work. Once you know it, you will not miss it even if you have never seen it before. Only you have to do is just knowing it. In this presentation, you will learn important facts and concepts for learning physical diagnosis through the case vignettes presented with many pictures or movies. Please enjoy!
Evidence-based preventive medicine for adults in 2016: you can practice for your outpatients and your inpatients immediately

Few patients receive preventative medicine proven by clinical evidence in Japan. In addition, doctors don’t have enough knowledge about what kind of preventive medicine they need to provide for their patients. This resulted in missed opportunity for preventative care in outpatient or inpatient setting. For example, only 25% of elderly people above the age of 65 have received pneumococcal vaccination in Japan. On the other hand, it is a routine to provide such preventative medicine in outpatient care by internist in the U.S. Most clinics are graded by providing such care in the U.S. In Japan, there are many preventative care not provided by the medical check-up by municipal governments or Ningen-doc including vaccinations. Internists are the most important player in providing preventative medicine in adult patients, since they provide continuous care. The preventative medicine can be provided in Japan as well, since our general internal medicine clinic has been providing such care for long time. In this session, we will explain each topic of preventative medicine for adult outpatients according to the evidence-based guidelines including one by U.S. Preventive Service Task Force (USPSTF) and ACIP (Advisory Committee on Immunization Practices). Those includes the followings: two vaccines against pneumococcus, influenza, tetanus, hepatitis B and HPV, cancer screening for colorectal cancer, gastric cancer, breast cancer, cervical cancer and lung cancer, and screening for hypertension, dyslipidemia, diabetes, smoking, osteoporosis, fall, abdominal aortic aneurysm, chlamydia infection and depression. After this session, audience will be able to understand evidence-based preventive medicine for each patients with or without reference material. This interactive session is an updated version for 2016. Thus, it is useful for people who attended this session last year as well.
Background: Do you use prediction models? There are several diagnostic and prognostic prediction models (i.e., Well’s criteria, APGAR score).

Can you interpret those scores accurately?


We translated the article into Japanese with permission for disseminate use of prediction models throughout Japan.

In this workshop participants will evaluate a designated article using TRIPOD checklist. You will understand the outline of appropriate development, validation, and clinical use of prediction models.

Intended Outcomes:
• To be able to explain EQUATOR network
• To be able to explain TRIPOD statement
• To be able to interpret an article about prediction model accurately using TRIPOD checklist

Structure:
0. Home work: use checklist
1. Ice break
2. Presentation on EQUATOR network, and TRIPOD statement.
3. Share homework
4. Feedback
5. Closing remarks
We discuss cases with musculoskeletal pain, rash or systemic symptoms. The purpose of this session is for participants to learn how to approach musculoskeletal complaints and be familiar with joint examination.
Physicians spend most of their medical training learning how to fight disease and to keep patients alive. Unfortunately, their training often ignores another natural part of the human life cycle: the process of dying. Just like doctors learn to counsel about healthy lifestyles, they also need to be prepared to talk to patients about the end-of-life (EOL) period. However, many physicians avoid this topic due to concerns of “bringing bad luck” or fears of taking away hope, or simply because they were not trained to talk about this highly emotional issue. The literature has shown that lack of advanced care planning discussions contributes to unnecessary treatment and increased suffering during the end of life.

In Japan, people feel pride about having the longest life expectancy in the world. There is growing concern, however, that there is too much focus on “prolonging life” rather than on “pain relief and other important aspects of quality of life (Hayashi & Kitamura, 2002).” In this country where 25% of the population is 65 years or older, having physicians ready to talk with their patients about death and dying is imperative.

We believe that holding these conversations is a skill that can be learned and that these discussions should become part of routine care. For this to happen, a significant cultural change may be necessary. This change would require physicians to explore their personal beliefs and attitudes about advance care planning and end-of-life care before they can talk to patients and their families.

During this workshop, participants will “break the ice” with the card game. This game was designed to stimulate discussions about the end-of-life in a positive way. Learning how to play it will be useful for future discussions with patients and their families. This part of the workshop will be held in Japanese. After the game, participants will receive information about the importance of EOL discussions as well as learn one approach to holding EOL discussions with patients using a clinical case scenario. This section of the workshop will be held in English. After observing this encounter, participants will be able to discuss in a group setting the challenges they may face when applying this model to their Japanese patients and discuss potential solutions to these challenges.

By the end of this session, all participants will know how to play and obtain additional information about the card game. Participants will also obtain the knowledge and skills to engage in end-of-life discussions with their patients and their families in clinical practice. Handouts outlining the EOL discussion process and a list of resources will be provided.
In a stunning series of policy changes over the past decade, the Central Government of the People’s Republic of China (PRC) has taken bold action to respond to major inequities in health care quality and accessibility that characterize the rural/urban divide in that nation. Lacking any semblance of a national health insurance, the PRC has developed health insurance for residents of rural localities, undertaken development of health care facilities at a village and district level, and sought to increase output of clinicians from its university schools of medicine (MDs) and junior medical colleges (Masters degree clinicians). The most recent reforms emphasize the need for assuring quality of care by requiring a three-year graduate training experience (residency) at an accredited teaching hospital as a capstone experience for all graduates of medical schools before being permitting them to enter the independent practice of medicine or surgery. This so-called “5+3 program” enrolls high school graduates into 5 years of university-based medical education and then finishes basic education and training with a 3-year hospital-based supervised residency training experience. The 5+3+R has now been designated the official national standard for preparation for a career in medicine, at least in urban areas, and may be followed by training of variable length for pursuing a career in subspecialties of medicine and surgery. The PRC has committed massive financial resources to implementing this new standard at all university medical schools, supporting the salaries of all 5+3 residents at 554 newly designated accredited teaching hospitals, strengthening supports for training at these hospitals and establishing a network of 24 ‘demonstration hospitals’ where innovations are expected to show the way forward for this new training requirement.

The challenges of this reform are many, including developing a national process and organization for training hospital accreditation, uniform certification of university medical school graduates who seek residencies at leading hospitals, developing a process and organizations for matching interested applicants for residency training with hospitals who need residents, and assuring uniform quality of residency training across the nation. Finally, it seems unlikely that the 5+3 standardized residency training process itself can have a major effect on the deficiency of qualified physicians for delivering primary care to the countryside. Will the PRC continue to permit a two-track system (MD and masters degree) for physician education to prevail? Will the junior medical schools preparing masters-level doctors continue to serve as de facto system for providing primary care needs? And, will the Chinese people themselves be satisfied with this situation?
Curriculum Vitae:

Thomas S. Inui is a Professor of Medicine at Indiana University School of Medicine and a Senior Investigator at IU’s Regenstrief Institute. A primary care physician, educator, and health services researcher, he previously held leadership positions at the University of Washington, Harvard Medical School, and as President and Chief Executive Officer of the Regenstrief Institute. He is the immediate-past Director of Research, IU Center for Global Health and the Joe and Sarah Ellen Mamlin Chair of Global Health Research.

Dr. Inui’s special emphases in teaching and research have included physician-patient communication, professionalism, health promotion and disease prevention, chronic disease control, the social context of medicine, and medical humanities. He has participated in the publication of more than 325 peer-reviewed articles as well as 8 books and monographs. His honors include elected membership in Phi Beta Kappa, Alpha Omega Alpha, the Johns Hopkins University Society of Scholars, a USPHS Medal of Commendation, serving as a member of Council and President of the Society of General Internal Medicine, election to membership in National Academy of Medicine and its Executive Council, and election to Mastership in the American College of Physicians.

Abstracts of ACP Japan Chapter Meeting 2016

June 4, Plenary

Residency Reform in China 2016: Major Developments in Asia’s Largest Health Care System

Nakanishi Naika Clinic
Shigekiyo Nakanishi
Nakanishi Naika Clinic

Tomoharu Yajima
Kyorin University Hospital

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Fukuchiyama City Hospital

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Disease Control and Prevention Center (DCC), International Health Care Center (ICC), National Center for Global health and Medicine

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Yusuke Miyasato
Osaka General Medical Center
Evidence Based Medicine gained popularity, and many physicians respect knowledge based on appropriate clinical studies. Also, properly developed practice guidelines are available, and clinical practice with scientific validity is widely accepted. The issue is beyond the science. Collection and extraction of good evidence in only a part of EBM. In order to understand medical problems or true concern of a patient, formal medical interview is inadequate. Judgement whether good clinical indices should be applied to an individual patient and motivational action of the patient are entirely different matters. Good information is not sufficient for good clinical practice. Alfa-Go can beat human and rapid evolution of robots for medical use is noted. We may not need human physicians just to treat diseases or pathologic processes. Empathy, complex and mysterious feeling of human occurs naturally in the communication with concerning patient and cannot be taught by others. Perhaps, it is impossible computers acquire this human feeling. In the days of evidence, human physicians with full of empathy will be expected.
Also known as Medical Jeopardy, ACP Doctor’s Dilemma is held each year at the scientific Internal Medicine Meeting with up to 50 teams comprising of residents from famous teaching hospitals from around the world compete in the USA for the title of national champion. In 2016 we will send a team to represent Japan in this competition.

Doctor’s Dilemma in Japan was created from the American competition, which is held during ACP annual meeting. We began the Japanese Doctor’s Dilemma in 2015. The questions from the quiz are created using the Medical Knowledge Self-assessment Program (MKSAP), Annals of Internal Medicine and DynaMed Plus.

10 teams from all over Japan participated this year. Audience members can form teams and participate by using their smartphones. Please support this exciting tournament and watch young physicians from Japan’s top ten teaching hospitals battle for the top spot of Doctor’s Dilemma champions 2016. The winners of the competition will represent Japan in the 2017 US tournament, which will be held San Diego.
Health disparities among populations in the USA have been well documented for many years. The causes are complex and include racial/ethnic, socioeconomic, geographic and genetic factors, among others. Awareness of the problem has been improved thru rigorous research and analysis and has been highlighted as a key issue to address in order to improve the USA's comparative world health rankings. The role of implicit bias among physicians and other healthcare providers is also a dimension that contributes to disparate medical treatment.
If you feel statistics is a barrier to conducting your clinical research, why don’t you join our workshop? Many clinicians may have given up their research because they had troubles in the phase of statistical analysis. We believe that study design is the most essential part of clinical research and is far more important than statistics. We thus have held workshops for study design so far.

On the other hand, it is also true that you need to understand the basics of statistics and know when and how you apply certain analysis. So from this year, we will start series of workshops on basics of statistics so you can understand and apply in designing and conducting your own research. The topic of this year is “How to calculate sample size needed for your study”.

In advance of the workshop, we will provide you with web-based lectures and short exercises you can work on. It will take about three hours. On site at the workshop, you will learn how to calculate sample size through lectures and hands-on practices using some examples of research question.

### Time table of this workshop (total 90 minutes on the day)

<table>
<thead>
<tr>
<th>Subject</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web-based lectures and exercises</td>
<td>2 to 3 hours</td>
</tr>
<tr>
<td>Opening remark with guidance of this workshop</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Lecture 1: how to calculate sample size</td>
<td>15 minutes</td>
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<tr>
<td>Hands-on practice for sample size calculation 1</td>
<td>15 minutes</td>
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<tr>
<td>Lecture 2: how to calculate sample size</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Hands-on practice for sample size calculation 2</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Feedback, Q and A</td>
<td>15 minutes</td>
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Think of career paths for the generalists

The specialty board system has been drastically changed recently to develop “True generalist” in Japan, where at last, more people start to think of its importance. It may be discussed who is the generalist, an internal medicine specialist, a family practice specialist, or a hospitalist. I personally believe that given that it is defined as a physician who can take care of patients as a whole person by seeing whole organ systems medically, considering his or her circumstances, that is, economical issue, family issue and social issue, facilitating preventive medicine and understanding their value, all 3 specialists are generalists. Actually, all physicians from any specialty and subspecialty are required to know the importance of these knowledge, skills, and attitude. We cannot overemphasize that all physicians need the generalism at least a certain level.

I was originally a cardiologist in Japan; however, I changed my career to a hospitalist during my internal medicine residency training in the USA. I have been often asked a question by students and interns whether a generalist need a specialty. Moreover, they are wondering how we catch up the wide range of knowledge of whole organ systems. If a generalist has subspecialty as well, they are wondering how we catch up the knowledge and skill of the subspecialty as well. To solve their concerns, we also plan to discuss these.

Hospitalists are internal medicine specialists working in a hospital. The community consists of patients, family, family physicians, hospitalist in community hospital, and specialist in the tertiary care centers, including university hospitals, and cancer centers, etc. We hospitalists need to play an important role for the hospital and for the community where the hospital is located. We will discuss our roles as well.

In Japan, the rate of subspecialist among internal medicine physicians is very high in comparison with the one in the USA. To take care of this rapidly aging society, we should fascinate students and interns to generalism to develop it. We would like to share our ideas. (Eiji Hiraoka)

In Japan the educational systems for the specialists are renovating. Especially, the specialists for “General Medicine” and “General Internist” has been in the news lately. I have been making efforts to train resident physicians to become the generalists who work in the clinics. I introduce my works and talk about training in the clinics. (Masaki Amenomori)
"Conflict of interest", "academic cheating," and "scientific misconduct" have become the major problems that rock the entire medical, educational, and medical research fields, respectively, in Japan. However, effective countermeasures have hardly been established as it stands. The leading reason of this lag is the lack of clear guiding principles to be referred to in responding to these issues. But, what are the principles we as professionals should follow?

Recently, human morality has been extensively exploited in the fields of evolutionary psychology and human ethology. It has been widely accepted that several revolutionary-acquired moral intuitions determine what are “right” and what are “wrong”. What are the moral intuitions expected to be displayed in physicians, medical students, and medical researchers, when different moral intuitions are expected in different professions? How should we deal with the issues above when we exert the moral intuitions expected in our profession? These are the questions addressed in this workshop-style session.

Those who pre-registered will receive a questionnaire by e-mail which is designed to understand one’s own morality profile. Please bring the completed questionnaire to this workshop.
Objectives:
Participants will be able
1) To appreciate the verbal and nonverbal skills required for international case presentations
2) To see a short case presented by a native English speaking physician to understand the difference between the slides being shown and the words used to describe the case
3) To interact with colleagues in English

Target audience:
Anyone who is interested in learning medicine in English and how to present case presentations effectively and concisely. This session will pay special attention to those who wish to learn effective presentation skills and to speak in open forums; it will use easy expression for beginners to understand.

Presentation Skills Tips
- How to present concisely and effectively

Joel Branch
Shonan Kamakura General Hospital, Kamakura City, Japan

Timetable – 90-minute session
0–15 minutes (15 minutes)
Introduction to members of the session
15–40 minutes (25 minutes)
How to present effectively and concisely
40–70 minutes (30 minutes)
Short case presentation with associated tips on how to present well
70–85 minutes (15 minutes)
‘Dr J’ small group discussion and differential diagnosis / feedback / questions
85–90 minutes (5 minutes)
Close of session
The medical knowledge and skills that general internists are expected to achieve is broad and vast. That is why it is essential for generalists to set a goal to acquire ‘simple and essential clinical general rules’. We named sharing and confirming this general rule as ‘5-minute bedside teaching’ (5MBT). Sharing this 5MBT is now routine in our hospital and it has also been published as a series articles in Hospitalist (MEDSi, Japan). One of the highlights of United States medical residency is, in my opinion, this process of acquiring, collating, verbalizing and developing consensus in ‘clinical general rules = 5MBT.

This WorkShop is composed of two parts:

1) The participants will make pairs and engage in 5MBT between each other for understanding how this tool will be used.

2) The participants will memorize the 5MBT contents and verbalize it at the checking booth with a facilitator. The 5MBT materials will be carefully selected, prepared and delivered via email beforehand by the workshop coordinators.

We are all clinicians pressed for time. We aim this workshop to be the time and place that you acquire the 5-minute bedside teachings that you can start using tomorrow.

We hope this workshop will be an eye-opener to get you out of a lifelong sense of insufficiency with endless knowledge of each subspecialty.
This workshop focuses on the concept of diagnostic threshold. In diagnostic reasoning, physicians generate a diagnostic hypothesis, i.e. the suspect of having a disease. In the next phase, they refine the hypothesis using medical information derived from the patient. If the likelihood of a given disease becomes highly unlikely, physicians abandon the hypothesis, namely ruling-out. If the likelihood of the disease goes higher enough to start treatment, the situation is called as ruling-in. Thus, the goal of diagnosis is ruling-out or ruling-in. In this workshop, we will discuss about the threshold for ruling-out and ruling-in in small groups. The target audiences are medical students and young residents.
In this educational session of General Internal Medicine, participants will learn Value-based Medicine which now become the one of core skills of General Internist. Effective implementation of Value-based Medicine needs basic clinical skills and decision-making based on better understanding of test characteristics and treatment effects. Basic clinical skills are required to practice without depending on unnecessary tests. Practice of Evidence-based Medicine is mandatory to make a good decision based on test characteristics and treatment effects. Several cases will be presented in a real world fashion for learning Value-based Medicine. Participation in this session will promote better understanding of the ensuing the special panel discussion of Choosing Wisely Campaign. Let’s enjoy this exciting time together by less is more cases!
Sarcopenia is characterized by a progressive and generalized loss of skeletal muscle mass and strength, and is categorized into primary, or age-related, sarcopenia and secondary sarcopenia, that can be activity-, nutrition-, or disease-related. Assessment and treatment of sarcopenia is very important, because sarcopenia is a common cause of bedridden, dysphagia, and respiratory disorder.

Sarcopenia is diagnosed by low muscle mass, and either low muscle strength or low physical performance according to the Asian Working Group for Sarcopenia definition. The AWGS cutoff values for usual gait speed is <0.8m/s. Cutoff value for calf circumference is <34cm for men and <33 cm for women.

Activity-related sarcopenia can result from prolonged bed rest, a sedentary lifestyle, and/or deconditioning, for example in low- or zero-gravity conditions. Unnecessary fasting and bed rest in hospitalized older people can be resulted in iatrogenic sarcopenia. Nutrition-related sarcopenia can result from the inadequate dietary intake of energy and/or protein. Inappropriate nutritional management in hospitalized older people can be resulted in iatrogenic sarcopenia. Older patients with hospital-associated deconditioning and aspiration pneumonia can complicate all causes of sarcopenia.

The treatment for sarcopenia can differ depending on its primary and/or secondary classification and its etiology, and the concept of rehabilitation nutrition can be useful. Rehabilitation nutrition can be implemented using the International Classification of Functioning, Disability and Health Guidelines to evaluate nutrition status and to maximize functionality in people with a disability. Resistance training is the best approach for the treatment of age-related sarcopenia. Increasing physical activity and avoiding prolonged and unnecessary bed rest or a sedentary lifestyle are good general strategies for mitigating activity-related sarcopenia. The treatment goals for nutrition-related sarcopenia involve the maintenance of a positive energy and protein balance.

A comprehensive approach, including rehabilitation nutrition, psychosocial interventions, and pharmacologic therapies may be used for treating sarcopenia. Early rehabilitation, early oral intake and appropriate nutritional management are important for doctors to prevent and treat iatrogenic sarcopenia. Doctors should avoid making iatrogenic sarcopenia in hospitalized older people.
Although complete blood count (CBC) is the most basic laboratory test in everyday practice, it often contains important information suggestive of serious condition which is left unnoticed.

In this lecture, nine interesting cases are presented in Q&A format to show how to interpret CBC data in clinical settings.

Points to be focused on are importance of MCV and reticulocytes in anemia, differentials in leukocytosis, and reference to the previous CBC data, and differential diagnosis of polycythemia and thrombocytopenia.
It is well known that about 65% of depressive patients consult physicians first, in contrast, less than 10% of them consult psychiatrists first. In addition, 20 to 40% of patients who consult to physician are considered to have comorbid psychiatric disorders. These indicate that to learn psychiatry is essential for physicians who aim to be generalists.

However, we unfortunately cannot say that learning and training systems of psychiatry for physicians in Japan are efficient to archive such reformations.

Furthermore, psychotherapy along with medication such as antidepressants has strong evidence to improve depression. It is also well known that Cognitive Behavioral Therapy (CBT), which is one of psychotherapy is more effective for some patients with mild to moderate depression than medication alone.

Nevertheless, learning and training systems of psychotherapy such as CBT for physicians in Japan who should be on the front line to manage the patients with mild to moderate depression and aim to be generalists are very much insufficient.

We organized the first-ever workshop for physicians to learn CBT for in such circumstances at ACP Japan chapter annual meeting in 2015.

We organize this workshop, “Introduction to Cognitive Behavioral Therapy (CBT) to be a skillful physician” under the supervision of psychiatrists with a lot of experience.

We will provide more powerful and practical workshop than that in last year including practice such as the Mindfulness or column technique under the supervision of psychiatrists with a lot of experience.

We believe you will perform better treatment and management of patients with psychiatric problems together with CBT and medication such as antidepressants as “skillful physician” fitting to be ACP Japan chapter member.
Mechanical ventilation seminar for a hospitalist in ACP Japan

There are many situations that hospitalists manage a ventilator in Japan, because of less the numbers of intensivists. Therefore, hospitalists are required basic knowledge and management skills of ventilator.

In this seminar, through the lecture with video, you will be able to understand the basic of ventilator, set the ventilator correctly and identify asynchrony.

<Timetable>
1. Basic lecture of the ventilator (Dr. Kataoka)
2. Discussion (Dr. Kataoka and Dr. Norisue)
Since December 2014, the referral outpatient clinic, which is exclusive for patients with fever of unknown origin (FUO), has started in our hospital. To our best knowledge, this is the first attempt in Japan. As a result, a lot of patients with medical problems associated with undiagnosed fever visited our "FUO clinic". Serious condition such as malignant lymphoma or acute endocarditis has been rarely seen in our series. On the other hand, the condition such as autoinflammatory diseases or habitual/functional hyperthermia, which is unrelated with mortality, was common as a cause of fever in our FUO clinic. Unlike a general impression, the disorders such as periodic fever syndrome or hyperthermia can strongly inhibit the patients' quality of life. In addition, contrary to our expectations, we have not yet encountered a patient with infectious disease ever since the FUO clinic (by appointment only) was open in our hospital. This is a suggestive result.

Fever is an extremely common symptom of many medical conditions. Indeed, many potential patients can be affected with a complicated fever, and also clinicians think a FUO is still challenging for leading a correct diagnosis. We believe that our attempt exemplified a form of outpatient clinic by a FUO specialist.

In summary, on our session ACP Japan 2016, the focus will be on FUO, like as recurrent fevers of unknown origin, especially in the outpatient setting.
We present demonstrations of clinical conferences which are held on weekly basis, here in the ACP Japan chapter. This time we would like to invite you participants to “the big 2” Joto conferences, which are Tokyo Joto Journal Club and The Manual Conference. Because of the short history since launched, these conferences have much room for development.

Through the actual experience of the conferences, we would like to discuss in groups to view the future perspective of clinical conferences which aim for the better educational and clinical outcome. Why don’t you join us and share that?
We will share latest information of the Choosing Wisely Campaign International and Japan. Young trainees will present actual clinical cases and participants will understand the concept of recommendations by the Choosing Wisely Campaign. Our agenda will include as follows:

1) Opening remarks about the Choosing Wisely Campaign Japan: Yasuharu Tokuda
2) Short lecture about the historical perspectives of the Choosing Wisely Campaign: Shunzo Koizumi
3) Case Discussion (Choosing Wisely Japan Working Group)
4) Panel discussion (Organizer: Fumiaki Ueno. Panelists: Working Group)
Teaching and learning clinical reasoning and its process is a key fact for realizing High Value Care. Diagnostic reasoning, namely diagnostic thinking process is a core asset of clinical reasoning. We introduce and demonstrate Diagnostic Strategy Conference (DSC), sharing diagnostic thinking process of each participants. This is a conference for improving diagnostic skills in patient encounter as well as exploring new ideas for better diagnostic process. In the initial phase of the conference the chairperson introduces a case with background patient information. Participants then discuss the differential diagnosis and diagnostic process they employ for reaching diagnosis. After that, the chairperson shows the final diagnosis, which is still within the early phase of the conference. Then using the latter phase of the conference, the chairperson and the participants spare times and thoroughly discuss searching what would be the better thinking way for the rapid and correct diagnosis.

The most important aspect of the DSC is the way to spend the latter part. Participants utilizes most of the latter part of the conference to look for the common aspect seen in both the presented case and the cases they have seen in the past or articles. In other word, it is a process to find a way to make strategies and tactics through multiple cases from the diagnostic aspect. It is important to conceptualize the DSC and to break it down to which practitioners, either expert or novice in diagnosis, can use in daily patient care. If they do so, the strategy gives variations of thinking process, and the variations of thinking process gives solutions to upcoming diagnostically challenging cases with utilizing the higher level of thinking process than previously used ones. On the other hand, if only focusing on to make diagnosis without the thinking process in daily patient encounters, one might not be able to do the same when confronting difficult cases.

In this conference, cases are mostly from real cases, but sometimes from modified cases in international peerreview journals such as Clinical Problem Solving in New England Journal of Medicine are used as well.

We intend to establish the medical education which is “Made in Japan” with the new way of training for diagnosis to reach High Value Care.
Obviously, history taking and physical examination are important in infectious diseases. Efforts to determine the etiologic agents are important as well. To do this, you should collect specimen for culture appropriately. Without culture, you can never know antimicrobial susceptibility of the etiologic agents. To infer etiologic agents, patient’s history and the Gram stain examination of patient specimens are essential. Although the Gram stain is essential in infectious diseases, some physicians do not perform it or cannot evaluate it appropriately. It is said that the Gram stain is one component of a physical examination. Therefore, if appropriate specimen is not collected, specimen should be collected again. If the smears are not correctly prepared or stained, the staining procedure should be repeated.

In this session, the basics of infectious diseases will be discussed.
Self-directed learning (SDL) dictates that learners discover tasks by themselves and do the necessary study when it is convenient. In Japan, study meetings which students have a main role in have been taking place, for example; study groups in which students study emergency medical care specifically and study groups in which students study clinical reasoning. Another example is students participating in study groups pondering medical activities in foreign countries as well as clinical study abroad causing them to study medical English in order to pursue these goals. This purpose is learning knowledge, skills, and attitude that are required in clinical settings and that aren’t taught enough in a regular lecture. It can be said that they practice SDL.

Recently, through popularization of social network site and so on, it has become easier for medical students to go beyond the boundaries of individual universities and meet together in a room for activities of a group. But, because of a deficiency of networks among study groups, there are few chances to know the activities of other groups at present. For that reason, it is difficult to overlook and interpret what is lacking for existing curricula of medical education and what is prior subjects. And there is at present no chance to share methods of achieving goals of study efficiently among groups.

In this session, two student groups, “PRIME”, in which students have study meetings regarding clinical reasoning and “WiNG”, in which students learn social problems and think about the solutions through seminars and field studies, will mount the platform. By presenting opinions of existing medical education problems found by the two groups which performed markedly different activities, we look at the present situation of medical education broadly and consider subjects of important SDL. Through discussion during the meeting, we are aiming at improving the quality of every SDL. Moreover, by sending a message of the results after this session, we intend to encourage network-building among groups nationally.
Today in Japan one in two people develop cancer, and one in three die of cancer. Unlike United States where oncologists play central roles in cancer care, medical subspecialists in certain organ systems and surgeons play major roles in Japan. On the other, both The Japanese Society of Internal Medicine and Japan Primary Care Association recommend the proactive involvement of generalists in cancer care (particularly in palliative care) in their curriculums. Generalists can have various roles in the management of cancer patients from diagnosis, medical care, and anticancer treatment to end-of-life care. However, many of them are struggling to find optimal roles in cancer care at their institutions.

The aim of this session is to discuss various roles of generalists in cancer care through case discussions with medical students, residents, fellows, and attending physicians. In detail, we will introduce two cases (one with generalist’s involvement from the initial presentation, and the other with generalist’s involvement from the middle of cancer care trajectory), and explore their roles in diagnosis, anticancer treatment, supportive care, multidisciplinary approach, advance care planning, symptom control, and end-of-life care. Our ultimate goals are to enhance generalists’ understanding of their roles and active involvement in cancer care, and to help generalists and students advance their career in cancer care.
Many physicians are not familiar with treating pregnant women, although they are told to "treat all female patients as though they are pregnant."

The U.S. Food and Drug Administration (FDA) removed pregnancy letter risk categories – A, B, C, D and X, so that, both healthcare providers and patients have more flexibility, allowing for more accurate usage of drugs during pregnancy.

In this session, you can understand the basic rules of drugs and pregnancy, practice how to inform the patients about the drugs’ risks on fetus, and learn how to get and use update information.
The clinical observership program at the University of California, Los Angeles (UCLA) affiliated hospital is an invaluable opportunity for the ACP members. Taking part in this program and experiencing American medical education systems for an entire month will definitely have significant impact on your career, and a way of thinking as a physician. This program is an essential experience for any physicians, regardless of their clinical experience who would like to broaden their horizon.

Participants will be able to learn how the medical systems and clinical education work at a typical teaching hospital in U.S. To exchange information with the physicians who experienced this program To learn how to apply for this program

<Time Table 90 minutes session>
Moderator: Harumi Gomi, MD, FACP
Chair: International Exchange Program Committee

0-50 min (50 min) Sharing experiences at Olive View-UCLA Medical Center, Akira Kuriyama, Yoshinosuke Shimamura, Shinko Soma, Narihiro Cho, Tetsuya Makiishi, et al.

50-60 min (10 min) Short lecture

60-75 min (15 min) Panel discussion

75-80 min (5 min) How to apply for this program

80-85 min (5 min) Questions and answers

85-90 min (5 min) Closing
NEW HOPE FROM APCJ
The best confidence builder is experience

Hideaki Shimizu, MD
Chief, Division of Nephrology Chubu Rosai Hospital
Member of Scientific Program Committee
Adviser of Resident Fellow Committee

Also known as Medical Jeopardy, ACP Doctor's Dilemma is held each year at the scientific Internal Medicine Meeting. 50 teams comprising of residents from famous American teaching hospitals compete for the title of national champion.

The 2016 annual meeting of the American College of Physicians (ACP) was held from May 5th to 7th in Washington, DC.

This year we sent a team to represent Japan in the ACP Doctor’s dilemma. This was our first time to participate in this event.

In the 2015 we were looking at ways to increase the membership of the ACP Japan chapter. During the ACP annual meeting Dr. Shibagaki talked to the director about the possibility of a Japanese team joining the American Doctor’s dilemma competition. Two months after getting approval to attend the event the process for selecting a team to compete took place at the Doctor’s dilemma event in Japan in June 2015. The event consisted of teams from five Japanese teaching hospitals, each team had two residents /fellows. The winner was Shirakawa STAR in Fukushima and runner up was Aso Iizuka Hospital Hospital in Fukuoka.

To compete in the American Doctor’s dilemma each team required three doctors. Because of this the team comprised of two doctors from the winning team (Shoko Soeno, Hiroki Takeda) and one doctor from the runner up (Masahiro Kimura).
The selection process and entry requirements were complicated by the differences between Japanese and American training programs. We had to negotiate with Ms. Kelly Lott, the Membership Programs Administrator for ACP. She was very helpful and allowed us a certain amount of leeway. We decided the requirements would be that attendees should be PGY5.

The Doctor’s dilemma was held during all three days of the meeting. The competition consisted of elimination, semi-final and final rounds.

The final round took place in front of a large audience on the last day of the meeting. This was the main event and was held in the main Ballroom.

During the competition we experienced some problems, for example being non-native speakers, jet lag and clinical practice differences.

Our team was briefed before the elimination round on the rules of quiz.

They were as follows.

A computing system randomly selects the category and which team will start and the team selects the amount points to they will receive if the answer is correct.

The quizmaster reads the statement during this time the buzzer cannot be used once the statement has been read. The buzzer is activated and the first team to hit their buzzer can answer the question.

If the question is answered correctly they receive the points that they selected. If they answer incorrectly within the limited time or failed to answer they will receive minus points for the amount chosen. This made answering the questions extremely difficult for our team.

The last part of the quiz was the final dilemma, only teams with plus points could proceed to this stage of the competition.

Elimination round was held on May 5 at 3:00 pm in Room 207A and 207B, there was a large audience in the room.

In the room 207B, twenty-five teams competed for five slots. Each session contained five teams. Japanese team came 4th in their session. The other teams were Southern CA II, Indiana, Louisiana and Ontario. Many Japanese ACP members came to support us.
The oral part of the quiz was quite difficult for non-native speakers because of this we reacted slower than the other teams and lost vital points. We tried our best to catch up, however the gap was too wide and in the end we didn’t qualify for the final elimination round. However we found that there were some categories of the quiz, which computing system randomly selects that we could answer, for example the picture quiz. Most of the quiz of ours was oral if the quiz had contained more picture rounds, we would have been able to reach the semi final.

This was our first time to participate in the American Doctor’s dilemma in Washington.

From the bottom of my heart, let me say that I sincerely respect the Japanese team’s bravery, and give special thanks to ACPJ members and ACP. In the future we hope to send our team all the way to the final stage.

At this year’s ACP japan annual meeting, ten teams from all over the country participated. Audience members could also form teams and participate by using their smartphones. Please support this exciting tournament and watch young physicians from Japan’s top ten teaching hospitals battle for the top spot of Doctor’s Dilemma champions 2016. The winners of the competition will represent Japan in the 2017 US tournament, which will be held San Diego.

reference
1) Doctor’s Dilemma
http://ddm.acponline.org/dilemma

2) Elimination Round math-ups and schedule The 2016 ACP Doctor’s Dilemma Competition

3) Doctor’s dilemma in ACPJ 2016.
What’s New

Coming soon!
ACP Japan Chapter Annual Meeting 2016
June 4 & 5, in Kyoto
http://acp2016.org/index.html

ACP bestowed Honorary Fellow on Dr Yasuo Ikeda
Dr. Yasuko Ikeda, President of International Society of Internal Medicine, has been bestowed Honorary Fellow by American College of Physicians.
Honorary Fellowships are granted to presidents or their equivalents of medical societies abroad. Dr Ikeda was honored with other four New Honorary Fellows in Convocation Ceremony at Internal Medicine 2016 in Washington DC.

New Master, Dr. Shunichi Fukuhara
Dr. Shunichi Fukuhara was awarded Mastership at Internal Medicine 2016. He is the sixth Master from ACP Japan Chapter.
Masters (MACP) comprise a small group of highly distinguished physicians who have achieved recognition in medicine by exhibiting a preeminence in practice or medical research, holding positions of high honor, or making significant contributions to medical science or the art of medicine. Mastership is considered a special class of membership.
https://www.acponline.org/about-acp/acp-international/acp-international-newsletter/international-newsletter-archive/may-2016/acp-internal-medicine-meeting-2016-highlights

Affiliate membership has been renewed
Affiliate membership is available to Japanese Physicians who maintain their professional credentials to practice but are not satisfied with full membership.
Applicants need a letter of recommendation from one of the councils of ACP Japan Chapter. Affiliate members can acquire all of the benefits of ACP, but do not have voting privileges or will not be able to hold office or become a Fellow in the College.
http://www.acpjapan.org/jpnchap/nyuukai.html
Editor’s Postscript

This issue of the newsletter consists of abstracts of the forthcoming annual meeting of Japan Chapter. There are various programs related to clinical practices. We hope participants of the meeting would be satisfied with them.

Some readers may have noticed that the appearance of the newsletter has wonderfully changed. Professor Akihisa Tatsumi (Visual Design course, Kyoto City University of Arts & Part-time Lecture Design School, Kyoto University) has joined in editing and served from the art design aspect of the newsletter. (Y.O)