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Policy Address[*1]

JMAJ 59(4):141-144, 2016

Yoshitake YOKOKURA[1]

At the 137th Regular General Assembly of the JMA House of Delegates, held yesterday, I was elected to serve as President for a third term. Healthcare in Japan is facing a major turning point as the year 2025 draws near,[*2] and I sincerely thank the JMA delegates and the JMA members for the trust they have bestowed upon me.

Coincidentally, this year marks the 100th anniversary of the Great Japan Medical Association, the predecessor of the JMA, which was established in 1916. In 1923, the JMA was approved by the government as a national medical association uniting medical associations nationwide. At its opening ceremony, Dr. Shinpei Goto, a physician and then Minister of Internal Affairs, stated, "I implore that the JMA work with local medical associations to advance conduct and skills in medical practice as an internal effort, and to improve public health facilities as society develops as an external effort, thereby contributing to the mutual prosperity of medical practitioners and the public." One century has passed, but the JMA's role has not changed at all in that time.

The JMA has worked to improve medical science and practice and to promote social welfare *continuously*, and we will not stop our steps toward progress. In addition, we have valiantly striven to realize necessary *reforms* to give the benefits of medical science and practice back to the public at large. It can be said that the good reputation of the JMA—and our response to the public's trust—lies in our determination to continue our progress hand in hand with Prefectural and Municipal Medical Associations and our courage to tackle needed reforms.

During the past century, the environment surrounding medical practice has constantly changed. We have a history of serving public healthcare by always nurturing advanced knowledge to meet the demands of the times. The JMA's stance on social security issues is clear when one closely examines our history. It lies in two criteria, namely "Will this policy contribute to safe healthcare for the public?" and "Will this policy allow protection of universal health coverage as a public healthcare program?"

In light of these criteria, Prime Minister Abe's recent decision to postpone the consumption tax increase to 10% for two and a half years was, in fact, truly regrettable from the standpoint of securing funding for social security programs. It is the local residents who suffer the most if the availability of healthcare services, including long-term care, falls short of local needs due to lack of funding for social security programs. The JMA has repeatedly insisted that the government should uphold the promise they made to the public and use the revenue from the consumption tax increase to fund social security programs. From now on, not only we will insist on the same points as before, we will also strongly urge the government to secure different sources of funding for social security in lieu of the consumption tax increase.

*1 This is a revised English version of the policy address delivered in Japanese at the 138th Extraordinary General Assembly of the JMA House of Delegates held in Tokyo, June 26, 2016.

*2 The baby-boomers (those born between 1947 and 1949) will be over 75 years old and over in Japan by 2025.

1 President, Japan Medical Association, Tokyo, Japan (jmaintl@po.med.or.jp).

Just the day before yesterday, the people of the United Kingdom expressed their will to withdraw from the European Union, which is likely to bring some confusion to the outlook of the international economy. In the midst of such economic chaos, when people's anxiety becomes elevated, it is all the more important to stabilize social security as a safety net, especially the universal health coverage that allows every citizen to seek medical and long-term care at ease. A sense of security contributes to social stability and leads to economic development.

As for the consumption tax issue's relation to healthcare, the JMA will demand measures for tax deduction or refund for taxable purchases and urge acquisition of the necessary funding.

Meanwhile, as healthcare providers, we must work toward and submit proposals on the proper framework of healthcare expenditures to establish sustainable social security programs, and above all, to protect universal health coverage. To address the recent problem of insurance coverage listing for expensive drugs and medical equipment, we must work to raise awareness for the Central Social Insurance Medical Council while remaining in line with the thoughts of patients and medical practitioners. New roles and guidelines should be set based on such an approach, and we must also encourage appropriate and cost-effective drug prescriptions and use of medical instruments. We can expect to positively influence healthcare expenditure by systematizing lifelong health programs to extend healthy life expectancy.

The key is that we, at the front line of healthcare delivery, take the initiative—not the government officials, including those from the Ministry of Finance. The JMA has continuously made various recommendations to the government as a leader in the areas of health, medicine, and welfare. Our unique feature comes from the fact that medical practitioners thoroughly analyze various issues using on-site opinions as evidence. The JMA conveys those voices to the government as the reality of the community, and urges realization of national policies that consider community health; and we fulfill our role at an appropriate level of administration so that a given policy is properly implemented at prefectural and municipal levels. The strength of the JMA lies in a close bond with communities.

To further expand this strength, we will work to introduce information and communication technology (ICT) in the area of medicine, which is now facing a turning point, and to effectively leverage information networking for collaboration between medical care and long-term care. The JMA has always led the framework of collaboration of community health in the ICT era by extended application of Medical Doctor Qualification Certificate cards and other efforts. In the future, we will use the data we obtain through our activities to understand the realities of communities and to propose healthcare policies based on the verified results of previous or existing policies. These thoughts led to the new announcement of the JMA Declaration of IT Introduction 2016, which clearly set forth promotion of IT application. A new section, the Information Section, will be launched in the secretariat office to strengthen our efforts.

In parallel with these projects, we are also preparing for concurrent revisions of medical fees and long-term care fees that are expected to take place in FY2018, and the upcoming debates for the launches of the 7th Healthcare Planning and the 7th Long-term Care Service (Support) Planning.

The aging society we face challenges the framework of terminal care. However, what we must consider in terminal care is what constitutes the best care for patients and how to emphasize patient dignity and quality of life in the medical approach. We will also need to discuss promotion and awareness-raising for the creation of "living wills" in depth in the years to come, not only amongst healthcare professionals but also with various stakeholders, including religious scholars and legal experts. The approach to terminal care with human dignity should not be based on financial viewpoints; it is important to involve the people of Japan in its examination.

On the other hand, the JMA has heard many voices of concern from the public and JMA members about the new specialist system. The system was originally intended to further ensure a sense of security for the people of Japan through professional autonomy of physicians. However, there was strong concern that physicians, both those who teach and those in training, might become concentrated in major cities at university hospitals serving as high-capacity acute-care hospitals, which would magnify the uneven distribution of resources between popu-

lated and unpopulated areas, and could bring big confusion to the workplaces of community health. In response to such fears, at the joint press conference with the Council of Four Hospital Organizations held on June 7th, 2016, the JMA and the Council announced that the specialist training program should start only after hearing the opinions of a wide range of stakeholders, and with due consideration not to collapse community health.

It takes a courage to stop the creation process for a new system. Still, we should never allow haste to create confusion and inconvenience to the people, because healthcare belongs to the people. Without the trust of the people, healthcare cannot exist. At the same time, a person cannot live where no healthcare is provided. Thus, a sustainable system for healthcare delivery is essential for people to live at ease.

Physicians long ago nurtured their academic background and provided their medical knowledge and care through individual effort. However, the flow of the times—systematic expansion of medical fields and their subdivisions and the increasing complexity of addressing social issues, for example—demanded that a union of physicians to make integrated effort to improve public health, and so the JMA was born.

Today, birthrate is decreasing, society is aging, and more populations move to city areas, and the people need a system that can continuously provide the necessary medical and long-term care with no excess or shortage. To respond to these needs, it is important to promote the division of functions and collaboration in the community as a whole, and to provide people with necessary information concerning nutrition, exercise, or care in an integrated fashion by encouraging everyone to have individual *Kakaritsuke*[*3] physicians. To realize this, we physicians must be involved in building a healthcare delivery system in which *Kakaritsuke* physicians play a central role and the Community-based Comprehensive Care System is customized to the circumstances of each community. This is an urgent challenge that we are expected to address to ensure the life of the people and to contribute to their sense of security.

While I was recalling the past history of the JMA and picturing how future community health should be, I decided to uphold three basic policies in the beginning of my third term. Those policies are "community development," with *Kakaritsuke* physicians at the core; "human resource development," to nurture those who will carry out future medicine; and "organizational development," in which a strong organization will continue to lead national healthcare policies.

In addition to these policies, I shall maintain three basic stances of proactive action, balanced policies, and challenge to new initiatives—namely, "Action, Balance, and Challenge"—to take a solid step forward in improving national health.

On top of that, I will work to further enhance Japan's healthcare system, which pushed healthy life expectancy to the world's top class, to the level of a global model that can provide a true "sense of security" to a super-aged society never before experienced in the world. The JMA's achievements will be transmitted to the wider world through the World Medical Association and other international activities so that the JMA can contribute to bringing happiness to people globally.

The history of the JMA is also the history of national healthcare development. Behind this development are many noble medical practitioners whose dedication and hard work was spent for the people. This year, the JMA reaches the milestone of its 100th anniversary, and it is a great honor to be appointed as the president. Once again I feel the weight of my responsibilities.

No matter how the next 100 years turn out, we must calmly dedicate our work to the good of the people through medical science and practice, and work to protect universal health coverage. This is a promise that the JMA also upheld in its Codes of Principles. I will stand to lead the efforts to improve medical science and practice and promote social welfare *continuously*, and to valiantly strive to realize necessary *reforms* to give the benefits of medical science and practice back to the public at large.

*3 "Kakaritsuke Physician" is a physician who people can consult on any issues, is well versed in the up-to-date medical information, can refer a patient to a specialist or specialized medical institution when needed, and is a trustworthy and familiar figure with comprehensive capabilities entrusted with community medicine, health, and welfare.

I will manage the JMA with determination and courage so it truly becomes a "national medical association that walks alongside the people" and a "medical association that walks with its members," along with all the board members. Finally, I would like to close my speech by humbly asking the JMA delegates and the JMA members for their continuous, utmost support of my third term.

JMA President Dr. Yokokura Was Elected to the WMA Presidency*1

JMAJ 59(4): 145-146, 2016

Japan Medical Association

The World Medical Association (WMA) General Assembly in Taipei was held on October 19-22, 2016, in Taipei, Taiwan. It should be particularly noted that the Japan Medical Association (JMA) President Yoshitake Yokokura became the President-Elect of the WMA at the election that took place during the plenary session on October 22. Three other candidacies stood in the election, one each from the Chinese Medical Association, the Croatia Medical Association, and the Nigeria Medical Association. Dr. Yokokura will serve as the WMA President-elect for a year before being inaugurated as the WMA President at the General Assembly in Chicago in October 2017.

Dr. Yokokura held a press conference on October 26 after returning to Japan as the next President of the WMA. He acknowledged that it is a great honor for himself and for JMA. He expressed his aspiration that "It has renewed my strong determination for my posts to fulfill my duty even more firmly," and made the following 2 points.

(1) JMA sometimes engages in a heated discussion with the government and the ruling party while maintaining a close relationship with them in its effort to provide appropriate healthcare to the people of Japan and lead the healthcare of Japan in the correct direction. The organization represents all types of physicians across the nation and its stance is highly appreciated by many other national medical associations of the WMA.

(2) There are few national medical associations in the WMA that maintain a face-to-face relationship with a national government that Japan does. For many developing countries, particularly in Africa and Asia, joining the WMA is one of the means to protect national healthcare. Those countries are counting on and looking forward to the activities, declarations, resolutions, and statements of the WMA, and seeking help.

Dr. Yoshitake Yokokura, President-Elect at the WMA General Assembly in Taipei, Taiwan

With Dr. Ketan Desai (President) and Sir Michael Marmot (Immediate Past President)

He then continued to say "I am aware that those national medical associations will have even more expectations of the WMA when the JMA President is also serving as the WMA Pres-

*1 This is an extracted and English-translated version of an article in the JMA News (November 20 2016 Issue) about the press conference held on October 26, 2016.

ident. I shall ensure that I live up to their expectations and address them."

Dr. Yokokura also mentioned that globalization has brought about many transboundary problems in healthcare that are global in scale, and the WMA has been playing an extremely significant role as the driver in solving these problems. Pressing issues, such as Healthcare in Danger, climate change, and problems pertaining to the social determinants of health, require the WMA to make urgent efforts.

He further announced that as the CMAAO President he will be hosting the General Assembly of the Confederation of Medical Associations in Asia and Oceania (CMAAO) under the theme "the terminal illness of aging" in Tokyo in September 2017. He plans to summarize the opinions of the countries in the CMAAO region and provide feedback to the WMA. As the JMA President, who is also deeply involved in the activities of both the CMAAO and the WMA, he stated that his mission is to energize the activities of the CMAAO, bring the CMAAO even closer to the WMA, and ensure the voices of physicians in the Asia-Oceania region are brought to the WMA.

Dr. Yokokura also recalled the statement he made in the policy address*2 when he started a third term of his presidency, in which he said "I will work to further enhance Japan's healthcare system, which has pushed healthy life expectancy to the world's highest level, to the level of a global model that can provide a true 'sense of security' to a super-aged society never before experienced in the world." He reminded listeners that the WMA needs to work on a wide range of healthcare problems because various countries in the world have different endemic health issues.

Dr. Yokokura also stated his opinion that fostering young physicians who can meet the needs of the time and preparing their work environment accordingly are very important. He made the assurance that he would firmly support the activities of young physicians through the World Medical Association Junior Doctors Network (JDN).

Lastly, he concluded by saying that "A physician's mission is to create an environment in which all people can live healthy and safe lives. To do so, physicians from all over the world need to maintain an intimate collaboration with each other through the WMA." He clearly showed his determination to elevate the presence of the WMA as much as possible, make its activities known to the public, and bring about further achievements.

*2 Please refer to pgs 141-144 of this JMAJ issue.

Lecture by Sir Michael Marmot, President of the World Medical Association—Asking for the engagement of doctors in "Social Determinations of Health"*1

JMAJ 59(4): 147-148, 2016

Japan Medical Association

A lecture by Sir Michael Marmot,[1] President of the World Medical Association (WMA), was held in the Auditorium of the Japan Medical Association (JMA) on September 5, 2016. The approximately 300 attendees included medical association members, medical students, medical-related organizations, and members of the general public. Sir Michael, whose lecture was delivered with the theme of "Social Determinants of Health (SDH)," postulated that the health gap is potentially avoidable, and advocated the engagement of doctors in tackling the factors contributing to this gap.

A series of SDH activities by Sir Michael have thus far been provided mainly in countries in Europe, North America, and Africa. This lecture was held with the aim of fulfilling Sir Michael's desire to talk to discuss SDH in Asia.

Dr. Yoshitake Yokokura, President of JMA, stated in his opening remarks, "It is a great honor for us to invite the world-renowned Sir Michael Marmot, President of WMA, to our Auditorium to give his lecture." He also expressed his views on the topic of SDH, saying, "In the context of the recent situation that relative poverty has been discussed in Japan, I greatly appreciate this lecture highlighting social determinants of health, an issue to which we have not as yet paid sufficient attention. I hope that the occasion of Sir Michael's lecture will inspire activities to reduce the health gap and alleviate health inequalities in Japan."

Sir Michael Marmot, WMA President

Following Dr. Yokokura's remarks, Sir Michael presented a lecture entitled "Health inequalities. Healthy women's lives." Regarding the health gap due to income disparities, Sir Michael noted that once income reaches a certain level, a further increase in income will not lead to additional promotion of health. He also pointed out that factors other than income, such as the level of education, experience in childhood, etc., are involved.

In regard to women's health, Sir Michael noted the distinct difference in infant mortality rates between mothers who had secondary or higher education and those with less education, and also referred to the relationship between

*1 This article is an English translation of a JMA News article (extracted) issued on October 5, 2016.

1 Immediate Past President, World Medical Association. Professor of Epidemiology at University College London.
Sir Michael Marmot served as WMA President from October, 2015 to October, 2016. In 2000, he was knighted by Queen Elizabeth II, for enduring services to epidemiological research on social disparity and health inequalities.

domestic violence and adverse childhood experiences. He emphasized the importance of education for women.

He underscored that the health inequities are avoidable, and emphasized that while the function of doctors is to treat the sick, it is also desirable for doctors to tackle the conditions that make people sick.

Lecture in the Auditorium of the Japan Medical Association

The 2nd World Veterinary Association-World Medical Association Global Conference on One Health*1

JMAJ 59(4): 149-153, 2016

Japan Medical Association

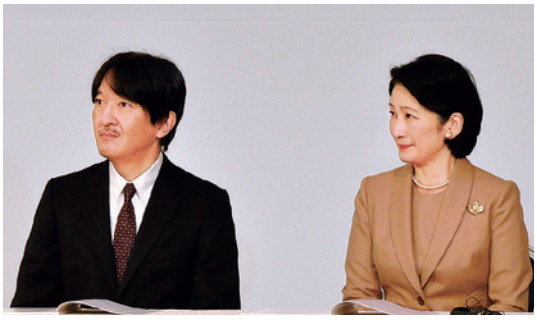
Opening Ceremony

The 2nd World Veterinary Association (WVA)-World Medical Association (WMA) Global Conference on One Health—Moving forward from "One Health" Concept to "One Health" Approach—was held on November 10 and 11 2016 in Kitakyushu City, Fukuoka, Japan, hosted by the Japan Medical Association (JMA), WVA, WMA, and the Japan Veterinary Association (JVA).

About 30 lectures were presented over the 2 days of this international conference, and the Fukuoka Memorandum (See p153), which set forth the determination to proceed to the practical implementation stage of the One Health Concept, was unanimously approved.

The 1st global conference was held in May 2016 in Madrid, Spain, upon conclusion in October 2012 of the memorandum of understanding that aims to foster cooperation between physicians and veterinarians under the One Health Concept to improve global health; the collaboration and partnership between JMA President Dr. Yoshitake Yokokura and JVA President Dr. Isao Kurauchi, recognized through their lectures, were highly appreciated, which led to holding the 2nd global conference in Japan. There were 639 participants from 31 countries.

*1 This is an extracted and English-translated version of an article in the JMA News (December 5 2016 Issue) about the 2nd Global Conference on One Health with the theme: Moving forward from One Health Concept to One Health Approach, held in Kitakyushu City, Fukuoka Prefecture, Japan on November 10-11th 2016.



Their Imperial Highnesses, Prince and Princess Akishino

Mr. Koichi Tanaka

Day 1

The opening ceremony was held on November 10 with the honorary presence of their Imperial Highnesses, Prince and Princess Akishino.

JMA Executive Board Member Dr. Mari Michinaga and WVA Veterinary Policy Officer Dr. Zeev Noga officiated the ceremony. First, the representatives of the 4 host organizations made opening remarks.

Dr. Yokokura stated, "Until now, physicians and veterinarians have each been making steady efforts from their respective standpoints. In the future, I am certain that physicians and veterinarians sharing the principal of One Health and consolidating their knowledge will lead to the further promotion of countermeasures against infectious diseases, and especially to the advancement of both medical science and veterinary science." He continued, "I regard the holding of this international conference as having great significance in terms of not only the international contribution it is making to the medical field, but also its role in furthering regional revitalization."

Prince Akishino graced the audience with his comment that "there is a concern about a global outbreak of infectious disease, and it is very significant to have researchers from many different fields of science gather at one venue to discuss infectious disease control. I would hope that this will serve as an opportunity to attract attention from many people for human and animal health and to deepen their understanding."

The opening ceremony was followed by a keynote lecture by Mr. Koichi Tanaka, Nobel Laureate in Chemistry in 2002 and Senior fellow/General Manager of Koichi Tanaka Mass Spectrometry Research Laboratory, Shimadzu Corporation, titled "Analytical Instruments for Further Contribution to Measures against Infections."

Mr. Tanaka stated that the roles played by analytical instruments have recently been expanding year by year, and he presented a lecture on 3 points, namely: 1) existing analytical instruments for contribution to measures against infection, 2) technologies aimed at next-generation medicine and drug discovery, and 3) ideas about further contributions to the future of medical testing and "One Health."

He introduced that a mass spectrometer (MALDI-MS) is contributing to early diagnosis and determination of appropriate drugs, and that analytical instruments have the capacity to identify already-known substances as well as to discover previously unknown compounds or phenomena.

He emphasized that "One Health is about the collaborative effort of multiple disciplines to attain optimal health for people, animals, and the environment, and this conference aims to strengthen the links and communications among these different fields. In that sense, planning and holding such a conference is epoch-making." He also commented, "I am certain that unconventional ideas will be inspired and presented through the cooperation of many different fields, and I hope to contribute further as a person involved in the research and development of analytical instruments."

In the afternoon, 2 sessions were held under the theme of "Zoonotic Diseases."

In Session 1, Dr. Ichiro Kurane, Director General of National Institute of Infectious Diseases, Japan, pointed out that wildlife-born zoonotic viral diseases such as Ebola virus disease (EVD), severe acute respiratory syndrome (SARS), and severe fever with thrombocytope-

Dr. Ichiro Kurane

Dr. Toru Takahashi

nia syndrome (SFTS) have occurred often in recent years, likely caused by "the expansion of infectious disease at a global scale accompanied by the increased movements of humans and animals" and "advance in surveillance systems and diagnostic techniques."

He also stated that the management of subclinical and asymptomatic infection is an urgent issue that requires various efforts, including rapid identification of the causative agent and continuous surveillance as well as the elucidation of the infection cycles of pathogens in nature and the development of protective and treatment measures against infection. He also said that "establishing and maintaining information exchange systems and research collaborations in advance between medical and veterinary sectors are essential as the basis for rapid countermeasures against zoonosis."

Dr. Toru Takahashi, Director of Department of Hematology, Yamaguchi Grand Medical Center, introduced the collaboration scheme of physicians and veterinarians in Yamaguchi Prefecture in 2012 when responding to the first SFTS patient in Japan. He stated that "the first SFTS case in Japan was successfully diagnosed, even though SFTS was hardly known in clinical practice at that time, thanks to the cooperation of Yamaguchi University Joint Faculty of Veterinary Medicine, Tokyo University of Agriculture and Technology, and the National Institute of Infectious Diseases," and that "this was indeed the practical implementation of the One Health Concept through the united effort of human medicine and veterinary medicine, which could serve as a model case when dealing with upcoming emerging infectious diseases and zoonoses."

Dr. Haruo Kusaba, President of the Fukuoka Veterinary Medical Association then introduced a framework for cooperation between physicians and veterinarians—case examples from the Fukuoka Prefecture, where an academic cooperation agreement at a local level was concluded for the first time in December 2013 between the Fukuoka Prefecture Medical Association and the Fukuoka Veterinary Medical Association. He stated that "55 local veterinary associations and the corresponding medical associations in Japan also signed academic agreements after us, and it created a basis for zoonosis countermeasures in Japan and will allow us to build a safe and secure society."

Dr. Takeshi Inamitsu

Dr. Takeshi Inamitsu, Board Member of the Fukuoka Prefecture Medical Association introduced the results of the zoonosis occurrence status survey that was carried out as the joint project of Fukuoka Veterinary Medical Association and Fukuoka Prefecture Medical Association, and pointed out that zoonotic infection from family pets is common, and that infants, elderly people, pregnant women, and people with decreased immunity due to primary disease need to stay more alert to the health of their pets. He commented, "I hope to strengthen the physician-veterinarian collaboration and promote more information exchange to help healthy

Dr. Mamoru Mohri

From Left: Drs. Kurauchi, Chiang, Deau, and Yokokura

humans and animals to live together."

In the Japan International Cooperation Agency (JICA) Session (Session 2), some international studies were introduced, including "Surveillance of Viral Zoonosis in Africa" from Zambia, "Ecological Studies on Flying Foxes and Their Involvement in the Rabies-Related and Other Viral Infectious Diseases" from Indonesia, and "Three Dimensions of One Health and Community Intervention Model for MDR Bacteria in Vietnam" from Vietnam.

Day 2

The Ministry of Health, Labour and Welfare (MHLW) Session "Antimicrobial Resistance (AMR)" on Day 2 established that AMR is an emerging public health threat at global, regional, and national levels, and that the Food and Agriculture Organization of the United Nations (FAO) is strengthening measures against AMR to ensure global food safety and public health. The lectures discussed the importance of prudent use of antimicrobials and domestic and international trends in the veterinary medicine.

Dr. Norio Ohmagari, Director of Disease Control and Prevention Center, National Center for Global Health and Medicine Hospital, cited the challenges for promoting AMR control in Japan, namely: 1) strengthening efforts to address the use of antimicrobials in outpatient care, 2) improving public awareness, and 3) organizing a comprehensive regional network for infection control involving medical associations.

In Fukuoka Prefecture Session, Dr. Mamoru Mohri, an astronaut and Chief Executive Director of the National Museum of Emerging Science and Innovation, gave a speech titled "Planet of Life Observed from Space."

Dr. Mohri emphasized the importance of protecting the Earth's environment based on his experience of having been in space twice. He appealed to the audience to understand that humans are not uniquely special as living beings, and that we should renew our awareness that humans can never control nature.

He continued to say that each person needs to individually become aware of his/her connection to the global environment in the future, and noted that people will live more easily in a society that succeeds in mastering "wisdom for the future," or the sagacity to survive. Japan is, in a sense, an advanced country for already having a culture of "compassion," and he urged that Japan should lead the world as a role model.

Mohri's lecture was followed by 2 sessions titled "Other Aspects of One Health" and "Considerations for the Future of One Health Concept."

Summarization Session provided the lecture titled "Practical Operationalization of the One Health Approach," and a recap of the conference by WVA President-elect Dr. Johnson Chiang. Dr. Chiang commented that "about 30 lectures and discussions were successfully held over the 2 days, and we were able to share many achievements," and emphasized that "what we achieved this time will surely lead the next conference."

Lastly, Dr. Yokokura, JMA President, Dr. Kurauchi, JVA President, Dr. Deau, Past President of WMA, and Dr. Chiang, President-elect of WVA appeared on the stage. Dr. Kurauchi declared that "we shall step up from the verification stage of the One Health Concept and pro-

ceed to the stage of action and practical implementation based on the One Health Concept," and he read aloud the draft version of the Fukuoka Memorandum, which was unanimously approved with the applause of the whole audience.

Fukuoka Memorandum

Humankind has a responsibility to show respect for all forms of life on Earth as well as for the environment. Physicians and veterinarians have the scientific knowledge, medical training, the statutory accountability, as well as the opportunity and the responsibility to engage in a wide range of employment fields that deliver services to the benefit of people, animals and the environment.

In October 2012, the World Veterinary Association and World Medical Association signed a memorandum to collaborate in a unified approach to tackle common health issues to improve Global Health, and to focus on zoonotic diseases, responsible use of antimicrobials and enhancing collaboration on education, clinical care and public health.

In November 2013, the Japan Medical Association and Japan Veterinary Medical Association signed a written agreement to share academic research information related to the development of human and veterinary medicine as well as to collaborate together to build a safe and healthy society. In addition, JMA and JVMA agreed to reinforce collaborations on infectious diseases, disaster preparedness and management according to the lessons learned from the Great East Japan Earthquake occurred in 2011. The conclusion of this agreement was also achieved by regional medical associations and regional veterinary medical associations throughout Japan.

In November 2016, the World Veterinary Association (WVA), World Medical Association (WMA), Japan Medical Association (JMA), and Japan Veterinary Medical Association (JVMA) jointly held the Second WVA-WMA Global Conference (GCOH) on One Health in Japan following the inaugural GCOH held in Madrid, Spain, in 2015.

Physicians and veterinarians from around the world gathered together in Fukuoka, Japan to exchange information and consider effective countermeasures to important global threats related to "One Health", including zoonotic diseases and antimicrobial resistance and laudable results were achieved.

Based on the outcomes of this conference, WVA, WMA, JMA and JMVA agree to move from the validation and recognition stage of the "One Health Concept," to the practical implementation stage.

We hereby declare the following:

1. Physicians and veterinarians shall promote the exchange of information aimed at preventing zoonotic diseases and strengthening cooperative relationships, as well as to undertake further collaboration and cooperation aimed at creating a system for zoonosis research.
2. Physicians and veterinarians shall strengthen their cooperative relationships to ensure the responsible use of important antimicrobials in human and animal healthcare.
3. Physicians and veterinarians shall support activities for developing and improving human and veterinary medical education, including understanding the One Health concept and approach to One Health challenges.
4. Physicians and veterinarians shall promote mutual exchange and strengthen their cooperative relationships in order to resolve all issues related to the creation of a healthy and safe society.

November 11, 2016

Japan Medical Association's Efforts in Dealing with Dementia*1

JMAJ 59(4): 154-158, 2016

Kunihiko SUZUKI[1]

Realizing a Society with a Longer Healthy Life Expectancy and Where Elderly People Can Play a Supportive Role

While Japan is the leading country worldwide in terms of having the longest life expectancy, it faces the important challenge of how to shorten the 10-year difference between mere survival and healthy life expectancy, in other words, how to prolong healthy life expectancy. The proportion of the elderly (% of population 65 years of age or older) is a little more than 27% as of 2016, but is estimated to reach 39.9% in 2060. Therefore, it is necessary for Japan to take the lead in realizing a society where elderly people can play a supportive role rather than being supported by others, by maintaining the social security system and prolonging healthy life expectancy while reducing the burden borne on working generations, the populations of which are continuously shrinking under uncertain economic conditions.

On July 10, 2015, the Japan Medical Association (JMA) and the Japan Chamber of Commerce and Industry jointly established Nippon Kenko Kaigi (Japan Health Conference). Business leaders, healthcare organizations, and municipal leaders came together, joining hands, with the aim of extending healthy life expectancy and optimizing reasonable healthcare expenditures, and began to support municipalities and individuals in promoting incentive projects for disease prevention and health promotion. Thus, the two organizations that have been fighting offensive and defensive battles regarding medical service fees paid under the current medical insurance system in Japan are now cooperating to extend healthy life expectancy and to optimize reasonable healthcare expenditures.

Entering the Era of the Care System Involving Kakaritsuke Physicians as the Central Core

As its own particular effort, the JMA pours more energy into the maintenance and improvement of the functions of Kakaritsuke Physicians, to which the JMA has also attached importance to date. We encourage Kakaritsuke Physicians to go out into the community and society, and a specific system to meet this goal is now in place and operational.

Figure 1 shows the definition of "Kakaritsuke Physician" proposed by the JMA. Although the major role of primary care physicians has been in vertical cooperation between large hospitals dealing with acute stages of diseases and local clinics, the main focus now is to have horizontal cooperation beyond the boundaries of healthcare and care for the elderly, which involves Kakaritsuke Physicians taking the leadership role and other elements such as home visiting nurse stations, comprehensive community support centers, and care managers. Therefore, we think that the role of Kakaritsuke Physicians is now more important than ever before.

Dementia is different from other diseases in that amelioration is possible through care services. It is essential henceforth that Kakaritsuke

*1 This article is a translation of the presentation published in the Report of the JMA-PhRMA Joint Symposium on the theme of "Seeking the ways to solve the issues on Dementia/Alzheimer's in Japan and overseas" held in Tokyo, Japan, on December 8, 2016.

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A locally-based and reliable physician with comprehensive capabilities in community health, public health and welfare who is available for consultation about any health issues, has good understanding of advanced healthcare information, and can refer patients to specialists or specialized healthcare facilities when needed.

"How Healthcare Should be Delivered" Aug. 8, 2013
Japan Medical Association and Four Hospital Associations Council

Fig. 1 What is "Kakaritsuke Physician"? (definition)

[Purpose]
Prepare for further decline in birthrate and aging of society, assess the functions of reliable Kakaritsuke Physicians for communities and conduct trainings to maintain and improve their capabilities.

[Organizer]
Prefectural medical associations that wish to implement this system

Launched on April 1, 2016

[Functions of Kakaritsuke Physician]
1. Deliver patient-oriented healthcare
2. Deliver continuity-focused healthcare
3. Ensure teamwork and multidisciplinary coordination
4. Implement social public health, medical care, long-term care and welfare activities
5. Deliver medical care according to community's characteristics
6. Deliver home medical care

Fig. 2 Training System for Enhancing Kakaritsuke Physicians' Capabilities

Physicians coordinate with care services. Currently, the development of the community-based comprehensive care system is underway, with the goal of completion by 2025. The development of a system for coordination is the responsibility of local governmental agencies and medical associations, like the two wheels of a cart. The JMA has improved the contents of training for coping with dementia in the training program for medical fee calculation requirements and in the "Training System for Enhancing Kakaritsuke Physicians' Capabilities" that was launched in April 2016 (**Fig. 2**).

Reinforcement of the Training for Enhancing Kakaritsuke Physicians' Capabilities

The Training System for Enhancing Kakaritsuke Physicians' Capabilities aims to promote physi-

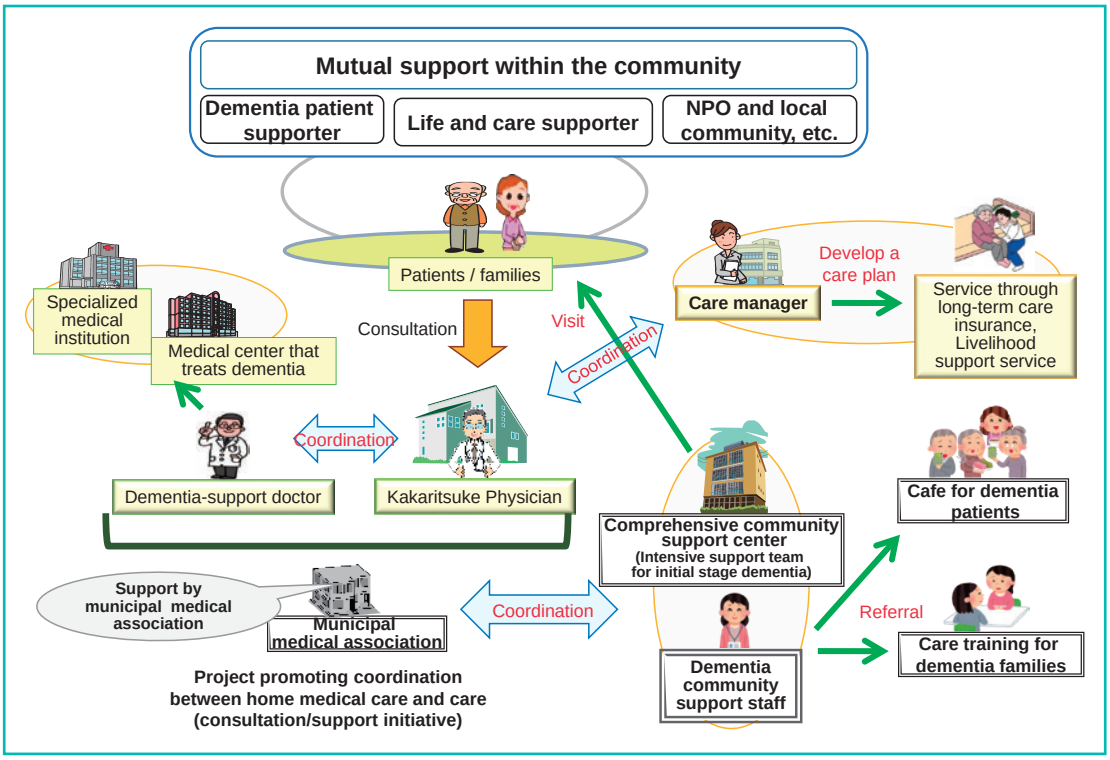

Fig. 3 Providing community-based support for dementia patients and their families

cians learning all skills required for Kakaritsuke Physicians, including teamwork, multidisciplinary coordination, and implementation of home medical care. The period of training is 3 years. More than 6,000 physicians attended the central training held in May 2016, and more than 8,000 have started their training in this system. Dementia is a subject for which a participant can acquire 1 unit. The training is designed to help participants to understand cognitive functional deterioration and problems arising from it, and to make an appropriate diagnosis and provide treatment. Participants are also expected to learn how to deliver continuous medical care that supports dementia patients and their families in cooperation with relevant organizations, to assure that people with dementia can continue to live in their communities from the mild cognitive impairment stage until the end of life.

In addition to Kakaritsuke Physicians, the community has dementia-support doctors who have attended the training program aimed at cultivating dementia-support doctors held by the Ministry of Health, Labour and Welfare as a means of supporting dementia patients and their families. Regional medical associations should coordinate with dementia-support doctors and medical centers that treat dementia. It is also important that, from the aspect of care services, regional medical associations closely coordinate with care managers, comprehensive community support centers, and dementia community support staff (**Fig. 3**).

Building a Community Based on Healthcare Reassurance

The basis of searching for ways that society can support people with dementia is the view that optimal dementia care lies in everyday life. It is very important to avoid changes in the environments of dementia sufferers and to value or prioritize the continuity of their current lifestyles. It is also important to make sure to keep pace with and reassure individuals with dementia. Employing these approaches, their physical and mental capacities should be maximized so as to allow them feel a sense of fulfillment in their lives. We

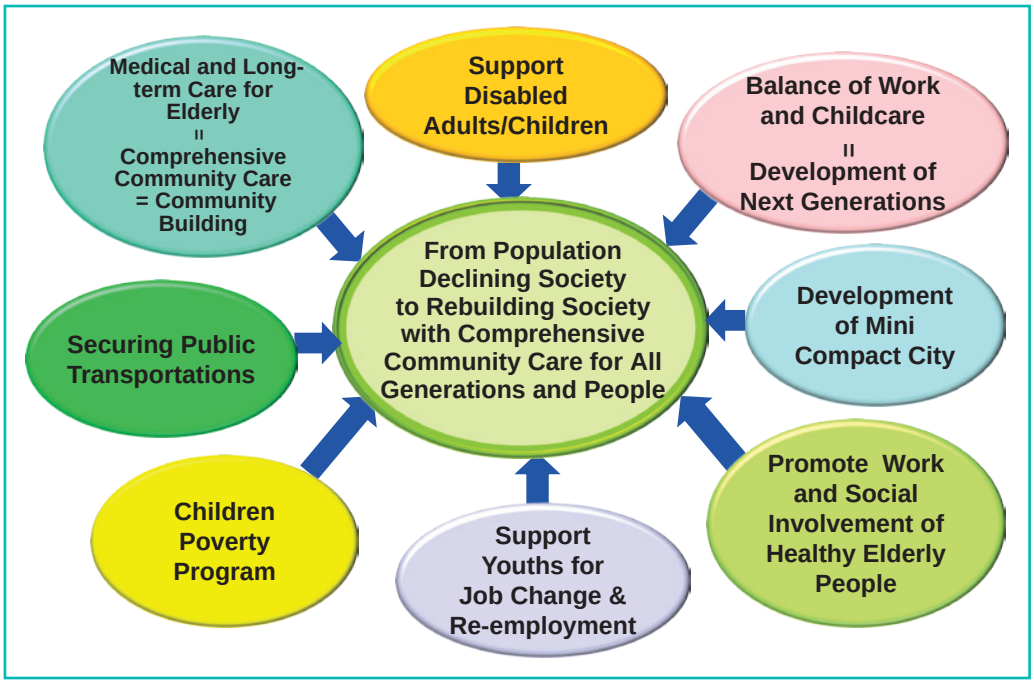

Fig. 4 Ever-evolving comprehensive community care

also convey these aspirations to Kakaritsuke Physicians because dementia is not a disease curable by drug treatment.

We hope to rebuild society with comprehensive community care for all generations, including those on the decline in the current population, by establishing a balance of work and childcare based on evolving comprehensive community care and by caring for elderly people with dementia. Through these efforts, the JMA is anticipated to be able to play a significant part in related fields (**Fig. 4**).

Daily Support Including the Issue of Driver's License Renewal

The final topic to discuss is the issue of driver's license renewal for dementia patients, a recently recognized social problem. Following the recent revision of the Road Traffic Act, drivers 75 years of age or older will be required after March 2017 to take a provisional aptitude test administered by a specialist or submit a medical certificate issued by their Kakaritsuke Physicians, if they have violated certain provisions of the law or have been determined to be at risk of dementia according to a cognitive function test at the time of driver's license renewal. When the driver is diagnosed with dementia, the driver's license is rescinded at the judgment of the prefectural public safety commission.

The number of drivers who lost their driver's licenses for such reasons used to be about 1,650 per year, but is estimated to jump to 40,000-50,000 after the new system begins. Although the police have only to cancel the driver's license, Kakaritsuke Physicians must pay close attention to people with dementia who have lost their driver's licenses. For instance, if they live in a community without access to supermarkets without a car, a problem arises as to how they should be supported in their daily lives, and this is a matter which must be discussed by governmental agencies and local medical associations.

In addition, much still remains unclear as to the criteria for judgment and the contents of the certificate when writing the medical certificate at the time of driver's license renewal. At present, preparation of a guide for writing the certificate is underway and is being led by Dr. Ken Watanabe, Vice President of the Tottori Medical Association. Addressing of this issue is also planned in the training for enhancing Kakaritsuke Physicians' capabilities.

Taking these factors into consideration, it is apparent that discussions among not only medical, care, and welfare service providers but also people in various other fields including the police, fire departments, public transportation services, private companies, and commercial facilities is necessary for building a community to support dementia patients. Cooperation with schools and other educational bodies to deepen understanding of children and younger generations is also necessary. In this situation in which community building may be further extended, it is important for local medical associations and Kakaritsuke Physicians to be closely engaged in this movement.

As efforts to support people with dementia progress and involve the entire society, a caring society for all will be realized. Because Japan is the country with longest life expectancy in the world, it is our responsibility to present a model super-aging society ahead of other countries. It is hoped that the idea of supporting people with dementia will result in closer ties among people who have not previously been known to each other and thereby propel the action of building caring communities for all.

Short Report

Healthcare Delivery to a Repopulated Village after the Fukushima Nuclear Disaster: A Case of Kawauchi Village, Fukushima, Japan

JMAJ 59(4):159-161, 2016

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Key words Healthcare delivery, Access, Fukushima nuclear disaster, Repopulation

Sustaining access to healthcare in a resource-poor setting is a key challenge in achieving global health.[1] While there exist huge differences in healthcare systems between developing and developed countries, shortages of doctors and other health professionals in rural and remote areas are universal issues.[2] In rural areas, both patient-specific and extrinsic factors affect access to healthcare.[3] Among these factors affecting access to healthcare, disasters represent one of the most complex conditions that aggravate healthcare access over the long term. While disasters cause tremendous damages every year around the world, little information is available on which approach is effective in sustaining long-term healthcare access in disaster-stricken remote areas.

Here, we describe the healthcare delivery in Kawauchi Village, Fukushima, which is located in a mountainous area 12 to 30 km southwest of the Fukushima Daiichi nuclear power plant (**Fig. 1**). While the Japanese government issued an evacuation order to nine municipalities including Kawauchi Village immediately after the Fukushima nuclear disaster, the local government declared that it is safe to start returning to the village in January 2012 considering the relatively low radiation level in the area,[4] and all areas of Kawauchi Village were ready for repopulation in June 2016. Among the total 2746 residents, 1820 people have returned to the village (as of July 1, 2016). However, the areas that regional foundation hospitals exist are still under the evacuation order; therefore, access to healthcare services continues to be difficult. The examination of healthcare delivery in Kawauchi Village will hopefully contribute to understanding the essential needs and responses to sustain healthcare access in disaster-stricken remote areas.

There is a national insurance clinic in Kawa uchi Village, which is the only medical institution in the village. One full-time physician provided by the Fukushima prefectural government works in the clinic. The number of patients and their reasons for visiting the clinic are shown in **Figure 2**. Hypertension, dyslipidemia, diabetes, chronic gastritis, gastroesophageal reflux disease, back pain, shoulder pain, arthritis, and sleep disorder are the major causes of visits. Needs to establish outpatient services for metabolic diseases, gastrointestinal diseases, orthopedics, ophthalmology, and psychosomatic medicine are present.

In response to these demands, specialized doctors in these fields are provided by private sectors (Hirata Central Hospital, Asaka Hospital, and Maeda Ophthalmic Clinic) that are in collaboration with local governments, thereby contributing to the delivery of healthcare services in Kawauchi Village. This system is significantly different from the one that was in place before the disaster, in which one physician handled all the patients who visited the clinic and

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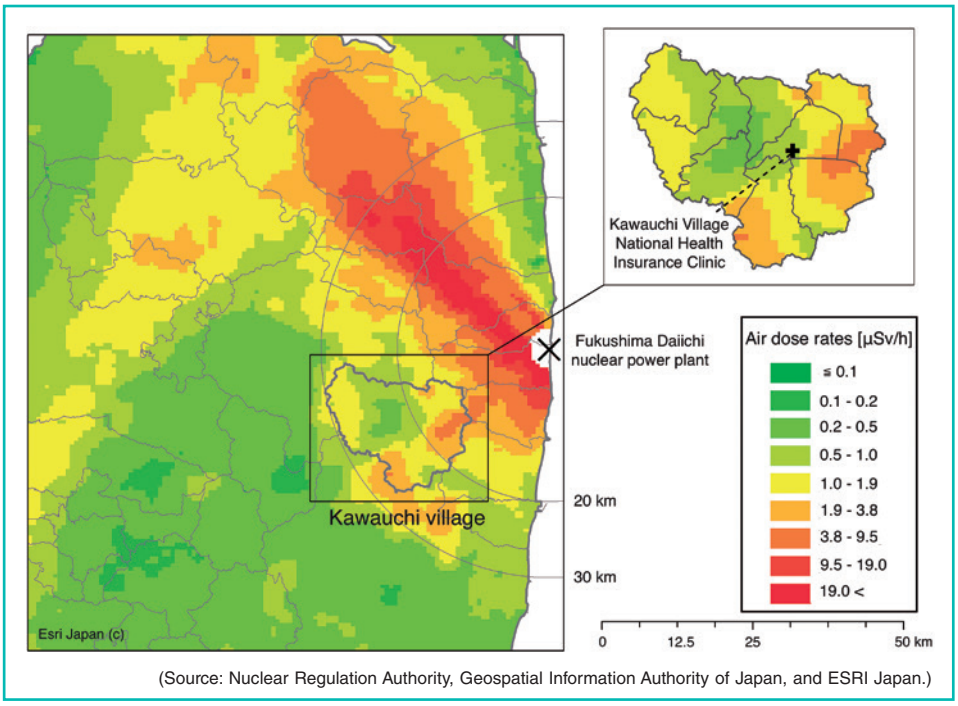

Fig. 1 The geographical location of Kawauchi village, Fukushima
The map is colored according to air dose rates at a height of 1 m above the ground on December 16, 2011.

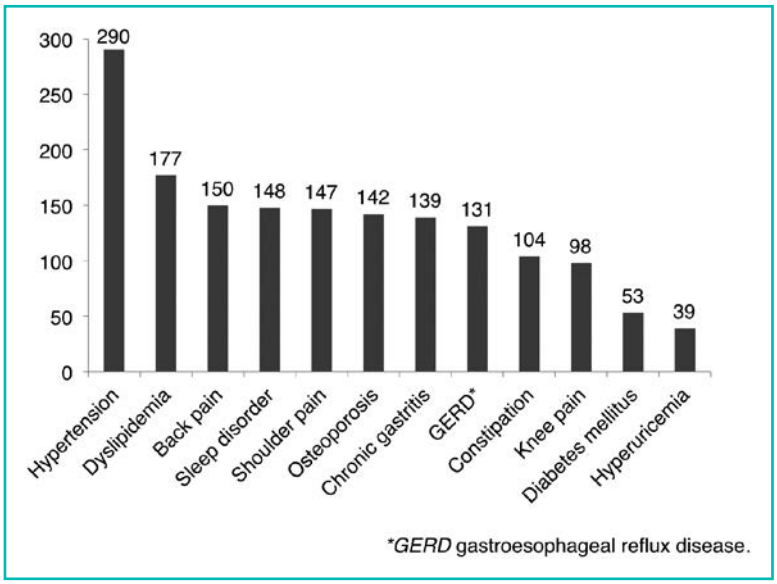

Fig. 2 Number of patients for each purpose of visits
The number of patients who periodically visited the Kawauchi Village National Health Insurance Clinic after the repopulation (from July 2015 to June 2016).

had to transfer difficult cases to other medical institutions when necessary. Although patient care by a single physician is usually expected in remote areas, the presence of specialists enrich

the quality of chronic care. Multilevel cooperation has been achieved to maintain residents' health.

However, several issues remain unresolved, such as home visit, other specialized outpatient services, rapid response to urgent cases, and long-term care. The first one, home visit, is difficult because the clinic physician commutes to Kawauchi from outside the village and cannot cover all the areas of the village (197.4 km^2), although up to six patients received home visits before the disaster. The second one, access to specialized care, is difficult since the foundation hospitals nearby are closed because their areas are still under the evacuation order. Although several specialists work in this clinic, patients with urologic, gynecologic, or dermatologic diseases occasionally need to visit other medical facilities in municipalities outside the evacuation area. The third one, rapid response to urgent cases, is also difficult because emergency hospitals nearby are in the evacuation area and are all closed, and currently accessible emergency hospitals are too distant. It should be noted that more than 50% of emergency patients in Kawa uchi Village were transferred to the hospitals in the evacuation area before the disaster. Finally, the need for long-term care is growing as the returned population is ageing. The number of people certified for long-term care or support in September 2010 and September 2016 are 182 and 249, respectively. Further modulation is needed to address these issues.

In summary, although there are some issues to be resolved, the examination of the healthcare delivery in Kawauchi Village suggests that multilevel cooperation among local and prefectural governments involved and private sectors have successfully contributed to the sound delivery of community healthcare even in a repopulated village after the Fukushima disaster.

Acknowledgments

The authors express their sincere gratitude to the entire staff of the Kawauchi Village National Health Insurance Clinic and Kawauchi Village Healthcare Center. The authors appreciate the members of the Japan Medical Association Junior Doctors Network (namely, Dr. Kazuhiro Abe and Dr. Daisuke Kato) for their insightful suggestions regarding community health and primary healthcare.

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Report on the World Medical Association General Assembly and the Junior Doctors Network Meetings, Taipei, 2016

JMAJ 59(4): 162-164, 2016

Chiaki MISHIMA,[1] Daisuke KATO,[2] Maki OKAMOTO,[3] Kouta SUZUKI[4]

Introduction

As members of the Japan Medical Association Junior Doctors Network (JMA-JDN), we had the chance to participate in the General Assembly of the World Medical Association (WMA), the Junior Doctors Network (JDN) Meeting, and the Asia Pacific Regional Junior Doctors Network Meeting, which were held October 16-22, 2016. In this report, we would like to share our experiences.

About the Junior Doctors Network

The JDN was installed within the WMA in 2010 as a platform for junior doctors all over the world. It is a network for sharing experiences and exchanging opinions about challenges faced by junior doctors; additionally, JDN makes proposals on WMA policies.[1]

In Japan, JMA-JDN was installed under the JMA's Global Health Committee in 2013, and junior doctors throughout Japan have joined. The JMA-JDN aims at developing international perspectives in young doctors, and it has been participating continuously in international conferences such as WMA and the Confederation of Medical Associations in Asia and Oceania (CMAAO). It has developed exchanges and mutual learning opportunities with junior doc-

Photo 1 WMA-JDN meeting

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tors abroad.[2]

In 2016, 4 junior doctors from Japan travelled to Taipei to participate in the WMA General Assembly and the JDN Meeting. We also attended the Asia Pacific Regional JDN Meeting, a venue for Asia-Pacific junior doctors to gather for the first time and learn more about each other.

Meeting Report

Asia Pacific Regional Junior Doctors Network Meeting

On October 16, we attended the Asia Pacific Regional JDN Meeting which took place before the WMA General Assembly. We had the opportunity to make a presentation about junior doctors' working conditions and well-being in Japan. This meeting was the first of its kind, enabling junior doctors working in the Asia-Pacific region to discuss medical issues impacting their home countries.

Today, the problem of overworked doctors is recognized globally. Data from many participating countries showed that doctors work on average 80 to 100 hours per week. To improve the situation, it is important that work hours are defined. Another important issue to solve is how to manage the burden on physicians working in rural areas, where fewer physicians are available and an increasing number of elderly people are in need of additional medical support.

Further, how to integrate a residency training program into the work of a physician is also important from the view of working conditions. In the US, the Accreditation Council for Graduate Medical Education (ACGME) has advocated that nurse practitioners (NPs) and physician assistants (PAs) should be able to assist young physicians without disrupting their educational opportunities. Indeed, 62% of hospitals in the US hire NPs and PAs.

By providing optimal working conditions, we can offer high-quality medical education, reduce physicians' stress, and achieve high satisfaction levels among the labor force. Securing optimal working conditions is a very important issue that everyone should face together; inevitably, it will involve junior doctors worldwide.

Those of us in JMA-JDN have organized a monthly meeting online to discuss our joint research projects, among other activities. This forum provides a great opportunity to exchange ideas according to an international perspective and examine the possibilities of implementing collaborative research in the future.

Junior Doctors Network Meeting

Following the Asia Pacific Regional JDN Meeting, junior doctors attended the WMA-JDN Meeting, which was held on October 17-18. The sessions included a tour of the National Taiwan University Hospital, the election of JDN officers, presentations by country, discussions about end-of-life care, and a meeting with the WMA president, Sir Michael Marmot (**Photo 1**).

On the first day during the country presentations, each member JDN shared experiences and presented the situation of junior doctors in the respective home country. It was interesting to hear about the many different situations of JDNs. For example, most Asian countries tend to have in common the problem of long working hours. Young doctors in Korea have an obligation to serve in the military or as public health doctors. Young doctors in Greece are affected by their country's economy; their salaries have been cut as a result of the economic crisis, and many graduates are still looking for residency opportunities. African junior doctors' working situations are greatly influenced by national problems such as a harsh climate and poverty, making it difficult to dispense doctors to rural or unsafe areas. Finding out about these differences gave us some keys to discovering new tips for making medicine better; additionally, it provided an opportunity to reevaluate the educational system, labor situations, and healthcare system of Japan.

On the second day, there was a panel discussion about end-of-life care; Canada recently legalized euthanasia, and WMA emphasized the development of palliative care. "Just because we can doesn't mean we should" was the most impressive and thoughtful expression of the session. There are many issues to consider before thinking about euthanasia, including family issues, ethical issues, and religious issues; the same is also true for palliative care. We realize that every country has different laws and medical situations, but the most important consideration for palliative care is to establish concrete *patient-oriented* care.

In another session, the election of the JDN

international management team for the 2016-2017 term took place. Chiaki Mishima from Japan was re-elected as Membership Director.

Throughout these 2 days, sharing the same time and place with JDNs from all over the world gave us a great opportunity to reflect on ourselves and our home countries. It was wonderful to find out that there are so many JDNs with passion, strong wills, and warm hearts to make medicine better in the future.

WMA General Assembly

More than 300 doctors from 58 countries—including official members of WMA and JDN from all over the world—took part in this year's WMA General Assembly. Sessions included reports from the Finance and Planning Committee, Socio-Medical Affairs Committee, Medical Ethics Committee, Scientific Session under the theme of "Healthcare System Sustainability," and the election of the president-elect.

The Scientific Session consisted of lectures by many experts, including researchers, clinicians, and the Secretary of the State for Health; in addition, a panel discussion took place. From Japan, Professor Dr. Kenji Shibuya, Department Chair of Global Health Policy, Graduate School of Medicine, University of Tokyo, made a presentation entitled "The Sustainability of Health Care in Aging Society: A Global View."

During the assembly, Dr. Yoshitake Yokokura, the JMA president, was elected as the next WMA president. We are happy to say that taking part in this WMA General Assembly provided us with a great opportunity to learn the latest developments in international health and observe the flow and operation of an international meeting. Moreover, we were able to communicate closely with members of other JDNs, and this opportunity will surely enrich our future activities.

Conclusion

The activities of junior doctors in the WMA have been developing step by step, and an increasing number of junior doctors are participating in them. Junior doctors from Japan are continuously participating in the international JDN meetings, and a Japanese member continues to be elected as an international board member, contributing to JDN operations. The meetings this year revealed that activities of JDN are actively taking place in each region of the world, as observed in the Asia Pacific Regional JDN Meeting. In addition to sharing experiences and knowledge gained through our domestic activities, we—the JMA-JDN—will support other colleagues and contribute toward building a better network of junior doctors in the Asia-Pacific region.

Finally, we would like to express our gratitude to the WMA and JMA for giving us this valuable opportunity.

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Essay

From a Far Eastern Study Room

JMAJ 59(4): 165-168, 2016

Tatsuo KUROYANAGI[1]

At the 51st WMA General Assembly, held in Tel Aviv, Israel, in autumn 1999, the World Medical Association (WMA) decided to develop "basic medical ethics education materials" for the use of those involved in the healthcare field, such as physicians, nurses, and medical students.

With the WMA Secretariat's Ethics Unit playing a central role and taking charge in this endeavor, Dr. John R. Williams in charge of ethics at the Canadian Medical Association's was requested to take on the position of director of the WMA's Ethics Unit. Dr. Williams comprehensively reviewed all of the WMA's past policy documents to draft "basic ethics education materials" using this knowledge as background. In 2005, the fruits of these efforts were published by the WMA as the "WMA Medical Ethics Manual." Although the original language is English, this manual has been translated into many other languages such as French, German, Spanish, Japanese, Chinese, various Eastern European languages, and Russian. The manual, including the 2010 and 2015 revised versions, is being used on a global scale.

However, the achievements of Dr. Williams (or "John-san," as we call him) did not stop there. From around the time that Dr. Otmar Kloiber was appointed to the position of WMA Secretary General in 2004, as director of the WMA's Ethics Unit and as an ethicist from Canada —a country that has two official languages, English and French—Dr. Williams fully demonstrated his exceptional writing abilities, making a tremendous contribution to the preparation and adoption of WMA declaration and resolution documents (in English) by committees, the councils, and the general assemblies. Incidentally, during committee discussions there were frequent conflicts between "Queen's English" speaking countries and "American English" speaking countries over expressions. In such situations, it was perhaps John-san who first showed that it was possible to create English-language documents that could harmonize the two. Dr. Williams was succeeded by Dr. Jeff Blackmer of the Canadian Medical Association, who served as director until the spring of 2016. They both played a very important role, and it is desirable that in future Canada continues with this tradition.

John-san was also appointed as facilitator for the working group to begin the work of the revision of the Edinburgh (2000) revision of the Declaration of Helsinki (DoH) that was decided at the WMA Council Session held in Berlin in April 2007, and he played a leading role in the revision process. As an advisor to the Medical Ethics and Socio-Medical Affairs Committees, the author attended the expert meetings held by the WMA working group in locations such as Sao Paulo, Divonne-les-Bains, and Helsinki. These expert meetings brought together world-famous controversialists, such as Dr. Robert Temple of the FDA, and as facilitator, John-san formed a tag-team with WMA Secretary General Dr. Otmar Kloiber with close cooperation of WMA Chair of Council Dr. John Edward Hill, formulating the draft for the DoH Seoul revision, including the declaration structure and text, and guiding it towards its adoption in October 2008.

Looking back again at the process that took place at that time, WMA Council Chair Dr. Hill can be regarded as having had an enormous presence. Dr. Hill introduced to the WMA a system for expediting proceedings and decision-making called the "Consent Calendar" method. This system enables important points to be dis-

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cussed intensively within a limited amount of time and decisions to be made based on these discussions, and Dr. Hill is truly worthy of the title "Famous Chair." At the same time, as Council Chair, Dr. Hill took care to reflect the opinions of each national medical association in the resolution as far as possible. He also attended all DoH working group meetings and expert meetings, providing support for those formulating the revisions from behind.

During the process of drafting the DoH Seoul revision, I was able to have various unexpected experiences. The first one was at the time of the expert's meeting held in Sao Paulo. Then-president of the Brazilian Medical Association, Dr. Jose Luis Amaral, kindly secured front-row seats for us at the opera theater, and we saw the opera *Ariadne auf Naxos*. Looking at the casting of this large-scale opera, I learned that Brazil and Europe are close regions on opposite sides of the Atlantic Ocean, unlike what I had imagined from the distant Far East. For the first time I was able to understand in a geographical sense the feeling of being trapped felt by Stefan Zweig, an author I hold in the highest regard, when he heard that Japan had entered the war soon after he had arrived in Brazil via the United States after escaping the madness of the Nazis.

My second unexpected experience occurred in March 2008, when the final experts meeting (which decided the working group draft to be submitted to the spring Council session) was held in Helsinki. In March, the sunlight in Tokyo is already springtime. While northerly and southerly winds play tug-of-war over the Japanese Archipelago, the season gradually moves into full springtime/cherry blossom season. Probably we flew via Germany, and when we landed at Helsinki Airport the clouds were low in the sky and snow was dancing around, so there was absolutely no sense of springtime. Just as we were leaving the airport in this cold air, we were reunited with Dr. Williams, or "John-san" as we call him. Since we had some time before hotel check-in, we visited the resting place of Finnish composer Jean Sibelius, and we invited John-san to come along. Located near a lake shore covered in snow, Ainola presented a beautiful snowscape, and we were instantly transported from spring back into winter. Alighting from the bus, we tramped through snow-covered fields and through the woods to the gate to Sibelius's former home, then turned back, all the while trying to bear the cold (**Photo 1**). In February 2017, as I listened to a Sibelius violin concerto performed by the NHK Symphony Orchestra, Tokyo, conducted by Paavo Järvi, for some reason I found myself remembering the snowy scene at Ainola House.

Photo 1 At Ainola House
From left, the author, Dr. J. Williams and Mr. H. Tsuruoka

On the afternoon of March 11, 2011, Japan experienced the catastrophic Great East Japan Earthquake and huge tsunami. The Sanriku coastal region which was hit by the tsunami comprises rugged mountains and a jagged ria coastline, and was previously known as the "Tibet of Japan." My wife was born in Morioka, the prefectural capital of the region, but her legal domicile is in Kamaishi, in the central coastal region that suffered catastrophic damage in the earthquake and subsequent tsunami. However, despite the Sanriku region being a somewhat remote area, it has produced some of Japan's representative international figures. One of these is Dr. Inazo Nitobe, who famously said, "We must become a bridge over the Pacific

Ocean." In his later years, Dr. Nitobe frequently visited his hometown on the Sanriku coast, leaving the words, "Life is a journey through Shimohei County. On the land there are mountain peaks; on the ocean, there are rough waves."

In October 2012, I attended the WMA General Assembly in Vancouver with my wife. Arriving at Vancouver Airport, I learned that Vancouver is the closest city to Japan on the American continent, and from previous investigations I know that Vancouver was also the place where Dr. Inazo Nitobe spent his last days.

At this WMA general assembly, we saw John-san and his wife again for the first time in a while. I learned that John-san is a "Vancouverite" as was raised in this wonderful city. However, he currently lives in Ottawa, where he is continuing to conduct research. From the perspective of Ottawa—located in the eastern side of the American continent, near the Pacific Ocean—Vancouver may seem to be a "remote" area of Canada, situated as it is on the western coast of the continent, over the Rocky Mountains. It occurred to me that John-san and Dr. Nitobe were raised in similar environments. With that in mind, I decided that I wanted to visit historical sites connected to Dr. Nitobe during our stay in Vancouver. I also heard that there is a Japanese garden commemorating Dr. Nitobe at the University of British Columbia, but although we managed to get to the university, we lost our way on the campus and regretfully were unable to visit the garden due to time restraints. Coincidentally, the following day—October 13—was our Golden Wedding Anniversary, and we had the unexpected good fortune to be able to celebrate with our companions at a restaurant near the hotel that evening.

In the summer of 2016, the "Professional Ethical Guidelines for Physicians"—newly revised by JMA President Yoshitake Yokokura—and the Japanese translation of the "WMA Medical Ethics Manual" (2015 revised version) were both published in booklet form and were to be distributed to all JMA members by the end of the year. Accordingly, the author reviewed the final versions of both booklets, and with regard to the latter (for which I had been representative of the group translating the 2007 version) in particular, read carefully through the entire translation together with the translation project's supervisor, Professor Norio Higuchi of the University of Tokyo. Consequently, I was immensely impressed by the structure of the booklets, the richness of their content, and their easy readability, and I felt strongly that they were essential reading for not only the 170,000 members of the JMA but also medical students, nurses, and other medical professionals in Japan. These are educational materials that could only have been created by John-san, who as head of the WMA's Ethics Unit, has a thorough knowledge of all WMA declarations and resolutions, and has been involved in the revision of various declarations including the Declaration of Geneva, the International Code of Medical Ethics, and the Declaration of Madrid. When I presented several volumes of the manual to a representative Japanese civil law scholar, after immediately accessing the original version, he praised the manual's content and explanations, saying that the manual was excellent and easy for even beginning students to understand. I would especially like to note that he also praised the Japanese translation.

It is no exaggeration to say that John-san is truly an expert in the implementation of medical ethics who has become a bridge for medical ethics over not only the Pacific Ocean, but also the world's five continents.

Following publication of the Japanese-language version of the "WMA Medical Ethics Manual" (2005 version) in 2007, the JMA newly published the Japanese-language version of the "WMA Medical Ethics Manual" (2015 version) in 2016, and as someone who was involved in the translation process both times, I was reminded of the existence of an extremely fundamental and important issue: to what extent can the WMA—an organization bringing together nations with a diversity of different cultures and languages—achieve unity of purpose through differing languages? The job of specialist litigation attorneys like us is to play the role of a bridge in the courtroom enabling the judge—who is a legal expert—to understand specialized technologies and specialized technological content that are the subject of the legal judgement. This job has aspects in common with translation. The WMA comprises people from various different cultural regions, and it can be said that having all these people discuss and reach complete agreement on an issue, and then formulate a declaration or resolution, is an extremely difficult challenge.

For example, even now there still remain doubts as to whether or not the Japanese translations of words such as "human," "integrity," "intervention," "autonomy," and "involve"—which are used in the Declaration of Helsinki—match the understanding of these terms of people in the UK, US, Canada, France, Spain, Germany, and other countries. However, it is necessary that people mutually recognize this wall impeding comprehension of words while continuously meeting face-to-face or communicating through telecommunications to discuss matters thoroughly, searching peacefully for points of agreement, and this is the duty required of those involved in national medical associations, which are nongovernment organizations. I think that this is also a problem that exceeds simple issues of translation and interpretation. As one of its missions, the WMA—which is a nongovernmental organization comprising physicians who are private citizens and not an organization comprising countries—surely needs to continue in future to make efforts to minimize differences in awareness and misunderstandings between people participating in WMA discussions conducted in various languages.

From the Editor's Desk

Thank you for reading the Japan Medical Association Journal (JMAJ) over these many years. This will be the final issue of the JMAJ in its present form. In accordance with changes in editorial policy, the JMAJ will be published as a peer-reviewed journal beginning during 2017.

Over the years, the JMAJ has presented a broad range of information—translations of articles on Japan's latest healthcare information published in the Japanese-language Nippon Ishikai Zasshi (Journal of the Japan Medical Association); domestic and international activities of the JMA; disaster medicine measures such as Japan Medical Association Team (JMAT) which provided medical support activities in disaster areas following the Great East Japan Earthquake; lectures and speeches at the Confederation of Medical Associations in Asia and Oceania (CMAAO) General Assemblies; etc.—in a timely manner as necessary.

This information will continue to be published in the future through such media as the JMA's English-language website (http://www.med.or.jp/english/) and the CMAAO Website (http://www.cmaao.org/).

Relaunched as a peer-reviewed general medical journal, the JMAJ aims to contribute to global healthcare by functioning as a medium for conveying high-quality information emanating from the JMA, as well as attain an impact factor.

The JMA intends to newly establish an Editorial Office within the International affairs Division and the JMAJ Editorial Board.

The transition from the JMAJ's current form into a peer-reviewed journal is expected to take a little time, but it is our sincere hope that going forward you will continue to read the JMAJ in its revamped form.

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Principles of Medical Ethics

Japan Medical Association

The mission of medical science and health care is to cure diseases, to maintain and promote the health of the people; and based on an awareness of the importance of this mission, the physician should serve society with a basic love for humanity.

1. The physician should strive to achieve a lifelong dedication to continuing education, to keep abreast of medical knowledge and technology, and to support its progress and development.

2. The physician should be aware of the dignity and responsibility of his/her occupation and strive to enhance his/her cultural refinement, education, and integrity.

3. The physician should respect the individuality of his/her patients, treat them with compassion, provide full explanations of all medical treatment, and endeavor to earn the trust of the patient.

4. The physician should maintain respect for his/her fellow physician, cooperate with medical care personnel and serve the cause of medical care to the best of his/her abilities.

5. The physician should respect the spirit of public service that characterizes health care, contribute to the development of society while abiding by legal standards and establishing legal order.

6. The physician will not engage in medical activities for profit-making motives.

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