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日本の内科学の過去、現在と将来

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Past, Present and Future of Internal Medicine in Japan

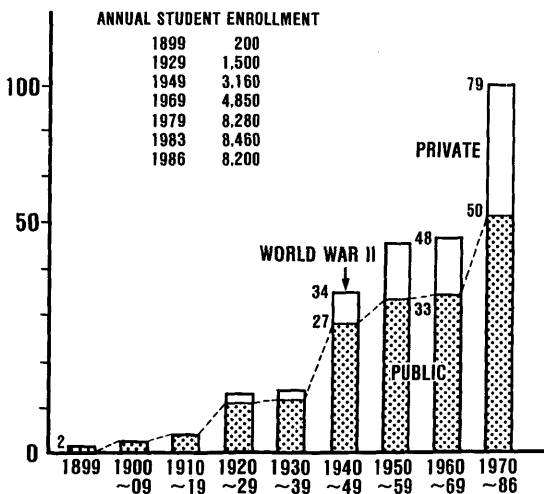
Shigeaki Hinohara, H.D.

I would like to briefly describe the history and current situation of internal medicine in Japan and also my personal views on its future prospects.

Western medicine was first introduced to Japan in 1555 by a Portuguese missionary doctor, which was followed by introduction of Dutch medicine shortly after. In 1877 Tokyo Imperial University Faculty of Medicine was established with a few German doctors who were invited by the Government. The Japanese Society of Internal Medicine was established in 1903. So it has a history of 84 years but it is still 16 years younger than its Italian counterpart who has a history of 100 years.

Today, there are 79 medical schools in Japan. (Fig.1) Shortage of physicians after the World War II prompted rapid increase of medical schools, and as a result by 1970 there were 48 schools and it reached 79 by the end of 1970s.

Fig 1
Number of Private And Public Medical Schools in Japan and Annual Student Enrollment



In 1986, there were altogether 8,600 students who were admitted to these medical schools. The Ministry of Health and Welfare estimated that if the number continued to increase at the present rate it would bound to have over supply of physicians. Therefore the Ministry has proposed to reduce the number of annual enrollment by at least 10 % by 1955. According to the calculation by the Ministry the number of physicians will continue to increase and reach 282,000 (220/100,000 population) in the year 2000 or 412,000 (348/100,000) in 2035. (Fig.2)

Now I would like to briefly refer to the graduate education in Japan. The medical school graduates obtain licence when they pass the examination given by the National Board of Medical Licensure. But in order to qualify for medical practice they must have at least two years graduate training, which is offered either by university hospitals or by one of

217 teaching hospitals accredited by the government.

Among the training curricula, 34% are straight programs, 42% are straight programs with elective, and 24% are rotating programs, (Fig.3) In Japan clinical medicine is roughly divided into 14 specialties. In some larger hospitals you will normally find 9 subspecialties under internal medicine, and neurology, geriatrics and psychosomatic medicine are likely to exist as independent sections. Nearly one third of the graduates receive their graduate clinical training in internal medicine (Fig.4), but their two-year clinical training tend to be

Fig 2 Estimated Number of Physicians in JAPAN

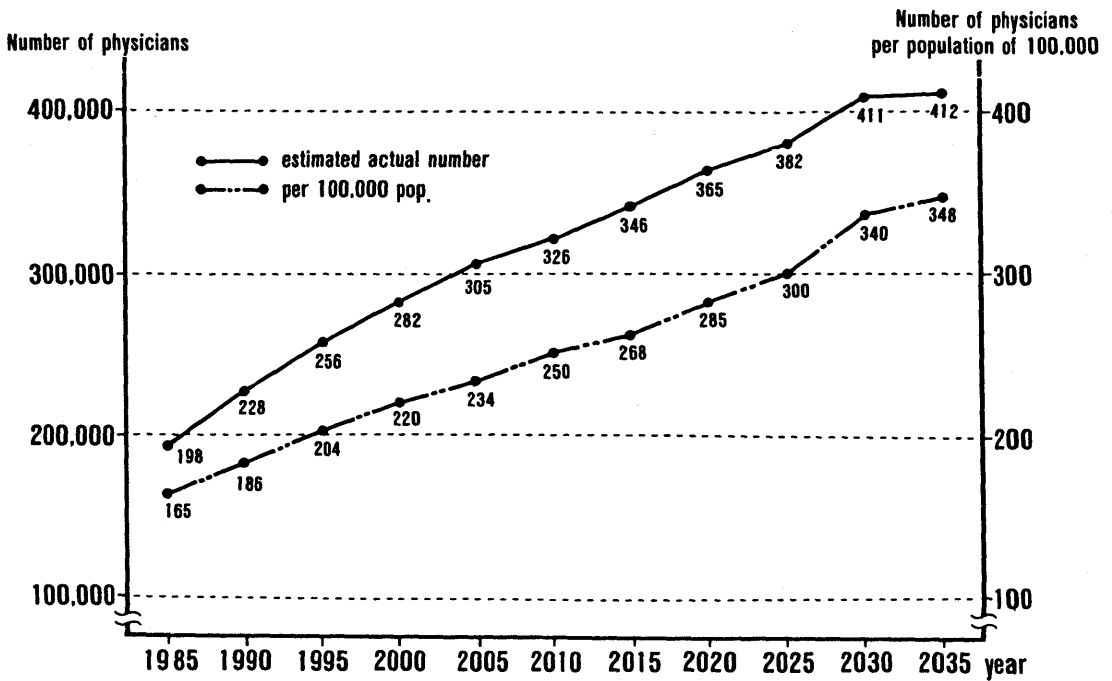


Fig 3 Classification of Clinical Training Programs

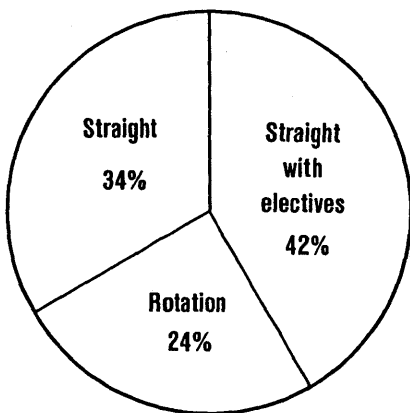
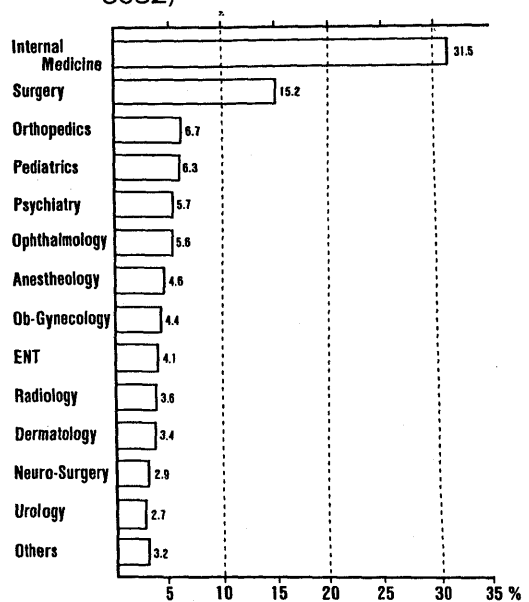


Fig 4 Number of Trainee Physicians by Specialties (Registration 1986-Total Number Registered: 8082)



limited to one or the other of its subspecialties, such as cardiology, hematology, gastroenterology, and so forth and they scarcely have chances to learn internal medicine on a more broader perspective. They can be subspecialists but they cannot be broad based internists as such.

If their graduate training is based on 'rotation program' whereby they are trained on various subspecialties of internal medicine as well as other disciplines of clinical medicine. They will be given a broader background

on internal medicine and will be better qualified as primary care physicians even after they have mastered one or the other of the subspecialties during their two year graduated clinical training.

Nowadays young physicians are very much attracted to specialty training, but the Ministry of Health and Welfare and Ministry of Education both feel it essential that the trained doctors receive more comprehensive clinical training and master broad-based clinical medicine. So they advise the training hospitals to build the curriculum so as not to produce narrow-based physicians. However, the feeling of opposition persistent among the medical academism is something to be surmounted if we want the internists to receive high level and broad-based medical training and serve the public for their primary health care. The Specialty Board of Internal Medicine which was started in 1973, plans to introduce some revision to its Board Exam in the near future putting more emphasis on primary health care aspect, in a hope that more internists will qualify for Board Certification.

The inauguration of the Japanese Society of Internal Medicine dates back to 1903, some 84 years ago, and today the Society has a membership of 29, 763. For the past 84 years the Society has always organized academic sessions during its annual meeting. The Society has several local chapters and these chapters hold their own meetings locally, where various papers, mainly case reports, are presented. The Society publishes its journal in Japanese. It also has an English edition quarterly which are distributed to 34 countries in the world.

Finally I would like to refer briefly to my view concerning the future direction of Japanese medicine. One of the problems that we are facing is that graduate education in internal medicine is too specialty oriented and lacks a program which provides the trainee physicians with more comprehensive training on various subspecialties of internal medicine.

I am of the opinion that we should have an independent discipline for General Internal Medicine in medical schools as they do in the United States. So-called Integrated Clinical Medicine that is now offered at five medical schools on trial basis could correspond to that. In General Internal Medicine they deal with primary care of adults as well as the elderly and studies wide range of internal medicine covering its 9 subspecialties. In addition they are expected to cover such fields as medical epidemiology, infectious diseases, bioethics, clinical decision analysis, medical economics and health education. General practitioners or family physicians or anyone practicing clinical internal medicine should be trained in General Internal Medicine. It will probably require at least three to five years for this training as it is the case in any other subspecialties of internal medicine. The important thing is that in the actual practice of internal medicine these generalists will work in team with other subspecialists, and furthermore work as consultants to the physicians and surgeons of other disciplines.

I would hope that these general internal medicine specialists with advanced training will take the leadership in development of internal medicine in future and thus contribute toward health promotion and disease prevention of people and also toward advancement of curative medicine.

日本の内科学の過去、現在と将来

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日本の内科学の発達の歴史と現状を述べ、将来への展望についての私見を述べる。

日本に欧州の医学が初めてポルトガルの伝道医師によって紹介されたのは1555年である。次いでオランダ医学が輸入され、1877年(明治10年)にはドイツの医師を招き、東京帝国大学医学部が開設された。1899年(明治32年)には京都に京都帝国大学に医学部がつくられた。日本内科学会が発足したのは、1903年(明治36年)で、以来今日まで84年の歴史を重ねたが、100年の歴史をもつイタリアに比して、16年若いと言えよう。

今日、日本には79の医科大学があり、これとは別に、防衛大学医学校がある。第二次世界大戦後、医師不足から医学校が増設され、1970年までは医科大学は総数48校であったが、1970台年末までには今日の79校を算し、1986年の入学者は8,200名である。厚生省は、現在の新規入学定員のままでいくと、医師数過剰になるとの見解から1995年(昭和70年)を目標に、新規参入医師数を最小限10%削減させることを提案している。(図1)

これによると、図2のごとき数にて医師数は増加し、2000年は医師総数282,000(220人/人口10万)、2035年には412,000(348/人口10万)となる計算である。

さて、医学校を卒業する者はどのような卒後教育を受けているかを概述しよう。

日本では卒業直後に医師国家試験を受けて合格したものが臨床医学を実際に行うには少なくとも2年以上の研修が要求される。卒後2年間の臨床研修は大学病院または政府(厚生省)により指定された217(1987年度)の臨床研修指定病院で行なわれるが、研修医師の76%は大学病院にて研修をうけ、24%の者が大学外の教育病院でなされている。このことは医師の卒業研修は大学病院での研修カリキュラムの内容により強く左右されることを示す。

尚、研修カリキュラムは、ストレート・プログラム

が34%、選択ストレート・プログラムが42%、ローテーション・プログラムが24%である。日本では医学は大きく14の分科にわかれているが、内科は大きな医療機関では9つの専門分科にわかれ、内科とは別に、神経内科、心身医学が独立して施設がある。内科医になるには、卒後の約三分の一(31.5%)は内科の領域で卒後研修を受けるが、これらのものの多くは、卒後内科学を幅広く学ぶことが少なく、循環器学、血液学、消化器学、などの専門分科にて2年の研修をうけ、狭い基礎の専門科のみを修得するものが多く、したがって、かれらは専門家になっても、広い基礎に根ざした内科医とはなり難い。

卒後の研修にローテーション・プログラムで内科の各領域や内科以外の臨床医学の研修を受けておれば、2年の研修後に何科の専門を標榜しても、内科の幅の広い基礎があるので、プライマリケア医師になるには適している。

日本では今日若い医師は専門志向であり過ぎるので、厚生省や文部省では、卒後はしばらくは幅広い臨床研修をまづ受けて、幅広い臨床医学をマスターすることが奨励され、卒後の教育病院での教育が幅の狭い基礎にならないような指導が勧められている。しかし、このような卒後の臨床研修システムに対して医科大学側アカデミズムの反発的な態度が依然とられていることが問題である。日本の住民のためには幅の広い内科医がもっとベル高く教育されて、国民のプライマリケアを担当することが望まれる次第である。

日本では内科の専門医制度の発足が遅れ、この制度をはじめたのは14年前の1973年以後のことである。この内科専門医制試験は日本内科学会の中の委員会によってなされるが現在この試験は、二種類に分けられている。一つは卒後3年間の指定病院で研修を受けたものは、パート1の筆記試験が受けられる。さらに2年または3年の臨床経験を重ねたものは高級の内科専門の試験(multiple choice of the tests and problem management tests)を受けることができる。

ただこの試験は非常に難しいので、この資格を受けたものは700名にすぎない、日本には現在22の専門医

(イタリア内科学会百周年記念総会にて発表(1987, 10, 20))

制度があるが、これらの分野では、それぞれの専門医制試験が行なわれている。日本内科学会の今日までの試験は近い将来、よりプライマリケア的な内容の試験を多くして、多くの内科医に内科専門医の資格をとってもらいたく、専門委員会のもとに目下その内容の改案が検討中である。

さて、日本内科学会の発足は、1903年にさか上はるが、これは今日29,763名の医師が会員となっている。

この日本内科学会は過去84年間毎年総会に学術総会をもち、またこのほかに数カ所の地方会があって、それぞれで地方会がもたれ、症例を中心とする発表がなされている。これとは別に1973年より「内科学の展望」について一年1回のシンポジウムが行なわれている。

この内科学会は、日本語の月刊雑誌を発行するとともに、英語版の雑誌が季刊で出版され、世界の34カ国に届けられている。

最後に将来の日本の内科学の方向について私見を述べよう。

日本では内科の卒後教育が専門科志向のものが多く、内科の各専門を幅広く研修するプログラムに欠けていることが問題である。

私は日本の将来医学校の中に一般内科 (General

Internal Medicine: GIM) がアメリカ同様に日本でもうち立てられることが必要と思う。今日、日本にはこれに準じる分野としては、総合臨床科と呼ばれるものが全国の医学校の中に5カ所実験的に開設されている。一般内科は成人や老人の人々のプライマリケアをも扱うが、これは、9つの専門にわたって幅広く内科の分野を学習すると共に心身医学、行動医学、疫学、感染、生命倫理、臨床問題分析、経済学、健康教育などの幅広い領域を包含することが望まれる。

内科の臨床を行う実地医家 (general practitioners) また、家庭医と呼ばれる医師は、このような一般内科 (GIM) を修得することが必要であり、これは卒後少なくとも3~5年間の他の専門分科と同様研修を必要とするものと思う。

これらの内科の generalists が内科の専門家とチームをなして、診療し、また他の領域の医師や外科医のためのコンサルタントとなって働くことが要請される。このようなレベルの高い一般内科専門医が、将来の内科学の重要な担手となり、また内科学を発展させ、人々の保健、予防医学や健康増進並びに治療医学に貢献することが期待されるのである。

Integration of New Preventive Medicine Programs Into the Community and Home

Shigeaki Hinohara, M.D.

Tuberculosis had long been the largest cause of death in Japan ever since the pre World War II period, and this led to amendment of Tuberculosis Prevention Act in 1951 and subsequent introduction of mass survey of chest X-ray to the whole population. As the result early diagnosis of tuberculosis was made possible and B.C.G. vaccination was given to those who were negative to tuberculin test. These compulsory T.B. control measures proved very effective that death by tuberculosis declined rapidly after 1950's and it was soon replaced by cerebrovascular accidents (CVA) as the top cause of death in Japan.

In order to cope with this change the Government of Japan launched in 1957 a campaign for annual health checkup for early detection and treatment of chronic diseases such as hypertension, heart diseases and diabetes mellitus which average adult population are apt to develop. In the campaign the special emphasis was given to the importance of blood pressure measurement and control.

Until 10 years ago daily intake of NaCl by the Japanese averaged more than 15g. It was therefore recommended to change it to low-NaCl diet of less than 10g per day in order to control hypertension. Along with reducing NaCl in diet, protein intake was encouraged to those who were on insufficient protein diet. These changes in dietary habit together with blood pressure control contributed toward significant reduction of death from cerebrovascular accidents. In 1981 cancer became the largest cause of death while cerebrovascular accidents came in second. And since 1985 cancer occupies the first place, heart diseases the second and cerebrovascular accidents come in for the third place. According to the government statistics the average life expectancy at birth of the Japanese reached 75.23 years for male and 80.93 years for female in 1986, being one of the longest in the world.

Japan has successfully managed to control tuberculosis and other contagious diseases. Instead, heart diseases and cerebrovascular diseases have now become the major causes of death, and they are known to be caused by some risk factors rooted in our dietary and other habits. In the past, strong government leadership contributed to control contagious diseases. Today, medical experts stress that cerebrovascular accidents, heart diseases, diabetes mellitus or cancers can be overcome if the general public become aware and commit themselves to change their dietary habits and other habits such as smoking tobacco and drinking alcohol. This is the primary prevention. Recently more and more people have come to realize that if this primary prevention is combined with the secondary prevention, e.i. regular health checkup followed by early diagnosis before any symptoms develop, then it will become an effective tool to prevent chronic diseases of adults.

Since the revision of Tuberculosis Prevention Act in 1951 it has become customary for every Japanese to have indirect chest X-ray test for early detection of tuberculosis. In addition, as a measure to detect hypertension and other chronic diseases mass health survey was introduced when the Adult Sickness Prevention Act took effect in 1965. However, in order for people to enjoy higher level of health all through their long life span without illnesses, it is high time that mass health screening test that been in the mainstream of public health system gave way to the primary prevention of adults' chronic disease.

Ten years ago I started a health campaign trial in three selected areas in Japan, in which I encouraged the