沖縄中部アラムナイセミナーシリーズ 第2回

卒後臨床研修



日時:2019年3月17日(日)09:00~14:30

会場:沖縄県看護協会・看護研修センター(〒901-1105沖縄県南風原町字新川272-17)

対 象 :全国の研修病院・医学部の管理者、研修責任者、研修医・医学生・指導医、

研修事務担当者、医師会関係者

参加費:無料

主 催:一般社団法人 沖縄県立中部病院研修医同窓会

参加申込:別紙申込書記載のうえ FAX かメール添付にて同窓会事務局宛

プログラム

開会の挨拶・司会 町淳二 (ハワイ大学外科教授)

金城 紀与史 (沖縄県立中部病院研修管理委員長)

「Introduction 中部病院研修の現状・将来」

Lee Buenconseio-Lum, MD

Designated Institutional Official (DIO) and Graduate Medical Education Director

Professor of Family Medicine & Community Health, University of Hawaii

"Competency-based graduate medical education (GME) in the US

: Overview of recent changes and future directions"

星 哲哉 (手稲渓仁会病院臨床研修部長)

「良医の育成一北海道からのメッセージ」

Coffee Break

江村 正 (佐賀大学医学部附属病院 卒後臨床研修センター専任副センター長)

「地方の新設医大の取り組みし

原永 修作(琉球大学医学部准教授)

「沖縄県における卒前卒後の seamless な医学教育-オール沖縄の教育・

研修の HUB を目ざして1

徳田 安春(群星沖縄臨床研修センター長)

「医学教育の課題とソリューション」

Coffee Break

パネルディスカッション・Q&A (ランチ提供) 座長:町淳二

閉会の挨拶 安次嶺 馨 (ハワイ大学プログラムディレクター)

事務局:一般社団法人 沖縄県立中部病院研修医同窓会(中部病院ハワイ大学事務所内) 電話:098-973-1515 FAX:098-974-2112 email:unihawaiioffice@hosp.pref.okinawa.jp

ごあいさつ

社団法人沖縄県立中部病院同窓会は、2018年、設立初年度から主な事業として、年2回の「沖縄中部アラムナイセミナーシリーズ」を開始しました。第1回セミナーは、2018年10月に「感染症」をテーマに開催し、多くの参加者から、有益なセミナーだったとの評価をいただきました。

第2回は「卒後臨床研修」をテーマに、内外から6人の講師をお招きし、開催することになりました。中部病院が半世紀にわたって連携したハワイ大学医学部から、Lee Buenconsejo-Lum 教授を招聘しました。教授は、ハワイ大学医学部の卒後研修の責任者であり、アメリカの卒後研修臨床プログラムについての課題と将来の展望について講演します。

本土講師としては、手稲渓仁会病院の星哲哉先生、佐賀大学医学部附属病院の江村正先生に、それぞれの施設の現状、研修、教育方針などについて、ご講演をしていただきます。

県内からは、群星沖縄臨床研修センターの徳田安春先生、琉球大学医学部附属病院の原永修作先生、沖縄県立中部病院の金城紀与史先生に講演していただきます。 ハワイ、本土、沖縄とそれぞれの地で、どのような臨床研修が行われているか、その報告の後、活発なデイスカッションを期待しています。

研修医、研修指導医、また医学生など、多くの方々のご参加を得て、日本の臨床教育の向上に沖縄から全国に向けて発信したいと考えています。

2019年3月

一般社団法人沖縄県立中部病院研修医同窓会 理事長 安次嶺 馨

沖縄中部アラムナイセミナーシリーズ

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09:00~09:10 開会の挨拶・司会 町淳二(ハワイ大学外科教授)

09:10~09:30 金城 紀与史(沖縄県立中部病院研修管理委員長) 「Introduction 中部病院研修の現状・将来」

09:30~10:20 Lee Buenconsejo-Lum,MD

Designated Institutional Official (DIO) and Graduate Medical Education Director Professor of Family Medicine & Community Health, University of Hawaii

"Competency-based graduate medical education (GME) in the US

: Overview of recent changes and future directions"

10:20~10:50 星 哲哉(手稲渓仁会病院臨床研修部長) 「良医の育成一北海道からのメッセージ」

10:50~11:00 Coffee Break

11:00~11:30 江村 正(佐賀大学医学部附属病院 卒後臨床研修センター専任副センター長) 「地方の新設医大の取り組み」

11:30~12:00 原永 修作(琉球大学医学部准教授)

「沖縄県における卒前卒後の seamless な医学教育-オール沖縄の教育・研修の HUB を目ざして]

12:00~12:30 徳田 安春(群星沖縄臨床研修センター長) 「医学教育の課題とソリューション」

12:30~12:50 Coffee Break

12:50~14:30 パネルディスカッション、Q&A(ランチ提供) 座長:町淳二

14:30 閉会の挨拶 安次嶺 馨(ハワイ大学プログラムディレクター)

Introduction 中部病院研修の現状・将来

金城 紀与史 沖縄県立中部病院研修管理委員長



戦後占領下にあった沖縄に米国式研修プログラムが導入されたのは歴史上の僥倖であった。卒後すぐに臓器専門研修を行うストレート研修(入局)が趨勢だったなか、全科的な力をつけるスーパーローテーション、徹底的に病歴と身体所見を繰り返し取る研修の場として救急研修を重視したこと、ベッドサイド教育の重視、教わり教えあう屋根瓦方式、ピアレビュー・チーム医療などをキーワードに厳しいながらも着実に実力がつく研修が確立した。離島僻地の医師確保という社会的成果を出したのみならず、研修医が患者ケアに主体的に関与することがよい研修であり、よい医療にも結びつくという「教育病院」の土壌ができた。

研修開始から50年経過した現在、問題も指摘できる。コミュニケーションスキル、侵襲的手技、保険制度の理解などベッドサイド実践だけでは学びきれない領域が増えていること、高齢化社会により病歴身体所見だけで勝負できなくなっていること、急性期医療だけ学ぶのでは医療人として不十分になったこと、長時間労働による燃え尽きやうつ、ジェネラル力と臓器専門医療の両立、新世代の学び方の変化などである。初期研修制度必修化により全国研修病院でも同様の研修が可能となり、新専門医制度により専門研修の前倒しの傾向が強まり離島も含めた5年間のジェネラル研修は遠回りのように見えてしまう。

中部病院の置かれた新たな環境において、研修が変化すべきところと、変わらず死守すべき点との見極めは難しいが、病院、指導医、研修医とも「あるべき研修」について関心を持って熱く議論しつづけるマグマは消えていない。

【略歴】

東京出身。東京大学医学部医学科卒、亀田総合病院、トマスジェファソン大学病院、マウントサイナイ医学部で研修。ユニオン大学大学院・アルバニー医学部修士(生命倫理)。手稲渓仁会病院を経て 2008 年から沖縄県立中部病院総合内科。2014 年から研修管理委員会委員長。

Competency-based graduate medical education (GME) in the US: Overview of recent changes and future directions



Lee Buenconsejo-Lum, MD

Designated Institutional Official (DIO);
Director of GME Professor of Family Medicine and Community Health
John A. Burns School of Medicine; University of Hawaii at Manoa

This presentation will provide a brief background of competency based medical education (CBME) and current approaches in the United States to implement and evaluate CBME. CBME is defined as "... an outcomes-based approach to the design, implementation, assessment and evaluation of medical education programs, using an organizing framework of competencies."

Until the 1980s, "graduation" from a Graduate Medical Education (GME) program was largely based on the time it took a trainee to complete their prescribed educational program. However, as the health care system has become more complex, it has become essential to produce doctors who have demonstrated the ability to practice their specialty in complex health care settings and in interprofessional teams. Important outcomes to measure in residents/fellows include educational outcomes, clinical care outcomes and other important competencies in communication, system-based practice, professionalism and practice-based learning and improvement. Better monitoring and assessment of these physicians in training is needed to ensure they can safely practice medicine independently and unsupervised.

In order to design an effective and efficient evaluation system, it is important that all faculty understand the various developmental stages of learning. It is also important that they come to agreement on how to measure/assess progress on the different skills, tasks, milestones and competencies. In the US and Hawaii, there is a large focus on faculty development and critically examining the evaluation system to ensure that faculty are able to accurately assess the residents, give them timely feedback and, if needed, remediation to help them become successful physicians. On the next pages contain some important tables that explain the developmental stages of learning and how they align with the RIME stages, ACGME Milestones and supervision requirements.

Additional information and references are included in Dr. Buenconsejo-Lum's slide presentation. Please feel free to contact her with any questions. lbuencon@hawaii.edu

Developmental Stages of Learning as Proposed by Dreyfus

Stage of Learning	Method of Learning (Teaching Style)	Learning Steps	Learner Characteristics
1. Novice	Instruction (instructor) Breaks skill into context-free, discrete tasks, concepts, rules	Recognizes the context-free features Knows rules for determining actions based on these features	Learning occurs in a detached analytic frame of mind
2. Advanced beginner	Practice (coach) Experiences coping with real situations Points out new aspects of material Teaches rules and reasoning techniques for action	Recognizes relevant aspects based on experience that makes sense of the material Learns maxims about actions based on new material	Learning occurs in a detached, analytic frame of mind
3. Competence	Apprenticeship (facilitator) Develops a plan or chooses perspective that separates "important" from "ignored" elements Demonstrates that rules and reasoning techniques for choosing are difficult to come by Role models are also emotionally involved in making decisions	Volume of aspects is overwhelming Performance is exhausting Sames of what 'important is lacking Stands alone making corners and incorrect choices Coping becomes frightening, discouraging, elating	Learner is emotionally involved in the task and its outcome to many subtle differences for rules; student must decide in each case Makes a missike, then feels remore Succeeds, then feels elated Emotional learning builds competence
4. Proficiency	Apprenticeship (supervisor) Gains more specific experience with outcomes of one's decisions Applies rules and maxims to decide what to do	Rules and principles are replaced by situational discrimination Emotional responses to success or failure build intuitive responses that replace reasoned ones	Learner immediately sees the goal and salient features Learner reasons how to get to the goal by applying rules and principles
5. Expertise	Independence (mentor) Experiences multiple, small random variations Observes other experts or experiences nonandom simulations Working through the cases must emotionally matter	Gains experience with increasingly subtle variations in situations Automatically distinguishes situations requiring one response from those requiring another	Immediately sees the goal and what must be done to achieve it Builds on previous learning experiences

From Dreyfus HL: On the Internet. Thinking in Action Series. New York, Routledge, 2001.

Novice = early medical student = Reporter

Advanced Beginner = advanced medical student = Interpreter

Competence = advanced medical student/early resident = Manager

Proficiency = advanced resident(supervisory) = Educator (team leader/Senior resident)
Expertise = faculty = Educator/Mentor

Alignment of Milestones, Dreyfus Model Stages, Observable Learner Behavior, RIME and ACGME Levels of Supervision

Milestone Level	Dreyfus Model Stages	Learner Behavior	RIME Stages	Transition to Practitioner	Appropriate Level of Supervision and Permission
1	Novice	Doing what is told, rule driven	Reporter	Introduction to elinical practice	Observation, no enactment
2	Advanced beginner	Comprehension	Reporter/Interpreter	Guided clinical practice	Act under direct, proactive supervision
3	Competent	Application to common practice	Interpreter/Manager	Early independence	Act under indirect, reactive supervision
4	Proficient	Application to uncommon practice	Managen/Educator	Full unsupervised practice	Clinical oversight
5	Expert	Experienced clinician	Educator	Aspirational growth after graduation	Provide supervision to others

From Holmboe textbook, Table 1.5

Different Assessment Methods

- <u>Medical Knowledge</u>: written, computer based, case-based discussions, observed teaching
- Patient Care:
 - Short practice: Mini-CEX, computer (clinical reasoning), handoffs, videos
 - Long-practice: multisource feedback (based on direct obs), review of shifts, longitudinal evaluations
- <u>Clinical Skills</u>: Simulation, *Direct observation* of procedural skills, Objective Structured Assessment of Technical Skills (OSATS), ??
- Interpersonal Skills and Communication: Simulation, Direct observation, ??
- Professionalism: Simulation, Direct observation, ??
- Systems-Based Practice, Care Coordination, Health Care Quality, Patient Safety: Simulations, Focused chart review, Event Analysis, Direct observation, ??
- Practice-Based Learning and Improvement: mentoring, review of practice data, ??

Dr. Lee Ellen Buenconsejo-Lum was born and raised in Wahiawa, Oahu into a family of teachers. She attended Leilehua High School, then Stanford University for her Bachelors of Science in Biology. She returned to Hawaii to complete her medical school and family medicine residency training at the University of Hawaii (UH) John A. Burns School of Medicine (JABSOM) in 1997. After her Family Medicine residency, she decided to pursue a career in academic medicine so that she could help to train physicians who would provide holistic and culturally-appropriate care to patients, their families and communities. Dr. Buenconsejo-Lum completed a faculty development fellowship which included emphasis on community-based participatory approaches to programmatic development and research.

Since 1997, Dr. Buenconsejo-Lum has held a variety of leadership roles within the JABSOM Department of Family Medicine and Community Health, but also remained active in teaching medical students. Dr. Buenconsejo-Lum is a full Professor with the Department of Family Medicine and Community Health and is currently the Designated Institutional Official and Director of Graduate Medical Education at JABSOM. In this role, similar to an Assistant Dean at other medical schools, she is responsible for the oversight and administration of the JABSOM residency and fellowship programs that train physicians in 17 different medical and surgical specialties.

In addition to training over 120 Family Medicine residents since 1997 - of whom about 80% have stayed in Hawaii to practice - her scholarly focus has been aimed toward strengthening health systems to reduce cancer health disparities in the U.S. Affiliated Pacific Island jurisdictions (USAPI). With numerous USAPI, US National and International partners, as well as local health leadership in each jurisdiction, she has helped the USAPI improve their capacity to prevent and detect cancer earlier and to care for patients diagnosed with late-stage cancer. She is the Principal Investigator for the USAPI Pacific Regional Central Cancer Registry Program and Co-Principal Investigator for the Pacific Regional Comprehensive Cancer Control program.

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	Completion Date	FIELD OF STUDY
Stanford University, Stanford, CA	B.S.	05/90	Biological Sciences
John A. Burns School of Medicine (JABSOM), University of	M.D.	05/94	Medicine
Hawai'i (UH), Honolulu, HI			
UH Family Medicine Residency Program, Mililani, HI		06/97	Family Medicine
UH Family Medicine Faculty Development Fellowship,		06/98	Faculty Development
Mililani, HI			

Selected Positions and Employment

7/97-present	Assistant Professor (1997), Residency Director (2008-15), Associate Professor
	(2011), Vice-Chair (2011), Professor (2016) of Family Medicine and Community
	Health, Department of Family Medicine and Community Health, JABSOM, UH
7/97-present	(current) Courtesy Medical Staff, Wahiawa General Hospital; Courtesy Medical
	Staff at Kapiolani Medical Center for Women and Children and Active Medical
	Staff at Pali Momi Medical Center
8/07-present	Associate Member, Prevention and Control Program, University of Hawaii
	Cancer Center
6/07-present	Co-Principal Investigator, Pacific Regional Comprehensive Cancer Control
	program (CDC)
6/09-present	Principal Investigator, Pacific Regional Central Cancer Registry (CDC-funded)
6/10-present	CDC USAPI Working group co-lead for prevention and control of cervical cancer
	in the USAPI
6/12-present	Governing Board Member & Treasurer, Intercultural Cancer Council (National)
7/16-present	Designated Institutional Official and Director of Graduate Medical Education,
	Dean's Office, JABSOM, UH

Honors

1994	Inductee, Alpha Omega Alpha Medical Honor Society
2003	UH JABSOM nominee for AAMC Humanism In Medicine Award
2011	Fellow, American Academy of Family Physicians
2014	Nominee, UH Board of Regents Excellence in Teaching Award

Competency-based graduate medical education (GME) in the US: Overview of recent changes and future directions

Lee Buenconsejo-Lum, MD, FAAFP

Professor and Designated Institutional Official (DIO); Director of GME

John A. Burns School of Medicine; University of Hawaii at Manoa

March 17, 2019 * Okinawa Chubu Hospital, Japan

Credit / References

- Eric Holmboe, Steven Durning, Richard Hawkins. Practical Guide to the Evaluation of Clinical Competence, 2nd Ed E-Book. Elsevier Health Sciences, Philadelphia PA 2018. ISBN: 9780323448949
- Accreditation Council on Graduate Medical Education (ACGME) <u>www.acgme.org</u>
 - Milestones Guidebook https://www.acgme.org/Portals/0/MilestonesGuidebook.pdf? ver=2016-05-31-113245-103
 - Clinical Competency Committee (CCC) Guidebook

https://www.acgme.org/Portals/0/ ACGMEClinicalCompetencyCommitteeGuidebook.pdf? ver=2017-10-18-141733-920

Edgar L, Roberts S, Holmboe E. Milestones 2.0: A Step Forward. JGME 2018 June: 367-369. DOI: http://dx.doi.org/10.4300/JGME-07-04-51

Learning Objectives

At the end of the presentation, the learner should be able to:

- 1. Describe the principles behind the Accreditation Council for Graduate Medical Education (ACGME) Milestones
- 2. Describe evidence of what has worked and what remains to be improved in delivering competency-based medical education
- 3. State the importance of interprofessional education to improve the quality of care, patient safety and to prepare GME program graduates to practice in the era of team-based care and healthcare reform in the U.S.

Competency-Based Medical Education (CBME)

"... an outcomes-based approach to the design, implementation, assessment and evaluation of medical education programs, using an organizing framework of

- What are the abilities of a graduate?
 - Vs. Did the trainee complete a prescribed educational program
- Need to produce physicians with the abilities needed to meet the complexities of the modern practice of medicine
- Educational outcomes
- Clinical care outcomes
- Includes more than medical knowledge and technical skills
- Need to better monitor (assess) doctors in training to ensure they meet predefined competency standards upon graduation to unsupervised practice

Frank J.R. Shell L.S, ten Cate O, et al. Competency-based medical education: theory to practice. Med Teach. 2010;32(8):638-645.

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Assessment

- Historical challenges
 - Lack of direct observation of performance
 - Lack of meaningful feedback
 - Overreliance on testing for assessment of medical knowledge
 - Lack of attention to other competencies that allow doctors to be effective members of highperforming healthcare teams
- Medical Knowledge: written, computer based, case-based discussions, observed teaching
- Patient Care:
 - Short practice: Mini-CEX, computer (clinical reasoning), handoffs, videos
 - Long-practice: multisource feedback (based on direct obs), review of shifts, longitudinal evaluations
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- Practice-Based Learning and Improvement: mentoring, review of practice data, ??

How to do we assessment performance at work?

- Continuous quality improvement and frequent feedback
- Culture of physician accountability
- ROUNDS
 - How are they gathering data?
 - How are they presenting data?
 - How do they interpret the data and incorporate into their assessment and plan?
 - Is this information added to prior knowledge, skills and experience?
 - Is this information properly applied to the unique context of the patient?
 - Co-morbidities, social, cultural, economic factors
 - Discharge planning
 - Coordination with other healthcare team members?
 - Situational awareness of what could go wrong?
 - Contingency planning?
 - Closed-loop communication to the other team members / safe handoffs?

Workplacebased assessments

- Faculty / observer agreement on
 - What is acceptable?
 - What is adequate?
 - What is appropriate for the different level of training
 - Mid-PGY1 vs. end-PGY-1, etc.
- Milestones do not necessarily correlate with the PGY- level of training (especially for 1-year fellowships)
- Faculty understanding the evaluation forms
- Faculty completing the evaluation forms or checklists
- Faculty able to give effective feedback*
- Feedback from other members of the care team
- Feedback from patients and families

Meyer AND, Singh H. The Path to Diagnostic Excellence Includes Feedback to Calibrate How Clinicians Think. JAMA. 2019 Feb: 321(8):737-738. doi:10.1001/jama.2019.0113

ACGME Milestones (1.0)

- 2013-2014: Benchmarks for effective assessment
- Early identification of residents having difficulty
- Better feedback to residents / fellows
- Guides development of better assessment approaches
- Framework for faculty development
- Forces a critical examination of the clinical learning environment:
 - Team functioning
 - Electronic health record
 - Quality and patient safety reports
 - Population/hospital and individual provider reports to direct:
 - Practice-based learning and improvement (individual)
 - Health system strengthening (team)
 - Population health strategies (team/larger system of health care)
 - Address inequities in health

Milestone Level	Dreyfus Model Stages	Learner Behavior	RIME Stages	Transition to Practitioner	Appropriate Level of Supervision and Permission
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From Holmboe textbook, Table 1.5

Alignment of Milestones, Dreyfus Model Stages, Observable Learner Behavior, RIME and ACGME Levels of Supervision

- Would I trust this trainee to execute this task or activity tomorrow morning with my relative, without a qualified professional present?
 - Knowledge and skill
 - Awareness of limitation and willingness to ask for help
 - Conscientious in carrying out tasks
 - Honest communications to staff and attendings

Trusting our learners

ACGME Milestones 2.0

2019-2020

The Milestones are designed only for use in evaluation of residents in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for the assessment of the development of the resident in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

PC Patient Care MK Medical Knowledge SBP System-Based Practice **PBLI** Practice-Based Learning and Improvement **PROF** Professionalism ICS Interpersonal and Communication Skills

- 6 Core Competencies
- Several Sub-competencies
 - PC-1, PBLI-2, SBP-3, etc.
- 5 levels corresponding roughly to the Dreyfus model
- Milestones to achieve within each level of a particular subcompetency
- If they do not meet all tasks within a given level, they should be marked in-between
- LEVEL 4 is the Graduation Target
- Harmonized Milestones: SBP, PBLI, ICS and PROF are the same for all specialties

Harmonized Milestones

Box Subcompetencies for the Harmonized Milestones

Interpersonal and Communication Skills (ICS)

- Patient- and Family-Centered Communication (ICS-1)
- Interprofessional and Team Communication (ICS-2)
- Communication Within Healthcare Systems (ICS-3)

Practice-Based Learning and Improvement (PBLI)

- Evidence-Based and Informed Practice (PBLI-1)
- Reflective Practice and Commitment to Personal Growth (PBLI-2)

Professionalism (PROF)

- Professional Behavior and Ethical Principles (PROF-1)
- Accountability/Conscientiousness (PROF-2)
- Self-Awareness and Help-Seeking (PROF-3)

Systems-Based Practice (SBP)

- Patient Safety and Quality Improvement (SPB-1)
- System Navigation for Patient-Centered Care (SBP-2)
- The Physician's Role in Healthcare Systems (SBP-3)

For each period, review and reporting will involve selecting the milestone levels that best describe each resident's current performance and attributes. Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert in the specialty. These levels do not correspond with post-graduate year of education.

Selection of a level implies that the resident substantially demonstrates the milestones in that level, as well as those in previous levels (see the diagram on page v).

- Level 1: The resident demonstrates milestones expected of an incoming resident.
- Level 2: The resident is advancing and demonstrates additional milestones, but is not yet performing at a midresidency level.
- Level 3: The resident continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for residency.
- Level 4: The resident has advanced and now substantially demonstrates the milestones targeted for residency. This level is the graduation target.
- Level 5: The resident has advanced beyond performance targets set for residency and is demonstrating "aspirational" goals that might describe the performance of someone who has been in practice for several years. Only a few exceptional residents are expected to reach this level.

Below is an example Set of Milestones for one sub-competency in the same format as the ACGME Report Worksheet. For each reporting period, a resident's performance within each sub-competency will be indicated by selecting the level that best describes that resident's performance in relation to those milestones.

Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of care coordination	Coordinates multidisciplinary care of patients in routine clinical situations (e.g., dressing change)	Coordinates and/or leads multidisciplinary care of patients in complex clinical situations (e.g., home parenteral nutrition [TPN], ICU)	Coordinates care of patients with barriers to healthcare access (e.g., trauma patient with no access to care) or other disparities in care	Leads in the design and implementation of improvements to care coordination
Performs safe and effective transitions of care/handoffs in routine clinical situations	Performs safe and effective transitions of care/handoffs in complex clinical situations	Supervises safe and effective transitions of care/handoffs of junior residents	Resolves conflicts in transitions of care between teams	Leads in the design and implementation of improvements to transitions of care
Comments:			Not Yet 0	Completed Level 1
Selecting a responded in the stones in the levels have been demonstrated.	implies that t level and in lower	betweer in lower demons	g a response box on to levels indicates that re- levels have been sub- trated as well as some les in the higher level(milestones stantially e

Level 1	Level 2	Level 3	Level 4	Level 5
Gathers necessary information and develops a differential diagnosis for patients in all clinical settings	Evaluates patients; orders and interprets diagnostic testing Manages non-operative straightforward patients and conditions (e.g.,	Develops a plan to manage straightforward patients (e.g., healthy patients) and conditions (e.g., colon cancer, breast cancer) Adapts management plan for changing clinical situation (e.g., drainage of		Develops a clinical pathway or guideline for the management of complex patients and conditions
	bowel obstruction, diverticulitis)	diverticular abscess)	pancreatitis)	

Medical Knowledge 1: P	athophysiology and Treatm	ent		
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates knowledge of pathophysiology and treatments of patients with common surgical conditions	Demonstrates knowledge of pathophysiology and treatments of patients with complex surgical conditions	Demonstrates knowledge of the impact of patient factors on pathophysiology and the treatment of patients with surgical conditions	Demonstrates comprehensive knowledge of the varying patterns of disease presentation and alternative and adjuvant treatments of patients with surgical conditions	Contributes to peer- reviewed literature on the varying patterns of disease presentation, and alternative and adjuvant treatments of patients with surgical conditions
Comments:			Not Yet C Not Yet R	Completed Level 1

Systems-Based Practice 1: Patient Safety and Quality Improvement Level 1 Level 2 Level 3 Level 4 Level 5 Demonstrates Participates in analysis of Conducts analysis of Identifies system factors Actively engages teams knowledge of common that lead to patient safety patient safety events and processes to modify patient safety events patient safety events events (simulated or actual) and offers error systems to prevent patient safety events prevention strategies (simulated or actual) Demonstrates Participates in disclosure Discloses patient safety Mentors others in the Reports patient safety knowledge of how to events through of patient safety events to events to patients and disclosure of patient report patient safety institutional reporting patients and families families (simulated or safety events events systems (simulated or (simulated or actual) actual) actual) Demonstrates Demonstrates the skills Describes local quality Participates in local Creates, implements, and knowledge of basic improvement initiatives quality improvement required to identify, assesses quality improvement initiatives at quality improvement (e.g., infection rate, hand initiatives develop, implement, methodologies and the institutional or hygiene, opioid use) and analyze a quality metrics improvement project community level Comments: Not Yet Completed Level 1

Practice-Based Learning and Improvement 2: Reflective Practice and Commitment to Personal Growth							
Level 1	Level 2	Level 3	Level 4	Level 5			
Establishes goals for	Identifies opportunities for /	Integrates performance	Revises learning plan	Coaches others in the			
personal and	performance	feedback and practice	based on performance	design and			
professional	improvement; designs a	data to develop and	data	implementation of			
development	learning plan	implement a learning plan		learning plans			
Comments:			Not Yet (Completed Level 1			

Level 1	Level 2	Level 3	Level 4	Level 5
Completes patient care tasks and responsibilities, identifies potential barriers, and describes strategies for ensuring timely task completion	Performs patient care tasks and responsibilities in a timely manner with appropriate attention to detail in routine situations	Performs patient care tasks and responsibilities in a timely manner with appropriate attention to detail in complex or stressful situations	Recognizes situations that may impact others' ability to complete patient-care tasks and responsibilities in a timely manner	Develops systems to enhance other's ability to efficiently complete patient-care tasks and responsibilities
Describes when and how to appropriately report lapses in professional behavior	Takes responsibility for his or her own professional behavior	Demonstrates professional behavior in complex or stressful situations	Intervenes to prevent and correct lapses in professional behavior in self and others Appropriately reports lapses in professional behavior (simulated or actual)	Coaches others when their behavior fails to meet professional expectations
Recognizes limits in the knowledge/skills of self and seeks help	Recognizes limits in the knowledge/skills of team and seeks help	Exhibits appropriate confidence and self-awareness of limits in knowledge/skills	Aids junior learners in recognition of limits in knowledge/skills	

Level 1	Level 2	Level 3	Level 4	Level 5
Respectfully requests and receives a consultation	Clearly and concisely requests and responds to a consultation	Verifies understanding of recommendations when providing or receiving a consultation	Coordinates recommendations from different members of the health care team to optimize patient care, resolving conflict when needed	Coaches flexible communication strategies that value input from all nealth care team members
Uses language that values all members of the health care team	Communicates information effectively with all health care team members Solicits feedback on	Uses active listening to adapt communication style to fit team needs Communicates concerns and provides feedback to	Maintains effective communication in crisis situation Communicates	Facilitates regular health care team-based
	performance as a member of the health care team	and provides feedback to peers and learners	constructive feedback to superiors	feedback in complex situations

ACGME Next Steps with Milestones 2.0

- All specialties are finalizing their PC and MK milestones (all done by 2020)
- Surgery, Pathology and the next will need to use these starting July 1, 2019
- ACGME is creating a supplemental guide for each specialty
 - Intent of subcompetencies
 - Examples for each level
 - Sample Assessment Methods
 - Other available resources
- Milestones Guidebook (current) → Implementation Guidebook

Next Step for GME Leaders

- Faculty development
- Critical look at current evaluation system
- Clear expectations for learners
- More synergy with hospital and/ or health system patient safety, quality and education efforts

CLER PATHWAYS TO EXCELLENCE

Expectations for an optimal clinical learning environment to achieve safe and high quality patient care

Version 1.1



Accreditation Council for Graduate Medical Education

CLER Focus Areas

CLER Evaluation Committee. CLER Pathways to Excellence: Expectations for an Optimal Clinical Learning Environment to Achieve Safe and High Quality Patient Care, Version 1.1. Chicago, IL: Accreditation Council for Graduation Medical Education; 2017.

- Patient Safety
- Health Care Quality
- Care Transitions
- Supervision
- Well-Being (Selected Topics)
- Professionalism (Selected Topics)

CLER Pathways to Excellence

CT Pathway 2: Resident/fellow engagement in change-ofduty hand-offs

Standardized, effective, efficient hand-offs are a prerequisite for safe patient care.

PROPERTIES INCLUDE:

- Residents/fellows use a common clinical site-based process for change-ofduty hand-offs.
- The focus will be on (a) department use of consistent or "standard" processes and template tools; as well as, (b) clinical site-wide use of consistent or "standard" processes and template tools reflective of setting and type of patient care.
- Resident/fellow change-of-duty hand-offs involve, as appropriate, interprofessional staff members (e.g., nurses) at the clinical site.
 The focus will be on the proportion of service areas in which there is interprofessional participation in change-of-duty hand-offs.
- Resident/fellow change-of-duty hand-offs involve, as appropriate, patients and families at the clinical site.
- The focus will be on the proportion of departments/programs in which there is patient/family participation in change-of-duty hand-offs.

CT Pathway 4: Faculty member engagement in assessing resident-/fellow-related patient transitions of care

Evaluation through direct observation of residents/fellows by faculty members is required to ensure residents'/fellows' abilities to perform standardized, effective, efficient hand-offs.

PROPERTIES INCLUDE:

- Through program-based standardized processes and direct observation, residents/fellows are assessed for their ability to move from direct to indirect faculty member supervision in the conduct of patient transfers at change-ofduty, and in patient transfers between services and locations at the clinical site.
 - The focus will be on the proportion of programs using standardized faculty member assessment (through simulation or clinical care) to determine resident/fellow readiness to move from direct to indirect supervision during patient transitions in care. This pathway progresses according to the proportion of programs in which faculty members use direct observation to assess residents'/fellows' abilities to conduct change-of-duty hand-offs and patient transfers between services and locations.
- Faculty members periodically monitor resident/fellow transfers of patient care at change-of-duty, and resident/fellow transfers of patients between services and locations for quality control at the clinical site.
- The focus will be on the proportion of programs that have a quality control process for monitoring residents/fellows during change-of-duty hand-offs and patient transfers between services and locations.

NEXT STEPS FOR GME LEADERS

Overview

Glossary

Requirements

Survey Information

Documents and Resources



Documents and Resources

- Foundational Requirements FAQs
- Institutional Site Visit
- Key to Standard Institutional Notification Letter
- Key to Standard Program Notification Letter
- NAS-I Overview
- Out-of-Country Postings
- Program Director Guide to the International Foundational Program Requirements
- Program Site Visit
- Review Committee-International approves variable program lengths for ACGME-I-accredited programs

- What are the abilities of a GME program graduate?
- What outcomes do we expect?
- What outcomes do our patients (public) expect?
- Who is responsible for making this change happen?
- How will we get there?
- https://www.acgme-i.org/

どうもありがとうございます

Lee Buenconsejo-Lum, MD, FAAFP lbuencon@hawaii.edu

良医の育成―北の大地から―

星 哲哉 手稲渓仁会病院 臨床研修部部長



当院は 1997 年、厚生労働省より臨床研修指定病院としての認定を受けた。当初は知名度も低く、ほとんど研修医の応募はなかった。

2001 年、この状態を打破すべく当院は「北米型臨床研修」を導入することを決定した。具体的方策として

- ・ 米国ピッツバーグ大学(UPMC)と提携を結び北米の臨床医学のエッセンスである病歴と身 体所見に重きをおいたベッドサイドティーチングを提供
- ・ 常勤米国人医師による英語での医学教育の提供
- ・ 沖縄県立中部病院出身の医師 4 名と米国で臨床研修を終えた日本人医師 3 名を迎え、日本の臨床医学からも逸脱しない On the job training を提供
- ・ 初期研修期間を3年に設定して時間をかけた育成をおこなう

を導入した。この結果、北海道のみならず全国的にも研修医病院として認知され、これまで 250 人以上の卒業生を輩出し、そのうち 20 名以上が海を渡り米国臨床留学を果たすに至った。

しかし、月日の流れとともに、グローバル化が進み、働き方改革が叫ばれ、専攻医制度の導入など臨床研修を取り巻く環境は大きく変わりつつある。また、研修医自身のゴールも多様化社会を反映し、多様化しつつあり、単一なゴール設定では多くの医学生を獲得できない時代にもなってきている。この社会の流れに対応すべく、当院では新たな取り組みを開始した。

具体的には

- ・ 北米に加え、イギリス、東南アジア、インド、オーストラリア、ニュージーランド諸国との医学 交流の開始
- ナイトフロート制度導入による、労働時間の管理と研修の質の担保
- ・ 専攻医制度に振り回されない、独自の初期研修内容の設定
- ・ 卒業生に対し、海外臨床留学をサポートし、帰国後に教育スタッフとして迎え入れる「Come back salmon program」の開始
- ・ 多様化する研修医のゴールと研修内容を整合させるための、研修医との密なコミュニケー ションの仕組み作り

といったことである。

これまで良医育成にこだわり、これからもこだわり続けていきたい当院の姿勢をご紹介することを 通じて、良医育成のためには何が必要なのか、発表を通じて参加者の皆様とともに議論を深めて いきたい。

【現勤務先】

医療法人手稲渓仁会病院

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電話番号:011-681-8111

【略歴】

1992年 山形大学医学部医学科卒業

1992-1994 年 沖縄県立中部病院内科初期研修

1995-1998 年 聖路加国際病院内科後期研修

1999-2007年 米国ミシガン州立大学家庭医療科、ワシントン州立大学老年医学科、

ワシントン州立大学リウマチ科で臨床研修

2007年- 手稲渓仁会病院 総合内科・家庭医療科・リウマチ科

2013年- 手稲渓仁会病院 臨床研修部部長

【資格】

日本リウマチ学会専門医、日本内科学会認定医、日本内科学会総合内科専門医、 米国家庭医療専門医、米国老年医学専門医

地方の新設医大の取り組み

江村 正 佐賀大学医学部附属病院卒後臨床研修センター 専任副センター長



佐賀大学関連初期臨床研修プログラムは、佐賀大学医学部が、無医大県であった佐賀県にできた新設医科大学からスタートしたことと、初代古川哲司学長の強力なリーダーシップのもとで、地域に貢献する良き臨床医を育成するための先進的な医学教育を抜きに語ることはできない。

近年は、地域の医師確保と定着が強く求められている。佐賀県は人口が少なく、地元出身で別の 医科大学に進学する人も少ないため、縁あって佐賀で学んだ医学生が、そのまま佐賀に残らない と医師の確保はできない。これが都会に古くからある大学と異なるところである。

県外出身の卒業生から、臨床実習を通して、自大学に残ることを決めたという声を聞き、臨床実習の充実が最も大事であると考えている。佐賀医科大学病院では、開院当時より実習生は Student Doctor と呼ばれ、一患者一カルテで、医学生も医師や看護師と同じカルテの紙面に記載してきた。人手が足らずまさに診療参加型臨床実習であったが、その文化を廃れさせてはならないと思う。

医学生は、1年生の外来付き添い実習や2年生のクリニカル・エクスポージャー(入院患者との面接)などを通して、佐賀の人が教育に非常に協力的であり、自分たちを応援してくれていることを知ることができる。卒前と卒後の教育をつなげ、真の地域医療を体験させるために、6年生の地域医療実習先と、地域医療研修先は、ほぼ同じにしていた。これらのことが佐賀への愛着につながっていると推測する。

メンタルヘルスを含め、研修医のストレスに対しては、教育専任教員によるきめ細かなサポートを行っている。研修医同士は非常に仲が良く、そのことはメンタル不全の予防にもなっていると考えている。制度開始後、徐々に研修医の勤務環境が改善された分、上級医や若手指導医の負担が少なくないことがわかってきた。研修修了後も可能な限り支援をするようにしている。研修環境を整え、指導医もサポートすることにより、On the job training がうまくいくと考えている。

大学病院であるが、地域の特性上、専門領域に極端に特化することはなく、幸い研修医は common disease も経験できる。今後も、地域に貢献できる医師の育成を最終目標に据え、より高い レベルの卒前・卒後教育をめざしていきたい。

【略歴】

- 1987年 佐賀医科大学医学部卒業
- 1991年 佐賀医科大学大学院医学研究科修了
- 1991年 沖縄県立中部病院救命救急センター(エクスターン)
- 1992年 佐賀医科大学医学部附属病院内科(医員)
- 1992年 社会保険浦之崎病院内科
- 1995年 佐賀医科大学医学部内科学(助手)
- 1998年 佐賀医科大学医学部附属病院総合診療部(助手)
- 2001年 米国ミシガン州立大学家庭医学科(客員研究員),
- 2004年 佐賀大学医学部附属病院卒後臨床研修センター(2008年より准教授)

現在に至る

日本内科学会認定内科専門医、日本プライマリ・ケア学会認定医、日本医師会認定産業医、日本 医学教育学会認定医学教育専門家

【施設データ】

施設規模(平成29年度)

病床数 604 床

外来

沖縄県における卒前卒後の seamless な医学教育 オール沖縄の教育・研修の HUB を目ざして

原永 修作 琉球大学医学部附属病院 総合臨床研修・教育センター 特命准教授



近年、卒前/卒後教育の seamless 化が求められるようになってきている。琉球大学医学部では、 早期より学生の医学教育担当として医学教育企画室を、臨床研修担当として卒後臨床研修センタ ーや専門研修センターを設置し医学生、研修医の教育・指導及び、指導医のサポートにあたって きた。医学生教育においては、医学教育企画室が中止となり「グローバル&ローカル対応琉大ポリ クリ方式」に取り組み、県立中部病院を含む県内の医療機関の協力も得て診療参加型実習を充実 させた。また、離島・へき地の医師不足の状況等を把握・分析し、医師のキャリア形成支援と一体 的に医師不足病院等の医師確保の支援等を行い、医師の地域偏在の解消を目的とする組織とし て地域医療支援センターを設置し地域枠学生および研修医のサポートにも当たっている。しかしな がら、ここ数年、初期研修医数の減少や新専門医制度への対応、医学教育との臨床研修の連携 など様々な問題に直面している。そのような中、平成28年に初期研修から専攻医研修、そしてコメ ディカルのキャリア支援の担当の部署として新たに総合臨床研修・教育センターとして組織の再構 築を行った。2017年10月からは専任医を配置し医学生、研修医のニーズの把握、プログラムの改 変や医学生に対する早い段階での積極的な情報提供、共通カリキュラムの充実化、研修医との定 期面談によるフィードバックなどに取り組んでいる。研修プログラムに関しては、地域枠を含め医学 生のニーズや将来のキャリアに対応するよう中部病院をはじめとする県内の研修病院とのたすきが けを含む 8 つのプログラムを整備し、マッチング者とは個々の進路に合わせたオーダーメイドロー テーションを提案、共に作成し、専攻医研修につながるキャリア形成のサポートを行っている。更に、 新しく始まった専門研修制度に対しては、当センター内の医師支援部門が各プログラムのサポート や情報発信を行い、専攻研修の充実を図っている。これらの取り組みの効果もあり、31 年度の初 期研修医のマッチングの増加につながっている。

また、指導医のサポートとしては平成16年以降、毎年RyuMIC指導医養成セミナーを開催し、これまでに530名あまりの県内の指導医の養成にも携わっている。医学生教育との連携においても、医学教育企画室と連携し、医学生/研修医指導の指導を効率よく行うためのFDを開催し、指導医のサポートにも努めている。

琉球大学医学部医学科では平成 28 年に 7 領域 49 項目からなる卒業時コンピテンスを定

めているが、今後このコンピテンスに沿って医学教育から卒後研修に至るまで継続的に行 う評価も行う予定である。

いまだ道半ばではあるが、当センターを含む本学・本院の各関係部署が県内の研修病院 や医師会、県との連携を強めオール沖縄の医学教育・臨床研修の HUB としての役目を果た すことで、医学生から研修医、専攻医に対して適切な評価に基づく教育・指導に取り組ん でいけば幸いである。

【職歴】

平成 8 年 4 月 琉球大学医学部第一内科入局

平成 9 年 7 月 豊見城中央病院勤務

平成 10 年 4 月 与論町立国民健康保険直営診療所

平成11年6月-13年6月 南フロリダ大学留学(肺炎クラミジア研究)

平成13年7月 琉球大学医学部第一内科医員

平成14年4月 沖縄県立中部病院呼吸器科

平成 15 年 4 月 琉球大学第一内科医員

平成 19 年 4 月 琉球大学医学部第一内科(感染症・呼吸器・消化器内科学) 助教

平成27年4月 琉球大学医学部附属病院第一内科講師

平成27年7月 琉球大学医学部診療准教授

平成 29 年 10 月 琉球大学医学部附属病院 総合臨床研修・教育センター特命准教授 現在に至る

【所属学会資格、学会での役割】

日本内科学会 総合内科専門医

日本呼吸器学会 専門医・指導医

肺炎診療ガイドライン 2017 システマティックレビューチーム

咳嗽・喀痰の診療ガイドライン作成委員

日本感染症学会 専門医・指導医

日本呼吸器内視鏡学会 専門医

日本結核病学会 結核・抗酸菌症認定医

医学教育学会、化学療法学会、日本呼吸ケアリハビリテーション学会

【研究歷】

平成11年6月-13年 南フロリダ大学留学(肺炎クラミジア研究)

平成17年2月 医学博士取得

【受賞】

平成29年2月 沖縄県医科学研究財団研究奨励賞

医学教育の課題とソリューション

徳田 安春 群星沖縄臨床研修センター長



群星沖縄は 15 年前に宮城征四郎先生のリーダーシップで立ち上がった研修病院アライアンスです。現在では、基幹型 8 病院、協力系病院診療所 20 施設、合計 28 医療施設からなる国内でも最大規模の研修アライアンスグループです。それぞれの研修病院の得意分野を選択できるようにしており、カスタマイズしたカリキュラムで研修できるスケールメリットを生かしたプログラムです。各病院の指導医には、沖縄県立中部病院研修出身者も多数活躍しています。

沖縄における医師養成の歴史的見地からみると、沖縄県立中部病院の出身者が新たに民間病院で立ち上げプログラムとも捉えられ、沖縄全体に沖縄県立中部病院の教育コンセプトを広げる役割を果たしています。宇宙論的にたとえるなら、ゴールト先生が立ち上げた沖縄県立中部病院プログラムがビックバンであったのに対し、宮城先生が立ち上げた群星沖縄プログラムは宇宙のインフレーションとみなせるでしょう。すなわち、救急研修と総合的な基本的臨床能力のトレーニングを中心としたプログラムとなっています。

プログラムの課題としては、1 学年約 60 人から 70 人と多数の研修医がいるために、それぞれの研修医とセンター長が個別教育として深く関わることが困難なこと、病院間にプログラム内容の差があることなどがあります。このような課題に対して、センター長と研修医をつなぐソーシャルメディア・ネットワークの構築、グループ病院の指導医群による初期研修医マニュアルの作成などの新たな取り組みを行っているところです。

医学生のからの研修応募者を増やす取り組みとして、ホームページ、研修紹介イベント、医学生 向けの勉強会、各病院による学生見学や学生実習などの活動を展開しています。専門研修に残る 研修医を増やすために、後期研修医プログラムの拡大充実、病院間後期研修医勉強会グループ の設置とそのサポート、臨床研究スキル教育プログラムの導入、研究倫理審査委員会の設置等に 取り組んでいます。働き方改革での取り組みとして、チーム医療を中心としたチームメンバーのコラ ボレーションを発足当初からの中心コンセプトにしており、研修医の業務が適切な程度となるような 工夫を各病院で行っています。 今回の講演では、群星沖縄プログラムについて上記について紹介することに加えて、医学教育の課題とそのソリューションについて、エビデンスおよびプロフェッショナリズムに基づいた私見を述べたいと思います。

【略歴】

沖縄県生まれ。1988年琉球大学卒業、沖縄県立中部病院で研修。その後、聖路加国際病院臨床 疫学センター、筑波大学水戸地域医療教育センター水戸協同病院、JCHO本部などを経て、2017 年より現職。

【施設データ】

施設規模、基幹型8病院及び協力型医療機関24施設。

研修医関連資料、初期の人数は 60 から 72、約半数は県内出身、専門医研修への残留率は約半分。

会場へのアクセス

沖縄県看護協会・看護研修センター 〒901-1105 沖縄県島尻郡南風原町字新川 272-17

