

*What foreign language skills are needed for the medical profession of the future?*

# **“Why is the Education of Foreign Language needed for Clinicians?”**

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Tetsuro Aita



# Why is the Education of Foreign Language needed for Clinicians ?



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# Why is the Education of Foreign Language needed for Clinicians ?

## Responsibilities as a clinician

- Delivering international standard medical care to the people
- Provide patients with a high level of what should certainly be offered
- Provide patient-centered medicine to patients with good

communication skills

“Continuing medical education (CME)” and

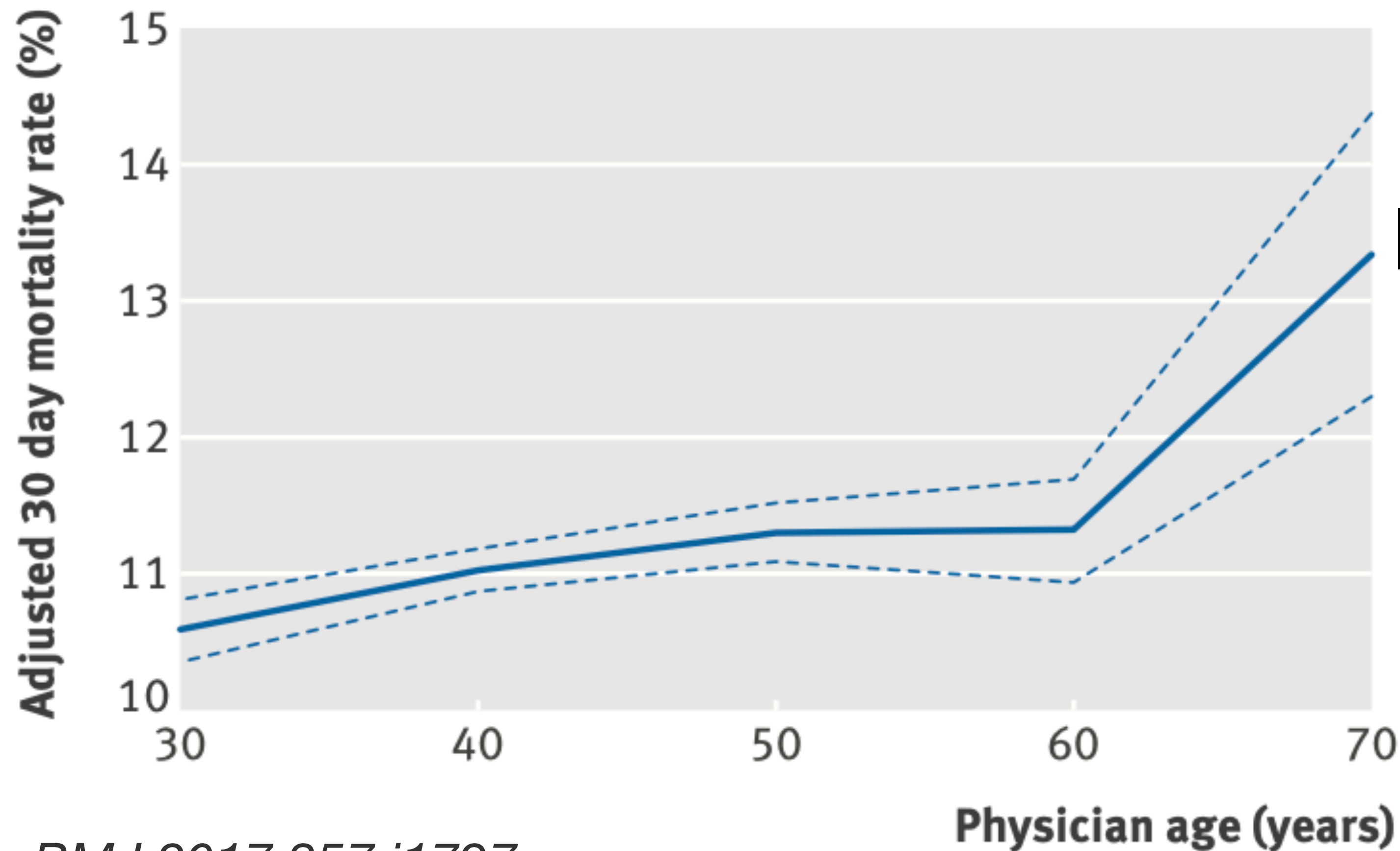
“Communication skills” are essential to practice these responsibilities.



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# Why is CME needed for Clinicians ?

Relation between the physician's age and patient mortality rate



- Clinicians need to keep learning.

*BMJ 2017;357:j1797*



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# Why is CME needed for Clinicians ?

## Medical evidence is ever-evolving.

Doubling period of evidences  
(estimation)

1950 : 50 years

1980 : 7 years

2010 : 3.5 years

2020 : 73 days

- Clinicians need to continue to study at a faster pace.

- Most of the evidence is published as English language papers.

*Trans Am Clin Climatol Assoc. 2011; 122: 48–58.*



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# Is learning foreign language necessary for CME ?

今日の臨床サポート®

すべて ▼ 検索



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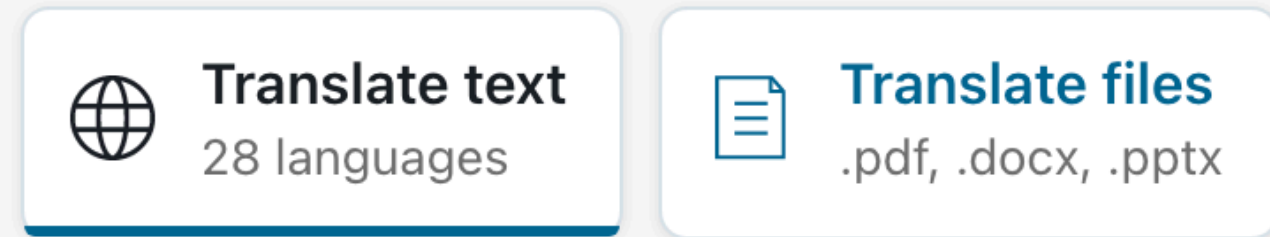


There are various contents and many good textbooks in Japanese these days.



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# Is learning foreign language necessary for CME ?



Machine translation is developing rapidly.

Grammarly, Inc.  
Software company



Linguee

English-Japanese Dictionary.  
Search 1,000,000,000 translations.

English is necessary to enhance the "quality" and "quantity" of CME!



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## Summary : Why is learning foreign language needed for Clinicians?

Foreign languages, including English, are powerful tools for clinicians to do CME with high-quality, communicate with patients smoothly, and practice medical care effectively.



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# **My experience since I realized the importance of learning English**



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# My encounter with learning English

## Medical student

- Answering in English improved my score
- Memorized medical English vocabulary
- Aimed to be passed into a program of a leading hospital to become a general internist

Started studying English because of the examination in English

None of the output training



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# Culture shock

## Residency

### Case conference

A 74 Year-Old Woman  
with generalized weakness and leg edema

PGY-2 Tetsuro Aita

- Surprised to see my seniors, peers, and juniors speak in English fluently
- Conferences, rounds in English
- Frequently discussed in English papers




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# Aiming for Breakthrough as a Clinician

## Young staff

- Prof. Hamaguchi taught me not only about medicine, but also about the fun of learning English and what I can learn from studying abroad.
- Started studying IELTS

International   
English  
Language  
Testing  
System

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# English in Medical Education •

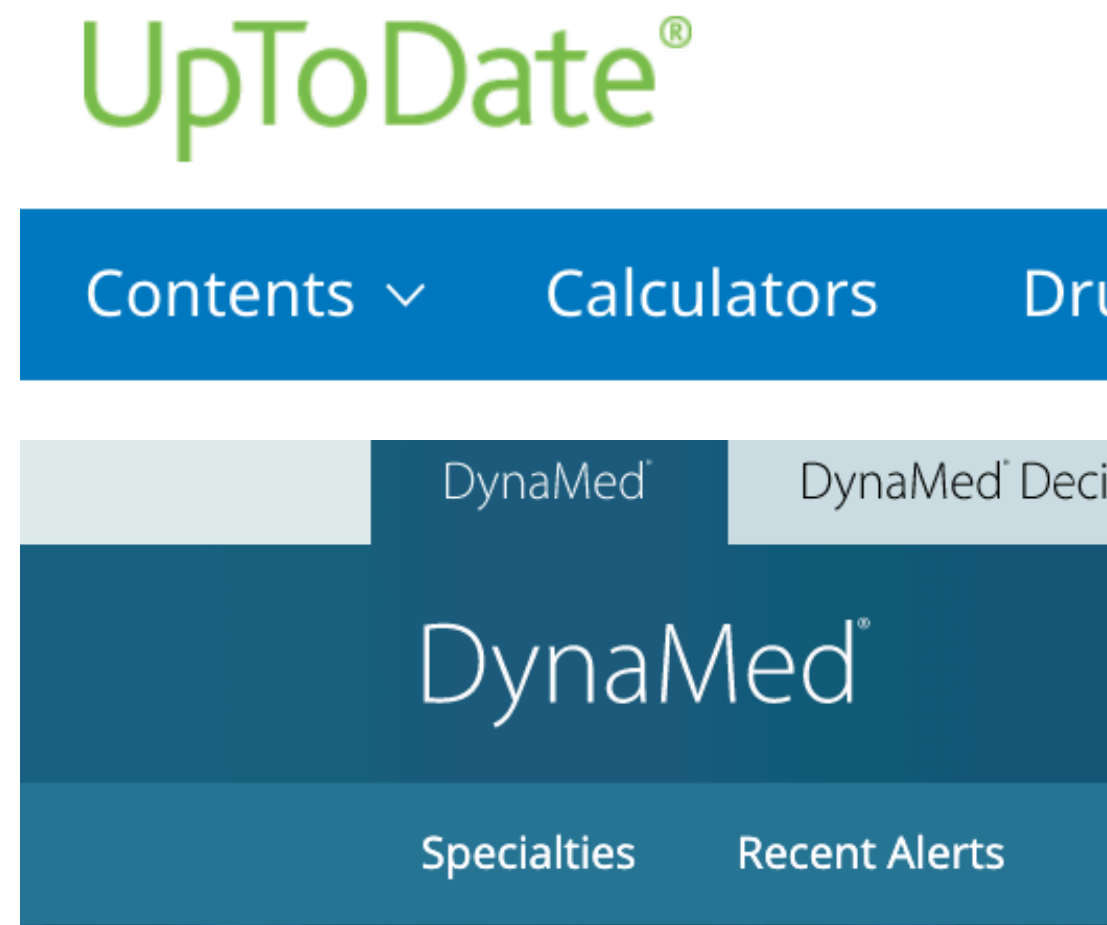
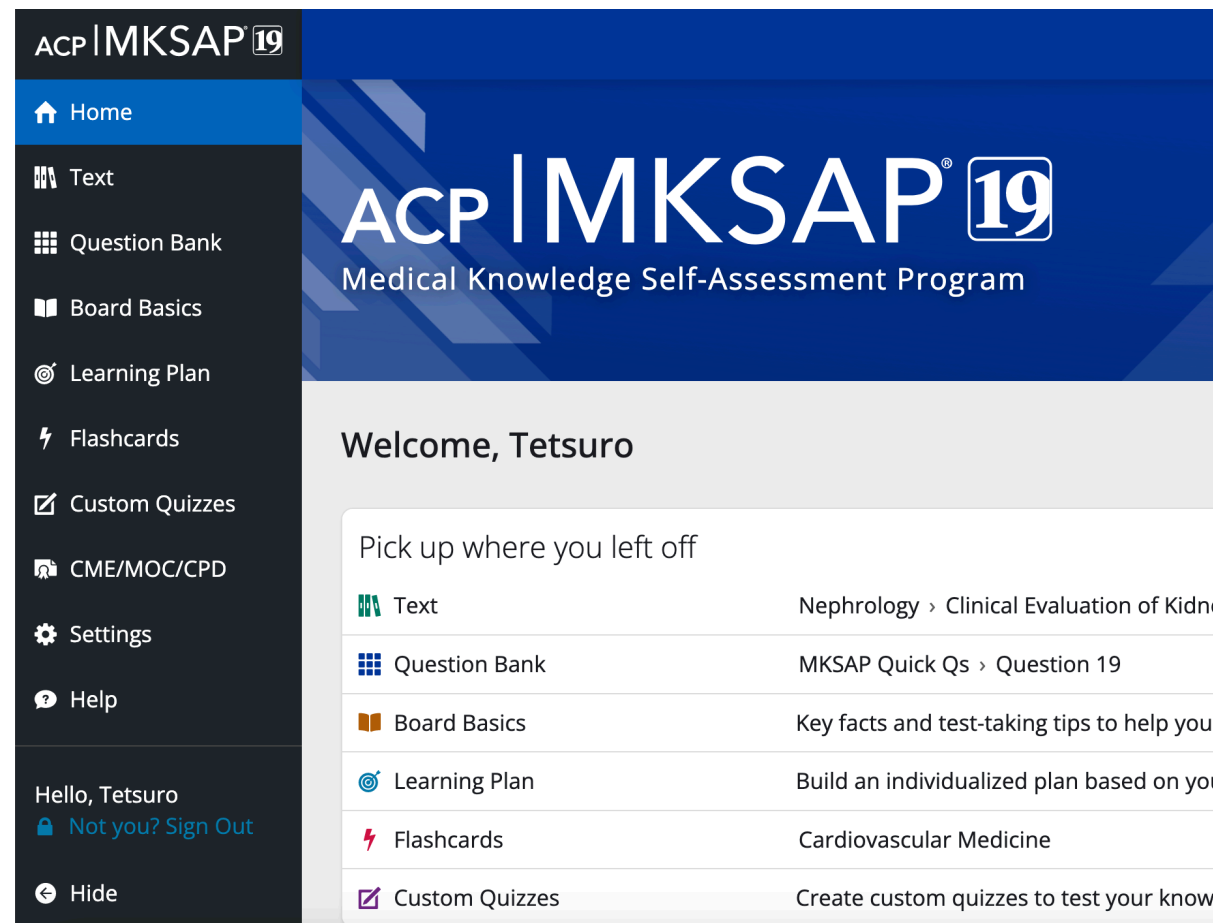
## My practice of learning English in CME



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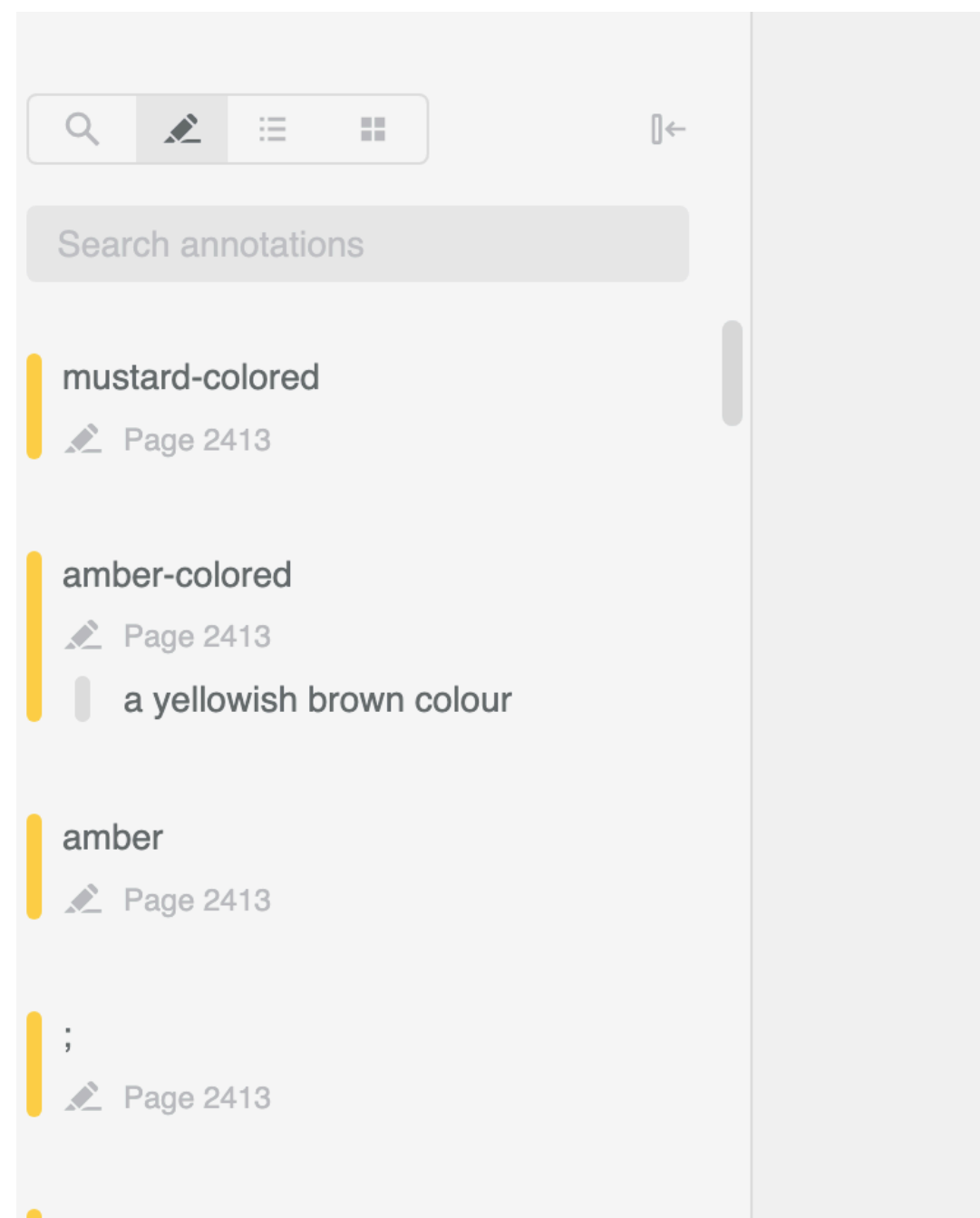
# Reading

*Journal of Medical Academics 2.2 (2019): 58-60.*



Reading skill is the basis of everything.

- Use MKSAP
- Use UpToDate, Dynamed, Google for heuristic search
- Read NEJM case records for training clinical reasoning



## CASE RECORDS of the MASSACHUSETTS GENERAL HOSPITAL

Founded by Richard C. Cabot  
Eric S. Rosenberg, M.D., Editor  
David M. Dudzinski, M.D., Meridale V. Baggett, M.D., Kathy M. Tran, M.D.,  
Dennis C. Sgroi, M.D., Jo-Anne O. Shepard, M.D., Associate Editors  
Emily K. McDonald, Tara Corpuz, Production Editors



### Case 19-2022: A 29-Year-Old Woman with Jaundice and Chronic Diarrhea

Jon S. DuBois, M.D., Avinash Kambadakone, M.D., Jennifer Y. Wo, M.D.,  
and M. Lisa Zhang, M.D.

#### PRESENTATION OF CASE

*Dr. Jon S. DuBois:* A 29-year-old woman was evaluated in the gastroenterology clinic of this hospital for the management of a soft-tissue mass in the head of the pancreas.

The patient had been well until 7 weeks before this presentation, when progressive pruritus throughout the body developed, along with nausea, bloating, and watery **mustard-colored** diarrhea. She had eaten sushi for dinner the previous night. She was evaluated in an urgent care clinic in the southeastern United States; she had recently moved there from New England. An injection of methylprednisolone was administered, and hydroxyzine and diphenoxylate-atropine were prescribed. During the next 3 weeks, the symptoms did not abate and jaundice developed, along with new discomfort in the right upper quadrant of the abdomen, decreased appetite, and **amber-colored** urine.

Four weeks before this presentation, the patient was evaluated in the emergency department of a local hospital. The alanine aminotransferase level was 327 U per

From the Departments of Medicine (J.S.D.), Radiology (A.K.), Radiation Oncology (J.Y.W.), and Pathology (M.L.Z.), Massachusetts General Hospital, and the Departments of Medicine (J.S.D.), Radiology (A.K.), Radiation Oncology (J.Y.W.), and Pathology (M.L.Z.), Harvard Medical School — both in Boston.

N Engl J Med 2022;386:2413-23.  
DOI: 10.1056/NEJMcp2201231

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CME  
at NEJM.org



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# Listening

*Journal of Medical Academics 2.2 (2019): 58-60.*



The Clinical Problem Solv...  
Updated Friday



NEJM This Week — Audio...  
Updated Wednesday



## Accelerate input by Listening

- Obtain information during my commute with podcasts



Core IM | Internal Medicin...  
Updated Wednesday



JAMA Clinical Reviews  
Updated July 15

- Harrison
- Clinical medicine (JAMA clinical review, Core IM, CURB SIDERS)



The Curbsiders Internal M...  
Updated Monday



Harrison's PodClass: Inter...  
Updated June 21

- Clinical reasoning (The Clinical Problem Solving)

- youtube



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Case report



## Idiopathic multicentric Castleman disease preceded by cutaneous plasmacytosis successfully treated by tocilizumab

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Accepted 5 October 2020

### SUMMARY

A woman aged 45 years with a 1.5-year history of violaceous plaques on the forehead and chest presented with fever, weight loss and aggravation of the plaques. Inflammatory markers and interleukin-6 level were elevated, and superficial lymphadenopathies and splenomegaly were identified by CT scan. Immunohistochemical findings of the lymph node and the skin showed polyclonal plasmacytosis and follicular hyperplasia, leading to the diagnosis of idiopathic multicentric Castleman disease (iMCD) after human herpesvirus-8 infection was excluded. The patient was successfully treated with anti-interleukin-6 receptor antibody, tocilizumab, following relapse after prednisolone therapy. Our literature review found 11 case reports of pathologically confirmed iMCD preceded by cutaneous plasmacytosis. The median duration of asymptomatic phase with only skin lesions was 7.5 years, whereas the phase lasted only for 1.5 years in our case. iMCD can develop shortly after asymptomatic cutaneous plasmacytosis. Tocilizumab can be a treatment of choice for this type of iMCD.

### BACKGROUND

Multicentric Castleman disease (MCD) is a polyclonal lymphoproliferative disorder characterised by multiple lymphadenopathies with systemic inflammatory symptoms. The disease is classified according to the presence or absence of human herpesvirus-8 (HHV-8) infection: MCD for the presence and idiopathic MCD (iMCD) for the absence.<sup>1,2</sup>

Although it is rare, skin manifestation such as violaceous plaques can be associated with iMCD, and such associated cases have been mostly reported from Asian countries with a histopathological finding of cutaneous plasmacytosis.<sup>3</sup>

Long-term asymptomatic phase with only cutaneous manifestations before the development of systemic inflammatory symptoms of iMCD has been reported in a small number of cases. Furthermore, the role of tocilizumab for the treatment of iMCD with cutaneous manifestations still remains empirical. Accumulation of cases is required to elucidate characteristics and natural history of iMCD.

We here report a rare case of iMCD along with literature review.

### CASE PRESENTATION

A 45-year-old woman was referred from the dermatology department of our hospital because of fever, weight loss and general malaise of 1-month duration. One and a half years previously, she noticed multiple small violaceous plaques on her forehead and chest. The plaques were neither painful nor pruritic. Half a year later, the plaques became more violaceous, increased in number and spread to the abdomen. Skin biopsy of the plaque showed infiltration of lymphocytes and plasma cells, and immunohistochemical study excluded malignant lymphoma. She was treated with topical steroid and phototherapy by excimer light, which did not improve the plaques.

About 1 month before the referral, she developed a low-grade fever and general malaise. The fever occasionally worsened to a high-grade fever 1 week previously and she lost 5 kg of body weight in 1 month.

On physical examination, the body temperature was 37.1°C. There were 5–10 mm violaceous plaques on the forehead, chest, abdomen, back and extremities (figure 1). Painful lymph nodes of 1–2 cm in diameter were palpable in the cervical, axillar and inguinal regions. The remainder of the physical examination was unremarkable.

### INVESTIGATIONS

Laboratory results were significant for anaemia (haemoglobin 86 g/L), elevated liver enzymes (alkaline phosphatase: 605 IU, aspartate transaminase: 318 IU and alanine transaminase: 346 IU), polyclonal hypergammaglobulinaemia (immunoglobulin G (IgG): 3515 mg/dL, IgA: 393 mg/dL and IgM: 370 mg/dL), high inflammatory markers (C reactive protein: 12.6 mg/dL and erythrocyte sedimentation rate 65 mm/hour) and elevated interleukin-6 (IL-6: 111 pg/mL; normal range: <5 pg/mL). Serum IgG subclass 4 concentration and Ig κ/λ free light chain ratio were normal. Tests for HIV and PCR for HHV-8 were negative. Antinuclear antibody, rheumatoid factor and anti-Ro/SSA and anti-La/SSB antibodies were all negative.

CT with contrast enhancement revealed multiple swollen superficial lymph nodes of 1 to 2 cm in diameter and splenomegaly. Positron emission tomography CT (PET-CT) showed increased uptake in the cervical, axillary and inguinal lymph nodes, the sternum, the vertebrae and the pelvic bone (figure 2).

# Output training in writing

## Case report

- Report on cases experienced as a clinician



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## Blood Culture Procedures in a Busy Emergency Room: Balancing or Biasing Groups During Randomization

TO THE EDITOR—We read with great interest the article recently published by Zimmerman et al, “Modification of Blood Test Draw Order to Reduce Blood Culture Contamination: A Randomized Clinical Trial” [1]. This article demonstrated reduced contamination during blood draws by using a sterile, nonculture tube before using a culture bottle, compared to using them in a converse order, because the blood in a venipuncture needle’s tip can hold deep-seated skin bacteria even when using a sterile technique. The authors performed a post hoc analysis using a subgroup and showed no baseline differences because there were differences in patient background characteristics between the 2 groups despite randomization. The control group patients were significantly older, more likely to be transferred from chronic care facilities, and more frequently admitted to the intensive care unit than those in the intervention group. We would like to make 2 suggestions for avoiding possible bias and for better randomization.

First, there is a possibility of selection bias due to inadequate allocation concealment during randomization. Although it is recommended that researchers use sequentially numbered, opaque, sealed envelopes for allocation concealment [2], the method adopted in this study may not have been as random because the authors described only “sealed identical envelopes chosen randomly by the phlebotomist.” Conventional techniques may be preferred to new and unfamiliar techniques in a busy emergency room. Envelopes with imperfect opacity or no sequential numbers can lead to manipulation by holding them against a light source or opening many envelopes until one finds the conventional technique [3]. Therefore, the allocation can be intentionally impaired, depending on the patient’s conditions or circumstances. Proper concealment methods should, therefore, be described in this study.

Second, there is another possibility of selection bias due to a lack of central randomization. On opening the envelope, the phlebotomist would have known which procedure is to be performed before attempting skin sterilization for a venipuncture, possibly leading to manipulation of the sterilization procedure. Central randomization can minimize selection bias [3]. If a third party opens the envelope and indicates the procedure, following sterilization by phlebotomists, then such selection bias can be prevented.

We believe that preventing these selection biases will reduce unexpected differences in background characteristics between the 2 groups after randomization in this study. We hope that our suggestions will lead to better randomized controlled trials with adequate allocation to address this important challenge in reducing blood culture contamination.

### Note

**Potential conflicts of interest.** The authors: No reported conflicts of interest. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest.

Tetsuro Aita,<sup>1,2</sup> Sugihiro Hamaguchi,<sup>1</sup>  
Hiroaki Nakagawa,<sup>1</sup> Sei Takahashi,<sup>1,2</sup>

## Letter

- Communicate with clinicians around the world through papers
- Glad to get a good response from authors



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## Speaking is important for communication

- Difficult to communicate our thoughts and feelings if we cannot speak English
- Be able to learn speaking through online English conversation services



# Speaking ~Clinical~



- See many foreign patients in Okinawa
  - Naval hospital is located in Okinawa.
  - Tourists exceeded 10 million in H30.

- See foreign patients in Fukushima
  - technical internship

○監修・協力：沖縄県立中部病院 感染症内科（医師） 高山 義浩 氏

○執筆：沖縄県立宮古病院 国際診療室 池原 啓介 氏

（執筆部分：「外国人患者を安心・安全に受入れるために知っておきたいこと」）

沖縄県立中部病院 感染症内科（医師） 横山 周平 氏

（執筆部分：「感染症が疑われる患者が受診した場合の留意点」）

有限会社くすりのミドリ・ミドリ薬局 代表取締役（薬剤師） 玉城 武範 氏

（執筆部分：「外国人患者を安心・安全に受入れるために知っておきたいこと（保険薬局編）」、  
「外国人患者対応会話集（保険薬局編）」の一部を加筆）



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# Speaking ~Academic~

My first conference presentation at PGY2

~Gaining the best presentation award in Asia at PGY10



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Faculty of Medicine COVID-19 response

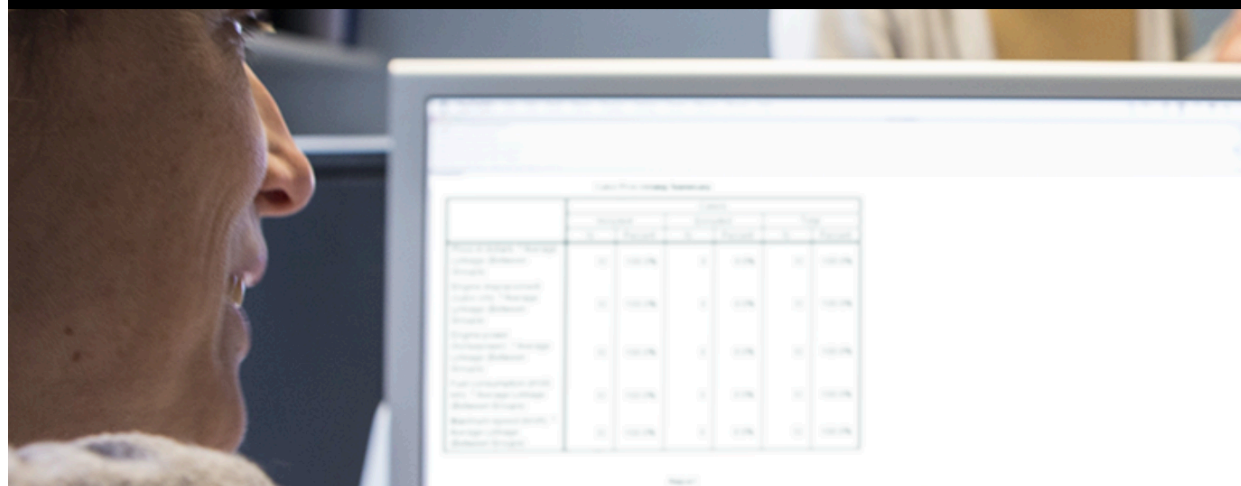
## MSc Patient Safety



Utrecht University

### Masters

Master's programmes Compare Master's programmes General information



Epidemiology



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# My idea of Undergraduate English education

- Symptomatology classes partially taught in English
  - Familiarize themselves with the medical vocabulary through looking up evidences using UpToDate etc.
  - Examinations partly in English (similar to USMLE or MKSAP)
  - Increase the score of examinations when answering in English
- medical terms
- Provides opportunities to give presentations in English
  - Conveying the joy of learning English



# Take home message

- English is the powerful tool for clinicians to do CME with high-quality, communicate with patients smoothly, and practice medical care effectively.
- Learning "English" makes "medical practice" more enjoyable and allows for self-improvement!

