<1. Ikuno>

Thank you very much. My name is Ikuno from the Center for the Promotion of Internationalization in Medical Education. I just started working at this center about a year ago, so I'm still relatively inexperienced and feel a bit humbled. However, before we begin today's meeting, I would like to give you an overview of our university's curriculum, focusing on the role of our center.

Today's presentation will proceed in this order: I will first explain the overall structure and flow, then provide an overview of the subject groups, and finally, discuss the areas our center mainly manages or is responsible for. Let me start with the position of the curriculum. The curriculum is one element within the educational program, and it refers to the educational process.

Kyoto University's Faculty of Medicine has set forth the following vision and goals, and based on this, it has established eight learning outcomes that students should achieve by the time they graduate. From this, the university has formulated the three main policies: the admission policy, the curriculum policy, and the diploma policy. One of these is the curriculum policy, and the curriculum is structured based on it.

The six-year curriculum structure from the perspective of faculty is shown on this course tree, which is displayed on the web. At Kyoto University's Faculty of Medicine, the curriculum has long been composed of a combination of level-based subjects such as anatomy and biochemistry, along with system-based subjects that focus on organ diseases. Rather than being organized by clinical departments or labs, multiple faculty members from various departments participate in teaching the subjects as needed.

This simplified curriculum map shows content almost identical to the course tree. Progress checks are conducted in all years, and I feel that these checks have become a bit more detailed compared to when I was a student 20 years ago.

Additionally, in recent years, there has been an increasing emphasis in medical education on professionalism, behavioral sciences, and the importance of vertically integrated subjects that span from admission to graduation. From this perspective, Kyoto University's Faculty of Medicine places great importance on cultivating a holistic and integrated viewpoint and ensuring continuity.

In the first year, students are exposed to practical experiences early on. In the second year, we provide opportunities for them to meet role models through career interviews. In the third and fourth years, they study human behavior scientifically from a behavioral science perspective, building on these experiences. In the fifth and sixth years, clinical clerkships take place, during which students engage in clinical clerkship reviews and participate in group work.

Since last year, a behavioral science working group has been organized, and efforts are being made to improve this continuous educational system. Up to this point, I have explained the curriculum from the faculty and institutional perspective, but I would also like to share how the students perceive it.

This is an excerpt from a freshman seminar document created by students for their juniors. For example, although the faculty allows students to take general education subjects during their second and third years, it's clear that students feel that general education should be completed during the first year.

Next, I will provide an overview of each curriculum component. Regarding general education subjects, the medical school places importance on accumulating a broad foundation. The general education guide, which is common across faculties, states in red that it is crucial to be aware of one's own expertise within the broader context and history, in order to demonstrate specialized abilities.

From the students' perspective, the illustration shows general education. The conversation mainly revolves around the difficulty of earning credits. During my time, easier subjects were referred to as "investment subjects," but nowadays, they are called "disappointments." Now, I'll discuss specialized subjects.

According to the curriculum policy, the structure consists of core, basic, advanced basic, and system subjects. From the students' perspective, they generally distinguish between basic and clinical subjects rather than focusing on whether they are advanced or basic. This is how the curriculum has been organized. Here, I would like to introduce the pre-course program, formerly known as the independent research period, which is implemented in the fourth year. The

mandatory period is 8 weeks, and those who wish can be assigned to a research lab for 12 weeks, including the summer vacation.

As you can see here, a wide range of options is offered, including basic, clinical, and cooperative departments. Moreover, some students take this opportunity to develop their own overseas study experiences. Next, let me explain clinical training. There is a growing emphasis on making clinical training more than just observation.

As some of you may already know, in the field of medical education, the term "Policlinic" has come to signify an observational form of training. Therefore, the term "Clinical Clerkship," abbreviated as "CliC," is becoming more common. Now, let me talk about clinical training from the students' perspective.

Students are well aware that after learning from the core clinical departments, they will undertake elective training. Moreover, they use their spring and summer vacations to visit hospitals and prepare for matching. At Kyoto University, the start and end of clinical training are slightly later than at other universities, meaning that preparation for postgraduate programs and the national examination begins after October.

The elective clinical training period lasts 14 weeks, during which students can choose from the list of clinical departments provided by the university. They also have the option to conduct research activities during this period. Additionally, students can negotiate with institutions to develop their own overseas clinical training programs.

In the curriculum, I would like to explain the subjects managed by our center. Although the term "managed" refers to our university's responsibility, the actual teaching and educational opportunities are provided primarily by the faculty at the clinical sites. Early exposure practice is a mandatory part of the first-year curriculum, and it began about 10 years ago in 2013.

This practice focuses on three key pillars: understanding the role of healthcare professionals, understanding interdisciplinary collaboration in healthcare, and understanding healthcare from the patient's perspective. It is conducted in collaboration with other faculties to promote interdisciplinary education. Here is the flow of early exposure practice. Two pre-guidance sessions are conducted, followed by a survey of students' preferences, and pre-learning is completed.

This year, students will spend three days at clinical sites as part of this practice. Finally, a joint workshop is held with participants from the Faculty of Medicine, the Department of Human Health Sciences, the Faculty of Pharmaceutical Sciences, and the Department of Pharmacy to share their learning experiences. The early exposure practice is also conducted for second-year students. Although this practice takes place at clinical sites, it mainly focuses on career interviews, with the goal of meeting role models and considering one's own career path.

This is the flow of early exposure practice for second-year students. After the pre-guidance session, students engage in career history interviews and site visits. There is no collective review session for the early exposure practice, and students are evaluated based on their submitted reports. The Clinical Training Introduction Course is conducted before clinical training in the fourth year.

The course is divided into two parts. The first part largely focuses on OSCE (Objective Structured Clinical Examination) preparation. Last year's OSCE was the first year it was conducted under new public health regulations, and there was concern that about one-third of the students might fail based on previous results.

Fortunately, the students worked hard, and all of them successfully passed. The current fifth-year students are from this class, and we hope to see the results of their efforts reflected in the clinical training. After completing the pre-clinical training OSCE, the students then learn various skills and knowledge in preparation for clinical training.

In clinical training, our center is responsible for the comprehensive general practice and community healthcare training. Of course, the actual training takes place at the clinical facilities, and we are responsible for the management of the placements and the final day's review.

Students gain valuable experience by participating in these practical elements, which are difficult to acquire at university hospitals. During the review session, students naturally presented topics involving interprofessional collaboration and sociological perspectives.

Many students also presented about how their views on gastric tubes and life-sustaining treatments changed significantly after completing the training. The clinical training review consists of a mid-term review during the clinical training and a final review after the training. The mid-term review also provides an opportunity for students to reflect on their career paths, for example, through "Meet the Seniors" sessions.

The final review includes clinical ethics workshops and graduation presentations based on actual case studies. In this way, our center has continuous contact with students from the first year through to graduation, focusing on the clinical aspects of their education. This is all thanks to the cooperation of the faculty.

As clinical experience becomes increasingly emphasized, we understand that this imposes some burdens on the faculty. However, when I hear from students, I feel that they are gaining more from these experiences than students did 20 years ago when I was in their place.

Thank you very much for your continued support. That concludes my presentation. Thank you for your attention.

＜2. Dr.Fukuoka＞

First, I would like to ask Dr. Toshio Fukuoka to present.

This is Fukuoka from Kurashiki Central Hospital. I would like to thank everyone for their continued support. Our hospital has been engaged in various initiatives, and although I have now largely stepped away from clinical duties in my role as vice chairperson, overseeing human resource development across the entire hospital, I would like to speak today based on the work we have done over the past 16 or 17 years since I joined the hospital in 2006.

Back then, the students and even those around them were often treated more like guests, and I was asked by the former hospital director and vice president to do something about that. So, I have worked on various initiatives. Today, I would like to discuss the state of student acceptance across the hospital, changes in the students and junior doctors we observe in the field, and how I have tried to ensure that the clinical staff feel less burdened by student training while still delivering services that allow students and junior doctors to give us good feedback.

Looking at our student training from last year, in fact, Kyoto University was not the largest source of our students; Kansai Medical University sent the most. We also had students from Tokushima University, Okayama University, and other institutions. In addition, we accept internships, referred to as clerkships, which students apply for individually. Last year, we hosted 71 students across 16 clinical departments.

Last year, for the first time, we also received a request from Australia for a hospital internship, and we hosted one student. Besides Kyoto University's early practical training program, we also received students from the Okayama Prefecture Medical Association's newly launched internship program for female students, and we accepted approximately 150 to 180 students for hospital visits and internships overall.

When I was appointed as the person in charge of education in 2006, I had to manage not only the goals but also the complaints, as I was the contact point for those as well. My priority was to ensure that the faculty were able to engage with education without feeling burdened and to encourage them to actively participate in student training.

Back then, many of the department heads and supervising doctors were not familiar with the concept of modern medical education, and I realized that this was something I needed to address. Many of these doctors had not had much opportunity to update their knowledge of medical education, so I worked to ensure that they could use their clinical experience, knowledge, and skills as a resource for training in a way that minimized contradictions and burdens.

To achieve this, I provided concrete examples of feasible actions and offered support and advice, such as sharing feedback from students and discussing how the number of applicants for junior doctor positions had increased (although there were also times when it decreased). I explained that the feedback we received was a good indicator of our success.

What I noticed most during this time was that before 2006, I worked as a faculty member at Nagoya University. During that time, there were significant changes to the curriculum under the leadership of prominent figures in medical education, including those who were also chairpersons at the Japan Society for Medical Education. I supported these efforts to drive major reforms in medical education. One of the key shifts was an increased focus on

professionalism, ethics, continuous self-improvement, and the ability to solve problems, rather than simply retaining knowledge. As Mr. Kojima mentioned earlier, clinical reasoning, critical thinking, and the OSCE (Objective Structured Clinical Examination) were also introduced as part of this process. Moreover, information utilization skills became an important focus of instruction.

As I spoke about these changes, I noticed that supervising doctors and department heads often mentioned that today's students "don't know anything." My response was, "No, today's students are being trained to look things up when they don't know something." Therefore, it is essential to test not only their knowledge but also their ability to utilize information effectively.

Supervising doctors often lamented that students "can't even examine a patient," but I would remind them that we had trained the students for this through OSCE. However, I would acknowledge that it is still important to actually observe how students perform at the bedside and provide constructive feedback. Some doctors also expressed concerns that students couldn't read English, but nowadays, translation tools are widely available. In fact, when we discuss resources like UpToDate in classes, many students don't read the English versions—they use translation tools to read them in Japanese.

Students' ability to use such tools efficiently is also valuable in serving patients, and I would often tell doctors that they could learn from the students in this regard. There were also times when doctors would say, "Students already know so much; I don't have anything to teach them." My response was, "No, that's not true. There's still so much they can learn from your decision-making and clinical procedures." Ethical considerations, legal backgrounds, societal norms, and, most importantly, your experience as a clinician in understanding patients' values and knowing what will bring them comfort or distress are all things students can learn from you. I would say that students with a good sense of these aspects can become very engaged with clinical work.

Sometimes, more radical doctors would say that "lectures are meaningless, and everything should be taught in the field." My response was, "Let's not go that far." The learning acquired in university settings is crucial, and experiences in the field should help students apply this knowledge. This is exactly what we aim to achieve with clinical clerkships, where the focus is on confirming students' knowledge and helping them apply it to real-life patient cases and their clinical experience.

Dr. Kataoka introduced this earlier, but in our hospital, we also encountered a situation where a student caused quite a significant problem. It was an unexpected encounter, but there was a student who exhibited serious behavioral issues. As the university requested a report on the matter, we filed it after the incident. What happened was that, during a patient examination in the emergency department, the student who was observing the examination started reading manga on a tablet immediately afterward. We warned the student once, but they repeated the same behavior. Therefore, we had no choice but to take firm action, suspend the training, and report the incident to the university, ultimately sending the student back and canceling the hospital training.

I believe that when you notice such issues early, it can provide an opportunity to correct the student's behavior. However, regardless of how diligently we warn or give them a pass, their fundamental issues will remain unresolved unless the university steps in. That's why we decided to send the matter back to the university for further action.

Another point when working with medical students in clinical settings is that well-prepared students want to participate in problem-solving in the healthcare environment. They are eager to test their abilities, and as long as patient safety is ensured, involving students in discussions about patients and allowing them to perform simple procedures can significantly change their evaluation.

Furthermore, the sense of accomplishment that comes from applying what they've learned in university settings to real-life clinical situations is something that instills in students a lifelong appreciation for the value of learning. Therefore, I always emphasize the importance of providing students with not just knowledge but opportunities, and more importantly, feedback rather than just results.

I often say this: even seemingly trivial tasks, like inserting an NG (nasogastric) tube, which may appear mundane or basic, offer a great learning experience for students who are well-prepared. They may notice various important details—such as the discomfort on the patient's face or the technical skills required to avoid causing undue distress. Each small observation contributes significantly to their growth as a healthcare professional.

I frequently remind educators to highlight these moments to the students. Fortunately, there is now a broader push across the hospital to provide students with meaningful experiences and opportunities during their training. However, there are still areas where we could improve, with some departments needing to take more initiative in student engagement. Nevertheless, I believe we can only continue moving forward with this approach.

Often, I hear comments like, "This student isn't motivated," or "They don't seem to know what they want to learn." In such cases, I always advise reflecting on this fundamental question: as educators, we sometimes become so fixated on the idea that *we* must teach, or that *we* must ensure the student learns, that we lose sight of the student's perspective.

It's a great thing when students recognize what we consider important. However, when they don't, it can be frustrating for us. Yet, from the student's point of view, not being taught what they want to learn can lead to negative experiences. So, I suggest starting by asking them what they want to be taught.

For example, "I hear you're interested in surgery. What would you like to learn in this emergency department?" or "You want to specialize in emergency medicine—what do you want to focus on during your pediatrics rotation?" A simple inquiry into their hidden needs can make a significant difference. This little extra effort goes a long way, and I often share this advice.

Moreover, if faculty are aware that a student isn't in the right mindset to learn, rather than becoming frustrated, they might try asking, "I hear you're interested in pediatrics, but how would you recognize a serious heart failure case in a child who seems to have a mild condition in this emergency department?" By highlighting the importance of the case they are about to discuss or see, you can engage the student more meaningfully. This is the kind of approach I often recommend.

So, when asking, "Is there anything that caught your attention today? Anything you're interested in studying? Any cases you'd like to explore?" If the student expresses interest, you could say, "Why don't you research that a bit further?" Then, you could follow up with, "How would you go about it? Where would you look it up? Would you use UpToDate?" or "Are you checking a textbook?"

Once the student shares their findings, you could respond with, "Ah, I see. That's a good point. Here's a paper that builds on that idea, or here's another perspective you could explore." This back-and-forth can minimize the burden on the supervising doctors while allowing students to engage in the learning process in a less stressful manner. I've offered similar advice in departments like emergency medicine, intensive care, and elsewhere in the hospital when consulted on this topic.

Another point I often mention is that learners have different styles. Some are dependent learners at first, needing a lot of guidance, while others gradually become more independent, choosing their study topics and tackling their challenges autonomously. Dependent learners are happy to be taught, but those who reach a more independent level are often happier when they are given autonomy.

For students at the stage where they're still curious and dependent on guidance, it's good to offer advice like, "If you're interested in this topic, here's something you can study." For those who are more engaged, a simple, "What are you planning to study next?" or "What do you want to focus on?" can provide the encouragement they need to keep going. I think it's important to assess where each student stands in this regard.

In doing so, we apply a sort of matrix. For example, dependent learners benefit from having someone actively teach them, and while they might enjoy this environment, it's not enough for their growth. We must encourage them to start researching on their own. By withholding some guidance and allowing them to find their own interests, we move them toward a more autonomous level.

Ultimately, the goal is to develop students into independent learners who can decide what they need to study on their own. We must skillfully guide them from where they are, step by step, toward autonomy. In this process, it's essential that both teachers and learners recognize and respect each other's contributions, fostering an environment where learning is mutual. This applies not only to medical students but also to junior doctors and specialized residents.

Nowadays, medical education is increasingly focused on practical skills and professionalism. As information technology advances, doctors are expected to constantly update their knowledge and apply it in practice. Therefore, when we guide students in clinical settings, we need to assess not just their knowledge or ability but whether they can apply basic skills like conducting

interviews, and if they are addressing any issues they encounter in practice.

Additionally, when it comes to ethical standards, it's not just about following the rules but about whether students can recognize when they're about to deviate from those standards and correct themselves. These are the kinds of things we're now required to evaluate, and I encourage everyone to keep this in mind as they guide students.

That said, I can't claim that our hospital has implemented all these practices perfectly or that we've managed to fully satisfy every student. However, what I've shared today reflects the work I've been involved in over the past 16 years at this hospital.

Thank you for your attention.

Thank you very much for your truly wonderful presentation. In particular, during the group work earlier, there were discussions about how to identify needs and match them appropriately, and I believe your talk provided exactly the answers to those questions.

<3. Dr. Kataoka>

Now, I'd like to briefly discuss a new development as time is limited. I will give a short report on inclusive education in clinical training and accreditation evaluation. Regarding inclusive education, we conducted a pre-meeting survey.

It's a term we hear frequently these days, but it was first internationally proposed by UNESCO in 1994. In terms of Japan's legal framework, the Act for Eliminating Discrimination Against Persons with Disabilities was enacted in 2016. A new amendment to this law came into effect on April 1 of this year, making it mandatory for businesses to provide reasonable accommodation to people with disabilities. This represents a significant shift.

The provision of reasonable accommodation has become something that many businesses must now actively address. In a pre-meeting survey on experience with reasonable accommodation for disabled students or workers, 16.5% of participants from outside the university reported having such experience, while 15.8% of participants within the university reported the same. Moving forward, we can expect the need for reasonable accommodations to increase and for the range of situations requiring them to diversify. We will continue to learn and adapt as we proceed, and we would appreciate it if you would reach out to us with any questions or concerns.

This visual is from the cover of the journal of medical education and provides a simple explanation of what inclusive education entails. Inclusive education ensures that all individuals, regardless of differences, can learn together equally. The UNESCO declaration I mentioned earlier supports this concept, but to achieve inclusive education, several phases must be addressed.

The top-left corner shows the "exclusion" phase, which reflects a state where inclusive education is not in place. Then, we move to the "segregation" phase, where individuals may be in the same physical space, but separate paths exist for them. The next phase is "integration," which means learning together but not yet fully learning from or supporting each other. Finally, we aim for "inclusion," the ultimate goal, where everyone is learning and benefiting from each other in a shared environment.

There's a lot of talk these days about diversity, equity, and inclusion. What's important is that we're not just aiming for "integration," where people are merely present together, but for true inclusion, where individuals help and elevate one another. That's what we should strive for.

In terms of inclusion in healthcare, I'd like to reference Dr. Kumagai, whose work and lectures I've encountered multiple times. He advocates for a paradigm shift from the "individual model of disability" to the "social model of disability."

The individual model of disability assumes that disabilities are personal conditions that must be addressed through individual effort, innovation, or treatment. In contrast, the social model of disability argues that society must make adjustments to accommodate individuals with disabilities, and if the right environment is provided, many individuals can thrive and contribute fully. This shift is part of a broader movement in recent years.

To eliminate health disparities for people with disabilities and achieve healthcare that leaves no one behind, it is essential to create an environment where medical professionals who themselves have disabilities or other minority characteristics can participate as colleagues. Dr. Kumagai, who overcame polio to become a pediatrician, often speaks from his personal experience, discussing how he has navigated challenges by working with the environment around

him. When we think about the very diverse patients we serve, it's also important for us, as healthcare professionals, students, and faculty, to consider how we promote diversity within our own ranks.

Now, I will briefly report on the JACME (Japan Accreditation Council for Medical Education) evaluation by specialty. This evaluation by the Japan Accreditation Council for Medical Education took place from June 4th to June 7th, covering the nine items listed here. Due to time constraints, I will skip over some details, but Kyoto University received its first accreditation in 2017, and this is the second evaluation.

We received tremendous support from many external experts as well as from our administrative staff, and the evaluation took place on June 7th. While the official evaluation report will not be available for a few more months, we can say that overall, the university received very high marks.

Several points were highlighted as areas where we performed well, as well as areas where we excelled. As Director Isa mentioned earlier, the Clinical Professors Conference was highly praised. It is no longer feasible to complete all of the medical students' learning solely within the university. The opportunity for students to learn and grow through the support of various regions and affiliated hospitals is extremely important. This conference, where we share educational challenges and future directions, was recognized as highly valuable and praised for its continuity.

However, some areas for improvement were also identified, particularly regarding clinical training. There were suggestions for improvement, especially in light of the revisions to the Medical Education Model Core Curriculum in 2022. These revisions will require changes to the curriculum itself, including extending the clinical rotations to a minimum of three consecutive weeks per specialty. Other areas, such as the pass/fail criteria, how to assess students in clinical settings, and the use of formative assessments to provide feedback to students for their learning, were also highlighted as points for improvement. While today's feedback is brief, there will likely be future requests for your cooperation, and we would appreciate your continued support.

The scope of medical procedures students are allowed to perform is regulated under the Medical Practitioners' Act, which has provided legal backing since 2005. However, the specifics of what students can and cannot do in practice remain somewhat unclear. We aim to make these guidelines more understandable moving forward.

On the left, you can see a poster jointly created by the Ministry of Health, Labour and Welfare and the Ministry of Education, Culture, Sports, Science and Technology. The poster states that 'Students training to become future healthcare professionals are conducting clinical training at our hospital.' Displaying this poster in medical institutions may help patients better understand the role of students. The poster is available for download from the Ministry of Education's website, and we encourage you to use it if you find it helpful.

Thank you for your attention. We look forward to your continued support in training and educating our students and young professionals.