Journal of Medical English Education

February 2016
Vol. 15 No. 1

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Official Journal of the Japan Society for Medical English Education (JASMEE)
Journal of Medical English Education
Vol. 15, No. 1, February 2016

Journal of Medical English Education, the official publication of The Japan Society for Medical English Education, was founded in 2000 to promote international exchange of knowledge in the field of English education for medical purposes. Until June 2006 (Vol. 5 No. 2), the registered title of the Journal was Medical English - Journal of Medical English Education; the current title, which was registered in December 2006 (Vol. 6 No. 1), should be used for citation purposes.

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2–30 Ichigaya–hommuracho, Shinjuku–ku, Tokyo 162–0845, Japan
第19回 日本医学英語教育学会 学術集会 開催案内

日本医学英語教育学会は1998年に第1回医学英語教育研究会を開催され、その後、医学英語に関する研究を推進し、医学英語教育の向上を図る目的で学会として発展して参りました。現在では400名以上に及ぶ会員を有しております。

医学英語教育は卒前・卒後・生涯教育として重要であり、医療の国際化、医師国家試験の英語問題導入や医学英語検定試験など、専門職教育の限られた時間でどのように教育を行うかが課題です。学術集会では年例、医療系の英語教育に係わる教員・研究者・医療関係者が参加し研究・事例を報告します。平成28年度学術集会は上記により開催します。日本医学教育学会の審査をもって本会に是非ご参加いただき、医学英語教育について情報を交換していただければと思います。

記

学会名：第19回医学英語教育学会学術集会

日時：平成28年7月16日（土）～17日（日）

会長：Timothy Minton（慶應義塾大学医学部 英語教室）

会場：慶應義塾大学日吉キャンパス（〒223-8521 神奈川県横浜市港北区日吉4-1-1）

演題募集：平成28年2月1日正午～3月31日 午前12時

（医学英語教育の目標・教育方法・評価、学生評価、語学教育と専門教育の統合、実践力教育、グローバル人材育成、医学・看護学・医療系教育における医学英語教育、英語教育による医学英語教育、医学・看護学・医療系教育者による医学英語教育、医学英語教育におけるシミュレーション教育・ICT活用、教員教育体系作成、医学英語論文指導・校閲・編集、医学論文作成における倫理、国際学会でのスライド作成と発表法、USMLE受験指導、医療通訳、医学英語検定試験。その他の医学英語教育に関する演題）

☆英語・日本語のどちらでも発表できます。学会ホームページよりご登録ください。

☆詳細は学会ホームページをご参照ください。

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Second Announcement
The 19th Academic Meeting of the Japan Society for Medical English Education

The Japan Society for Medical English Education (JASMEE) held its first meeting as a study group in 1998. Since then, the society’s main aims have been to promote research in fields related to medical English, and to support and encourage improvements in medical English education. JASMEE now has more than 400 members.

With the globalization of medicine and such recent developments as the introduction of questions in English in Japan’s National Medical Practitioners Qualifying Examination, the challenge of how best to make use of the limited time available for medical English education in university curricula is ever more pressing. JASMEE’s annual academic meetings seek to address this challenge with a wide variety of presentations, symposia, and workshops given by experts in the field.

Information about the 19th JASMEE academic meeting is presented below. We look forward to welcoming JASMEE members and non-members alike to this meeting, where they will be able to share their experiences and expertise with others in the field to the greater benefit of medical English education in Japan and beyond.

Dates: Saturday July 16 and Sunday July 17, 2016
Venue: Keio University Hiyoshi Campus
4-1-1 Hiyoshi, Kohoku-ku, Yokohama
President: Timothy D. Minton
(English Department, Keio University School of Medicine)

Call for papers: Proposals for papers on the following subjects (or similar) should be submitted by March 31, 2016.

- goals, methods, and assessment of medical English education
- student evaluation
- integration of language education and specialized education
- global human resource development
- medical English for nursing and other healthcare-related fields
- the use of technology in EMP education
- faculty development
- teaching of medical writing
- medical English editing
- the art of presenting at international meetings
- USMLE preparation
- medical interpreting
- EPEMP

Submissions will only be accepted from JASMEE members in good standing. To submit a proposal, please access the JASMEE homepage (http://www.medicalview.co.jp/JASMEE/gakuju.html).

Inquiries should be addressed to the JASMEE Secretariat (c/o Medical View, Attn: Mr. Eguchi)
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# Journal of Medical English Education

The official journal of the Japan Society for Medical English Education

[jasmee@medicalview.co.jp](mailto:jasmee@medicalview.co.jp)

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<td>Tokyo</td>
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### Former editors-in-chief

- Reuben M. Gerling, 2008–2014
- Nell L. Kennedy, PhD, 2004–2008
- Shizuo Oi, MD, 2000–2004

### Executive adviser emeritus

Kenichi Uemura, M.D.
Editor’s perspectives

Into 2016

This, the first issue of 2016, contains two articles that did not quite make it into last October’s special issue on extracurricular activities. No matter: such activities play a vital role in medical English education both here and abroad, so we will always welcome articles describing innovative programmes that others in the field can usefully adopt at their institutions.

This issue also contains four summaries of presentations given by invited speakers at JASME’s 18th Academic Meeting last year in Okayama, along with three original articles on studies that will certainly be of interest to JMEE’s readers. Sadly, we are also including two obituaries (one in Japanese, and one in English) for Nell Kennedy, who died last October. As many members will know, Nell played a leading role in the society’s activities from its founding in 1998 until ill health forced her to retire in 2008.

At this time of the year, our thoughts turn to the annual Academic Meeting, which will be held as usual on the third weekend of July (16th and 17th). We are already accepting proposals from JASME members for presentations on general topics related to medical English education; please see pages 1 (Japanese) and 2 (English) for a list of suggested topics, bearing in mind that the list is not exhaustive. The deadline for submitting proposals is March 31st.

Highlights of the July meeting include a keynote address by Professor Makoto Suematsu, President of the newly established Japan Agency for Medical Research and Development (AMED), who will speak on AMED’s efforts to prevent the Balkanization of medicine; a panel discussion on cooperation between clinicians and English teachers, chaired by Professor Alan Hauk; updates on JASME’s key activities by Dr Takayuki Oshimi (clinical skills seminars), Professor Masahito Hitosugi (JASME’s new EMP textbooks), and Professors Isao Date and Masanori Ito (EPEMP Levels 1 and 2); and two workshops, one involving a discussion of key issues in medical English education between EMP teachers and medical students (facilitated by Dr Oshimi, et al.), and the other on creating interactive e-learning materials for EMP (facilitated by JASME’s ITC Subcommittee under the chairmanship of Professor Raoul Breugelmans).

The weekend of July 16/17 is, I think, one that we can all look forward to.

Timothy D. Minton
Editor-in-Chief
Journal of Medical English Education
An extracurricular clinical English program for Asian medical undergraduates

Takayuki Oshimi,* Eric H. Jego,* and James C. Thomas**
*Division of Medical Education Planning and Development, Nihon University School of Medicine
** Medical Education Center, Keio University School of Medicine

**BACKGROUND:** There exists a growing need for Japanese medical undergraduates to develop their clinical communicative competencies in English. This study describes a short-term extracurricular pilot program that was developed at Stanford University and other institutions in the San Francisco Bay Area to assist Asian medical undergraduates with non-English speaking backgrounds improve their English communication skills for clinical purposes. These skills include: 1) patient encounter skills, 2) clinical case presentation skills, and 3) clinical research article discussion skills. This report also includes participants’ self-assessment of their clinical communication skills before and after taking the program.

**METHODS:** This clinical English program consisted of eight 90-minute sessions covering the three aforementioned skill sets using lectures, tutorials, and problem-based learning formats. Thirty-four Asian medical undergraduates from Japan, Taiwan, and Mainland China were enrolled in 2014. These students evaluated their own progress in clinical English skills by answering 30 specially prepared can-do statements before and after training.

**RESULTS:** On completion of the program, a significant improvement was observed in the answers to the can-do statements, except in the eight referring to areas that require substantial clinical reasoning skills or comprehensible pronunciation.

**CONCLUSIONS:** This short-term clinical English pilot program was effective in improving clinical communicative English competencies that do not require substantial clinical reasoning skills. The program may serve as a useful extracurricular program to help address rising demand for educational opportunities to develop clinical English skills.

**Keywords** English for medical purposes (EMP), clinical English, extracurricular activities, can-do statements

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1. Introduction

English is widely recognized as the lingua franca in medicine, and acquiring a high level of English proficiency is assumed to be a prerequisite for a successful career in this profession. Many medical schools in non-English speaking countries provide English for medical purposes (EMP) education, which addresses academic and medical knowledge acquisition in English. Currently, not many medical schools in Japan have curricula that adequately address clinical proficiency in English. A recent survey revealed that Japanese medical students wanted more opportunities to develop their clinical communicative English competencies, including patient encounter skills, clinical case presentation skills, and clinical research article discussion skills. These three skill sets are also essential for clinical clerkships in the United States.

We developed a short-term extracurricular pilot program in the San Francisco Bay Area to assist Asian medical undergraduates from non-English speaking backgrounds improve their clinical communicative competencies in English. Participants’ self-assessment of the improvement of their clinical communication skills before and after the course was used to evaluate the effectiveness of the program.

2. Methods

2.1. Description of the program

The authors are collaborating with a non-profit organization that offers a cross-cultural exchange program in the San Francisco Bay Area aimed at medical undergraduates of Asian extraction. This program is known as “Medical
Exchange and Discovery (MED)." The first author of this study was invited to develop a short-term pilot extracurricular clinical English course for inclusion in this program. Thirty to forty medical undergraduates from Japan, Taiwan, and Mainland China are accepted every year. While staying at a dormitory at Stanford University for three weeks in August, participants have the opportunity to visit a variety of health care organizations in the San Francisco Bay Area, including Stanford School of Medicine and University of California in San Francisco. During the program, participants have opportunities to: 1) increase their understanding of health care issues in the United States, 2) compare those health care issues with those in their home country, 3) reflect on what they want to accomplish as a doctor in the future, and 4) improve their practical clinical English skills. After the program, Bay Area students who served as student coordinators and mentors have the opportunity to travel to the Asian participants' countries to learn about health care there.4

The organizer of the program, formerly known as Volunteers in Asia (VIA), is a non-profit organization founded in 1963 to send Stanford University student volunteers to Asian countries. VIA has been organizing short-term educational programs for Asian students at Stanford University since 1977.5 The MED program is modeled on their Exploring Health Care (EHC) program, which initially started with two Japanese private medical universities (Tokyo Women's Medical University and Tokyo Medical University) in 1996, and has since expanded to include other Japanese medical schools.6 Observing the positive post-program feedback from participants in this all-Japanese spring program, VIA started the MED program in 2012 by accepting 21 medical undergraduates. Application to the MED program is currently open to any medical undergraduates from three Asian countries, and the number of participants increased from 28 in 2013 to 34 in 2014 and 41 in 2015.

To achieve the four objectives identified above, the MED program provides a diverse array of activities: 1) clinician shadowing at various Bay Area hospitals and clinics; 2) guest speaker presentations and panel discussions on topics such as organ transplantation, American medical education, American health care economics, and palliative care; 3) organized visits to various Bay Area health care institutions; 4) small and large group reflections; and 5) a clinical English program.3

The objective of the clinical English program is to prepare participants for their clinical shadowing responsibilities during the MED program. Experience gained in the two MED programs held in 2012 and 2013 led to the content of the clinical English program for MED 2014 being reorganized into the following three sets of clinical skills: 1) patient encounter communication skills (PE), 2) clinical case presentation skills (CP), and 3) clinical research article discussion in a journal club format (JC). The clinical English program for MED 2014 consisted of eight 90-minute sessions covering the three above-mentioned skill sets using lectures, tutorials, and problem-based learning formats. The instructor is the first author of this study, who is a bilingual Japanese medical doctor with seven years of experience in medical English education.

The objectives of the clinical English program appear in the form of can-do statements in Appendix 1 for the PE skills, Appendix 2 for the CP skills and Appendix 3 for the JC skills. The can-do statements for the PE skills are based on the three subcomponents of the United States Medical Licensing Examination Step 2 Clinical Skills: Spoken English Proficiency (SEP), Integrated Clinical Encounter (ICE), and Communication and Interpersonal Skills (CIS).7 The can-do statements from PE-1 to PE-3 in Table 2 reflect SEP skills; those from PE-4 to PE-7, ICE skills; and those from PE-8 to PE-10, CIS skills.

The can-do statements for the CP skills were modeled on subcomponents of the SNAPPS case presentation format, which is a learner-centered model for case presentations to the preceptor consisting of six steps: (1) Summarize briefly the history and findings; (2) Narrow the differential to two or three relevant possibilities; (3) Analyze the differential by comparing and contrasting the possibilities; (4) Probe the preceptor by asking questions about uncertainties, difficulties, or alternative approaches; (5) Plan management for the patient’s medical issues; and (6) Select a case-related issue for self-directed learning.8

It is difficult to formulate a universally acceptable format for clinical research article discussion skills in a journal club format. After observing many journal clubs in the United States and Japan, the first author created a pilot journal club format that includes not only traditional journal club components such as a techniques for formulating clinical questions in terms of the problem/population, intervention, comparison, and outcome (PICO),9 but also authors’ affiliations, original contribution of the article, editorial articles, correspondence articles, and conference reports of the original article.

### 2.2. Subjects

In 2014, 34 Asian medical undergraduates were enrolled in the MED program; of those 18 were from Japan, 13 from Taiwan, and 3 from Mainland China. The characteristics of the participants are shown in Table 1.
2.3. Assessment

After observing the challenges faced by MED program participants during clinical shadowing in 2012 and 2013, the authors created 10 learning objectives for each set of required clinical English skills and described them in the form of a “can-do statement” checklist (Table 2). Can-do statements are self-assessment descriptors widely used in the field of foreign language acquisition. They provide learning facilitators with performance indicators and a way to chart learners’ progress through incremental steps. Our in-house can-do statements (Appendix 1–3) were distributed to the participants immediately before and after the program. The participants were asked to check the “yes” box for each can-do statement they felt applied to them. The number of checked boxes was counted and tabulated. We hypothesized that any changes that occurred in specific skills did so as a result of the clinical English program.

3. Results

3.1. Skills without significant improvement by the end of the clinical English program

The pre- and post-program responses to individual can-do statements are shown in Table 3.

The first assumption of this study was that the pre-program responses to the 30 can-do statements accurately identified which skills the participants believed they had or had not yet acquired; the second assumption was that the post-

Table 1. Characteristics of the participants of the MED program in 2014

<table>
<thead>
<tr>
<th>Home country</th>
<th>Total (male:female)</th>
<th>1st year (male:female)</th>
<th>2nd year (male:female)</th>
<th>3rd year (male:female)</th>
<th>4th year (male:female)</th>
<th>5th year (male:female)</th>
<th>6th year (male:female)</th>
<th>Average year (male:female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>18 (4:14)</td>
<td>5 (0:5)</td>
<td>0</td>
<td>3 (1:2)</td>
<td>3 (1:2)</td>
<td>7 (2:5)</td>
<td>0</td>
<td>3.4 (4.3:3.1)</td>
</tr>
<tr>
<td>Taiwan</td>
<td>13 (6:7)</td>
<td>0</td>
<td>6 (4:2)</td>
<td>5 (1:4)</td>
<td>1 (0:1)</td>
<td>1 (1:0)</td>
<td>0</td>
<td>2.8 (2.7:2.9)</td>
</tr>
<tr>
<td>China</td>
<td>3 (0:3)</td>
<td>0</td>
<td>3 (0:3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2.0 (0.2:0)</td>
</tr>
<tr>
<td>Total</td>
<td>34 (10:24)</td>
<td>5 (0:5)</td>
<td>9 (4:5)</td>
<td>8 (2:6)</td>
<td>4 (1:3)</td>
<td>8 (3:5)</td>
<td>0</td>
<td>3.0 (3.3:2.9)</td>
</tr>
</tbody>
</table>

Table 2. Can-do statements

<table>
<thead>
<tr>
<th>Code</th>
<th>Can-do statements for patient encounter (PE) communication skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE-1</td>
<td>I can use appropriate non-medical language that a patient can understand.</td>
</tr>
<tr>
<td>PE-2</td>
<td>I can use comprehensible pronunciation.</td>
</tr>
<tr>
<td>PE-3</td>
<td>I can minimize the need to repeat questions or statements.</td>
</tr>
<tr>
<td>PE-4</td>
<td>I can summarise information provided by a patient.</td>
</tr>
<tr>
<td>PE-5</td>
<td>I can cover the main areas of a medical history.</td>
</tr>
<tr>
<td>PE-6</td>
<td>I can identify appropriate differential diagnoses.</td>
</tr>
<tr>
<td>PE-7</td>
<td>I can form an appropriate plan and management strategy.</td>
</tr>
<tr>
<td>PE-8</td>
<td>I can develop a level of rapport with a patient.</td>
</tr>
<tr>
<td>PE-9</td>
<td>I can support a patient’s emotions, concerns, and expectations.</td>
</tr>
<tr>
<td>PE-10</td>
<td>I can use good verbal and non-verbal communication techniques.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Code</th>
<th>Can-do statements for clinical case presentation (CP) skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP-1</td>
<td>I can understand case presentations at a clinical setting.</td>
</tr>
<tr>
<td>CP-2</td>
<td>I can identify what is a good case presentation.</td>
</tr>
<tr>
<td>CP-3</td>
<td>I can summarize a medical history.</td>
</tr>
<tr>
<td>CP-4</td>
<td>I can narrow the differential diagnoses to 2 or 3 relevant possibilities.</td>
</tr>
<tr>
<td>CP-5</td>
<td>I can distinguish between relevant and irrelevant information for a case presentation.</td>
</tr>
<tr>
<td>CP-6</td>
<td>I can use appropriate expressions in my case presentation.</td>
</tr>
<tr>
<td>CP-7</td>
<td>I can analyse the differential diagnoses by justifying and contrasting the other possibilities.</td>
</tr>
<tr>
<td>CP-8</td>
<td>I can ask questions to an attending doctor about uncertainties, difficulties, or alternative approaches.</td>
</tr>
<tr>
<td>CP-9</td>
<td>I can plan management for a patient’s medical issues.</td>
</tr>
<tr>
<td>CP-10</td>
<td>I can select a case-related issue for self-directed learning.</td>
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<tr>
<th>Code</th>
<th>Can-do statements for clinical research article discussion in a journal club (JC) format</th>
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<tbody>
<tr>
<td>JC-1</td>
<td>I can guess the type of medical article from its title.</td>
</tr>
<tr>
<td>JC-2</td>
<td>I can guess the conclusion of an original article from its title.</td>
</tr>
<tr>
<td>JC-3</td>
<td>I can determine if an original article is global or local research by examining its authors’ affiliations.</td>
</tr>
<tr>
<td>JC-4</td>
<td>I can determine what is new about an original article by examining its Background section.</td>
</tr>
<tr>
<td>JC-5</td>
<td>I can identify the type of research and the clinical question of an original article by examining the “PICO*” or “PECO**”</td>
</tr>
<tr>
<td>JC-6</td>
<td>I can evaluate the results of an original article by examining its ratios, confidence intervals, and p values.</td>
</tr>
<tr>
<td>JC-7</td>
<td>I can identify the interpretation of the results and generalisability of an original article by examining its Discussion section.</td>
</tr>
<tr>
<td>JC-8</td>
<td>I can determine the value of an original article by examining its Editorial article.</td>
</tr>
<tr>
<td>JC-9</td>
<td>I can evaluate articles that are similar to an original article by examining its Correspondence article.</td>
</tr>
<tr>
<td>JC-10</td>
<td>I can evaluate the impact of an article on the community by examining its Conference Report.</td>
</tr>
</tbody>
</table>

*patient (problem), intervention, comparison, and outcome **patient (problem), exposure, comparison, and outcome
program responses did the same. The hypothesis based on these two assumptions was that differences in pre- and post-program responses would indicate how much the participants felt they had improved on completing the program, and in which skills.

To test this hypothesis, 30 separate 2x2 McNemar tests for paired proportions were used to compare the pre- and post-program responses to individual statements (Table 4). Results were considered significant at an a priori alpha level of 0.05. On the basis of these criteria, participant responses showed no significant difference: PE-2 (“I can use comprehensible pronunciation.”), PE-4 (“I can summarize information provided by a patient.”), PE-6 (“I can identify appropriate differential diagnoses.”), PE-7 (“I can form an appropriate plan and management strategy.”), CP-4 (“I can narrow the differential diagnoses to 2 or 3 relevant possibilities.”), CP-5 (“I can distinguish between relevant and irrelevant information for a case presentation.”), CP-7 (“I can analyze the differential diagnoses by justifying and contrasting the other possibilities.”), and JC-1 (“I can guess the type of medical article from its title.”).

3.2. Skills that over 50% of all the participants did not acquire by the end of the clinical English program

The second hypothesis of this study was that there would be some particularly challenging skills that over half of the participants would not feel they had successfully acquired through the program. Table 3 shows that over 50% of the participants believed they had not acquired the associated skills for the following five can-do statements on completion of the program: PE-6 (“I can identify appropriate differential diagnoses.”), PE-7 (“I can form an appropriate plan and management strategy.”), CP-4 (“I can narrow the differential diagnoses to 2 or 3 relevant possibilities.”), CP-7 (“I can analyze the differential diagnoses by justifying and contrasting the other possibilities.”), and JC-1 (“I can guess the type of medical article from its title.”).

### Table 3. Can-do statements responses (yes)

<table>
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<tr>
<th>Code</th>
<th>Pre-program: Japan (n=18)</th>
<th>Post-program: Japan (n=17)</th>
<th>Pre-program: Taiwan (n=13)</th>
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<th>Post-program: China (n=3)</th>
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</thead>
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<tr>
<td>PE-1</td>
<td>2 (11.1%)</td>
<td>10 (58.8%)</td>
<td>7 (53.8%)</td>
<td>13 (100%)</td>
<td>2 (66.7%)</td>
<td>2 (66.7%)</td>
</tr>
<tr>
<td>PE-2</td>
<td>6 (33.3%)</td>
<td>10 (58.8%)</td>
<td>7 (53.8%)</td>
<td>13 (100%)</td>
<td>2 (66.7%)</td>
<td>2 (66.7%)</td>
</tr>
<tr>
<td>PE-3</td>
<td>3 (16.7%)</td>
<td>9 (52.9%)</td>
<td>9 (64.4%)</td>
<td>12 (92.3%)</td>
<td>2 (66.7%)</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>PE-4</td>
<td>5 (27.8%)</td>
<td>9 (52.9%)</td>
<td>11 (84.6%)</td>
<td>12 (92.3%)</td>
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<td>3 (100%)</td>
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<tr>
<td>PE-5</td>
<td>2 (11.1%)</td>
<td>9 (52.9%)</td>
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<td>13 (100%)</td>
<td>1 (33.3%)</td>
<td>2 (66.7%)</td>
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<td>PE-6</td>
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<td>2 (11.8%)</td>
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<td>5 (38.5%)</td>
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<td>PE-7</td>
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<td>PE-8</td>
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<td>7 (41.2%)</td>
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<td>10 (76.9%)</td>
<td>1 (33.3%)</td>
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<td>PE-9</td>
<td>5 (27.6%)</td>
<td>14 (82.4%)</td>
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<td>9 (69.2%)</td>
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<td>PE-10</td>
<td>1 (5.6%)</td>
<td>7 (41.2%)</td>
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<td>0 (0%)</td>
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<td>5.4 (41.5%)</td>
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<td>10 (76.9%)</td>
<td>1 (33.3%)</td>
<td>2 (66.7%)</td>
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<tr>
<td>CP-2</td>
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<td>14 (77.8%)</td>
<td>6 (46.2%)</td>
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<td>CP-3</td>
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<td>3 (100%)</td>
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<td>CP-4</td>
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<td>7 (38.5%)</td>
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<td>CP-9</td>
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<td>4 (22.2%)</td>
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<td>2 (15.4%)</td>
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<td>CP-10</td>
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<td>2 (66.7%)</td>
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<td>4.8 (36.9%)</td>
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<th>Pre-program: Taiwan (n=13)</th>
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<td>JC-2</td>
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<td>17 (94.4%)</td>
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<td>JC-3</td>
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<td>JC-4</td>
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<td>JC-6</td>
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<td>JC-7</td>
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<td>14 (77.8%)</td>
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<td>4 (30.8%)</td>
<td>13 (100%)</td>
<td>0 (0%)</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>JC-9</td>
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<td>7 (38.9%)</td>
<td>3 (23.1%)</td>
<td>12 (92.3%)</td>
<td>0 (0%)</td>
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<tr>
<td>JC-10</td>
<td>1 (5.9%)</td>
<td>8 (44.4%)</td>
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<td>12 (92.3%)</td>
<td>0 (0%)</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>JC Average</td>
<td>4.0 (23.5%)</td>
<td>13.4 (74.4%)</td>
<td>5.3 (40.8%)</td>
<td>12.6 (86.9%)</td>
<td>0.8 (26.7%)</td>
<td>2.9 (96.7%)</td>
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</table>
3.3. Skills that over 50% of the Japanese participants did not acquire by end of the clinical English program

In relation to the second hypothesis, we found that other than the five can-do statements described above, the following eight can-do statements were not checked by more than 50% of the Japanese participants after the program (Table 3): PE-8 ("I can develop a level of rapport with a patient."); PE-10 ("I can use good verbal and non-verbal communication techniques."); CP-5 ("I can distinguish between relevant and irrelevant information for a case presentation."); CP-6 ("I can use appropriate expressions in my case presentation."); CP-8 ("I can ask questions to an attending doctor about uncertainties, difficulties, or alternative approaches."); CP-10 ("I can select a case-related issue for self-directed learning."); JC-9 ("I can evaluate articles that are similar to an original article by examining its Correspondence article."); and JC-10 ("I can evaluate the impact of an article on the community by examining its Conference Report.").

3.4. Can-do statement responses: Japan vs Taiwan

Regarding the average of the pre- and post-program responses (Table 3), all of the PE, CP, and JC statement response averages were significantly higher among the Taiwanese participants than among the Japanese ($p < 0.05$).

4. Discussion

4.1. Skills without significant improvement by the end of the clinical English program

Although the clinical English program was designed to improve the skills identified in the 30 can-do statements, the statistical survey results presented in Table 4 shed some light on the skills that participants found particularly difficult to acquire through this short-term clinical English program. Both PE-2, which requires comprehensible pronunciation, and JC-1, which demands skills for predicting the type of medical article from its title, were not interpreted to be challenging by the participants prior to the program. On the other hand, responses to six other can-do statements showed no significant skill acquisition by the end of the clinical English program (PE-4, PE-6, PE-7, CP-4, CP-5, and CP-7). These were regarded as being particularly challenging at the beginning of the program as well as at the end. Why PE-4 (summarizing a patient story) was regarded as challenging may be understood as follows: (1) summary requires multifold skills, such as listening comprehension, memory retention, identifying key issues, and delivering in a patient-centered manner, which are difficult to master in a short period of time; (2) this result is due to lower self-assessment score among the Japanese participants. Tendencies unique to Japanese participants will be discussed in section 4.4.

The results for the other five can-do statements (PE-6, PE-7, CP-4, CP-5, and CP-7) are discussed in 4.2.

4.2. Skills that over 50% of all participants did not acquire by the end of the program

Can-do statements PE-6, PE-7, CP-4, CP-5, and CP-7 are all related to clinical reasoning skills such as identifying and reasoning appropriate differential diagnoses, and forming an appropriate plan and management strategy. Over 50% of the participants felt they had not acquired these skills by the end of the program, as shown in their responses to the self-evaluation surveys. This suggests that specific clinical communicative English competencies that require substantial clinical reasoning skills cannot be successfully acquired in such a short-term training program.
4.3. Comparing Japanese participant responses with those from Taiwanese and Chinese participants

Compared with the Taiwanese and Chinese participants, the Japanese participants found the eight skills represented by statements PE-8, PE-10, CP-5, CP-6, CP-8, CP-10, JC-9 and JC-10 more difficult. Both PE-8 and PE-10 are related to CIS subcomponents (rapport and verbal and non-verbal communication techniques). The four CP statements on which the rate of affirmative answers was lower among the Japanese participants are relevant to proactive learning attitudes such as asking questions and selecting a case-related issue for self-directed learning. Skills addressed by statements JC-9 and JC-10 were also judged to be difficult by the Taiwanese and Chinese students. This indicates that these two skills are difficult not only for the Japanese participants.

4.4. Taiwanese participants appeared more skilled than Japanese participants both before and after the program

The fact that the pre- and post-program averages were significantly higher among the Taiwanese than among the Japanese participants leads to the following discussion point regarding can-do statement implementation in a short-term clinical English program: Can Japanese medical undergraduates evaluate their own abilities accurately?

Throughout the program, the Taiwanese participants were generally more proactive than the Japanese in engaging with the guest speakers and tutors, which may have undermined confidence in the latter group, causing them to answer in the negative to many of the statements where they might not have done so under other conditions. We also have to take into consideration the fact that five of the Japanese participants were first-year students, and that the survey was only conducted after the program. Great thanks are also extended to Professor Seiichi Udagawa of the Department of Mathematics, Nihon University School of Medicine, for his advice on the statistical analysis.

4.5. Generalizability and implementation

This study has some limitations, including the small sample size (n = 34) and self-selecting nature of the sample, including the participants and instructor. Therefore, the findings cannot be generalized. However, we believe that the findings merit a further larger-scale study involving a statistically significant number of students and instructors with different backgrounds.

4.6. Conclusions

This short-term clinical English pilot program was effective in improving clinical communicative English competencies that do not require substantial clinical reasoning skills. The program may serve as a useful extracurricular program to help address rising demand for educational opportunities to develop clinical English skills.

Disclosure

The first author reports receiving fees from VIA for serving as the Medical Exchange Programs Advisor for the organization.

Acknowledgements

The authors are indebted to Kazutoh Ishida, VIA Senior Stanford Programs Director, and Ellison Weeks, VIA Stanford Medical Programs Director, for providing data from the MED program. Great thanks are also extended to Professor Seiichi Udagawa of the Department of Mathematics, Nihon University School of Medicine, for his advice on the statistical analysis.

References

Appendix 1. Patient Encounter Skills

Medical Exchange & Discovery 2015: Clinical English Lessons

Patient Encounter Skills

<table>
<thead>
<tr>
<th>Can-Do Statements</th>
</tr>
</thead>
</table>

China

Japan

Taiwan

Name

- I can use appropriate non-medical language that a patient can understand. Yes
- I can use comprehensible pronunciation. Yes
- I can minimize the need to repeat questions or statements. Yes
- I can summarize information provided by a patient. Yes
- I can cover the main areas of a medical history. Yes
- I can identify appropriate differential diagnoses. Yes
- I can form an appropriate plan and management strategy. Yes
- I can develop a level of rapport with a patient. Yes
- I can support a patient’s emotions, concerns, and expectations. Yes
- I can use good verbal and non-verbal communication techniques. Yes

Appendix 2. Case Presentation Skills

Medical Exchange & Discovery 2014: Clinical English Lessons

Case Presentation Skills

<table>
<thead>
<tr>
<th>Can-Do Statements</th>
</tr>
</thead>
</table>

China

Japan

Taiwan

Name

- I can understand case presentations at a clinical setting. Yes
- I can identify what is a good case presentation. Yes
- I can summarize a medical history. Yes
- I can narrow the differential diagnoses to 2 or 3 relevant possibilities. Yes
- I can distinguish between relevant and irrelevant information for a case presentation. Yes
- I can select a case-related issue for self-directed learning. Yes

Appendix 3. Journal Club Presentation Skills

Medical Exchange & Discovery 2014: Clinical English Lessons

Journal Club Presentation Skills

<table>
<thead>
<tr>
<th>Can-Do Statements</th>
</tr>
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</table>

China

Japan

Taiwan

Name

- I can guess the type of medical article from its title. Yes
- I can guess the conclusion of an original article from its title. Yes
- I can determine if an original article is global or local research by examining its authors’ affiliations. Yes
- I can determine what is new about an original article by examining its Background section. Yes
- I can identify the interpretation of the results and generalisability of an original article by examining its Discussion section. Yes
- I can determine the value of an original article by examining its Editorial article. Yes
- I can evaluate articles that are similar to an original article by examining its Correspondence article. Yes
- I can evaluate the impact of an article on the community by examining its Conference Report. Yes
The use of vocabulary learning strategies and technology among Japanese medical school students

Kaoru Kobayashi and Andrea Little
The School of Life Sciences, Tokyo University of Pharmacy and Life Sciences

Japanese medical school students are required to learn both general and medical vocabulary within the constraints of their tight schedules. For better acquisition and retention of vocabulary terms, it is essential that they be introduced with vocabulary learning strategies. The main objective of the present study was to clarify which vocabulary learning strategies first- and second-year medical students and third- and fourth-year medical students are already familiar with. The second objective was to shed light on the students’ use of technology when learning English vocabulary, as technology has become an important part of teaching and learning in general. To meet these objectives, a survey using a five-point Likert scale was conducted among 293 medical students studying in two medical institutions in Japan. The statistical analyses demonstrated that the students do not make full use of metacognitive and memory strategies in general when learning vocabulary, and that their use of technology is limited. In light of these results, the authors propose that instructors train learners in applying vocabulary learning strategies when teaching new vocabulary. The introduction of the use of technology may also help students build both receptive and productive knowledge of new vocabulary terms.


Keywords: English for medical purposes, vocabulary learning strategies, computer-assisted language learning

1. Introduction

A needs analysis conducted among English teachers at Japanese medical faculties revealed that the teachers expect their students to learn both medical terminology and general vocabulary used in oral and written communication with patients, colleagues, and other researchers before they begin their careers.¹ For students to learn general and medical vocabulary effectively and efficiently, we believe English teachers should introduce vocabulary learning strategies (VLSs). For this, teachers need a clear image of which VLSs students are already using. The primary objective of this study was to clarify which VLSs students studying at medical institutions in Japan already use when learning vocabulary.

In addition, the students’ use of technology when learning English vocabulary was investigated. We asked the following research questions.

1. Which VLSs are lowerclassmen (first- and second-year students) and upperclassmen (third- and fourth-year students) familiar with?
2. Do students in each group feel positive about using online programs and resources?

The study was conducted with two groups of students during the 2014 spring term: 104 lowerclassmen and 189 upperclassmen who study medicine at two institutions, a medical school and a faculty of medicine, in the Tokyo area. As Schmitt’s research on strategy use by Japanese of different age groups showed that VLS use and preferences change with maturity and proficiency,² we felt dividing our participants into two groups would give us more insight into their VLS usage.

Neither research question sought to distinguish between general vocabulary and medical vocabulary. Instead our focus was on which VLSs and technology the students are using to learn any vocabulary. Students are exposed to and learn both types of vocabulary, even in classes where English
medical terminology textbooks are used, since they have not yet mastered all general vocabulary (e.g., “be associated with,” “range,” “variables”). In addition, some vocabulary terms overlap, so it is difficult to tell which vocabulary category a term belongs to, general or medical. For example, while “aorta” is a medical term, “blood” belongs to both medical and general vocabulary categories. Finally, we recognize that vocabulary terms in either group may cover a range of terms, including, but not limited to, single words, phrases, and figurative expressions.

2. Literature review

2.1. The need for learning strategies

After conducting an action research project aimed at making students active participants in their own language learning processes by introducing learning strategies, one researcher concluded “language classrooms should have a dual focus — not only on teaching language content, but also on developing learning processes.”

2.2. Benefits of VLSs

It is well-known that vocabulary learning is both incremental in nature and multifaceted, involving many kinds of word knowledge. In addition to receiving guidance on which vocabulary terms to learn, learners can also benefit from help in developing effective strategies for learning these terms. Among other things, VLS studies have shown significant positive correlations between VLS use, EFL proficiency, and vocabulary size. They have also shown VLSs are effective tools for helping learners decide what vocabulary to learn, learners can also benefit from

2.3. Classifying VLSs and VLS scales

Over the years, various researchers have identified and created learning strategy taxonomies. From these, scales for measuring various VLSs have been developed. Schmitt’s inventory, developed in the 1990s, is particularly relevant for Japanese EFL learners as it was based on survey results showing how Japanese intermediate students studied vocabulary. The 58 strategies identified were categorized into two major classes and six groups: discovery strategies, comprised of determination and social strategies, and consolidation strategies, comprised of social, memory, cognitive, and meta-cognitive strategies.

As the name implies, the first class of strategies is used for discovering a new word’s meaning and usage. Learners use determination strategies to decipher an unknown word’s meaning when they have no one to ask. These strategies involve guessing (from context, from L1 cognates, and from their existing structural knowledge of the language) or using a dictionary. In contrast, social strategies involve interacting with other people to discover a new vocabulary term’s meaning. This may entail asking someone for the meaning or translation. In short, determination strategies help learners make the initial form-meaning link, the first step in acquiring word knowledge.

The second class of strategies is for consolidating a word in memory so it can be used later. This class, too, includes social strategies. Examples are group work to practice vocabulary, and interacting with native speakers. Another group within this class is memory strategies. Generally, these strategies entail some type of elaborate mental processing which facilitates recall. For example, linking the term to be retained with some previously learned knowledge using pictures/imagery or grouping (e.g., the keyword technique, semantic maps, Loci method). These strategies involve deeper processing, which has been found to lead to better long-term retention. In particular, the keyword technique results in faster, more secure learning for both receptive and productive recall. This group also includes studying affixes and roots, using cognates, using new words in sentences, connecting words to a personal experience, and using physical action, to name just a few.

Cognitive strategies are also included within the class of consolidation strategies. These resemble memory strategies, but involve less manipulation and are thus cognitively shallower as they entail less semantic processing. Examples include word lists, word cards, written and verbal repetition, labeling, and keeping vocabulary notebooks. Though not deep, these strategies are effective for acquiring various kinds of word knowledge (e.g., form and pronunciation), con-
solidifying the form-meaning connection, and as a first step toward deeper processing.\textsuperscript{12} Word cards are especially efficient for quickly increasing vocabulary size.\textsuperscript{12} Moreover, research shows using L1–L2 word pairs leads to better retrieval and recall for foreign language learners of both high and low proficiency.\textsuperscript{6}

The last group of consolidation strategies is metacognitive strategies, involving conscious decision-making about the learning process,\textsuperscript{5} have also been found effective.\textsuperscript{8} Students use these broader strategies to control and evaluate their own learning to be more efficient learners. This group includes using English-language media to increase access to L2 input, self-testing, spaced word practice, deciding which words to learn or skip, and persevering with chosen words.

More recently, Mizumoto and Takeuchi developed and validated a 25-item VLS scale designed for Japanese university EFL students.\textsuperscript{13} Using qualitative data from 122 Japanese university EFL students, they identified 47 commonly used strategies. Social and affective strategies, which their informants rarely used, and strategies such as guessing from context, dictionary use, and note-taking, which the developers felt did not ensure learning leading to acquisition, were excluded.\textsuperscript{14} In essence, they eliminated Schmitt’s first class of strategies for discovering a new word’s meaning.

These 47 items were reduced to 25 after piloting, with overused and rarely used items eliminated. The resulting scale measures six subscales of strategic vocabulary learning behaviors: self-management, input-seeking, imagery, writing rehearsal, oral rehearsal, and association. Using Schmitt’s taxonomy, these six subscales can also be categorized as metacognitive, involving conscious decision-making about the learning process (self-management) and maximizing exposure to the L2 (input-seeking); cognitive (writing rehearsal and oral rehearsal), involving shallower processing; and memory strategies (imagery and association), involving deeper, more elaborate processing thereby facilitating long-term retention.\textsuperscript{2,26} As this scale was developed specifically for Japanese university EFL students, we adopted it for this study.

### 2.4. Technology and language learning

Increasingly, studies are investigating how to effectively use electronic devices for mobile assisted language learning (MALL).\textsuperscript{15-18} Regarding vocabulary learning, studies using mobile devices have examined their use with various types of vocabulary activities,\textsuperscript{15,16,19} how learners acquire vocabulary using them,\textsuperscript{17} the environment (inside or outside the classroom),\textsuperscript{20} and the platform.\textsuperscript{14} Although not all learners are willing to use mobile technology, learners have generally exhibited a favorable attitude toward it, and evaluated the activities positively, despite problems such as the small screen size, inconvenient keypads, and slow connection speed.\textsuperscript{21}

As using mobile phones and other forms of technology is a current trend in language learning, we felt that including questions about students’ technology use and perceptions of online tools and resources for vocabulary study would provide a more complete picture of their strategy use.

### 3. Data collection and analysis

To answer the research questions, we conducted a survey in June 2014. The survey (see Appendix for the English translation) was the aforementioned one created by Mizumoto and Takeuchi.\textsuperscript{13} However, for this study, items related to technology use were added. The survey contained 34 items, including one requesting the students’ consent and guaranteeing anonymity. The other 33 items were classified into seven categories: self-management (7 items), input-seeking (4 items), imagery (5 items), writing rehearsal (3 items), oral rehearsal (3 items), association (3 items) and the use of technology (8 items). All student responses, except for Item 34 in the technology category, were measured on a 5-point Likert scale (1 = never or almost never true of me, 2 = not true of me, 3 = undecided, 4 = true of me, 5 = always or almost always true of me). Item 34 asked the students to select as many choices as they liked regarding which technologies they used to learn vocabulary. The lowerclassmen took the survey online using SurveyMonkey, a commercial online survey tool, and the upperclassmen completed a printed version of the same survey during English classes. The questionnaire items using the Likert scale (N = 32) all had high reliability (Cronbach’s \( \alpha = .92 \)).

To answer the first research question, asking which VLSs lowerclassmen and upperclassmen are familiar with, Items 2-26 dealing with the six VLS categories were analyzed. These categories were metacognitive strategies (i.e., self-management and input-seeking), cognitive strategies (i.e., writing rehearsal and oral rehearsal), and memory strategies (i.e., imagery and association). The mean score per respondent for each category and the standard deviation were calculated. To compare values across categories with varying numbers of items, the mean of the total score per person was divided by the number of items in each category. The significance of the difference between the two groups was evaluated using Student’s t-test. A Kolmogorov-Smirnov test was run to check the normality of the data. Almost all data were found to be significantly non-normal, \( p < .001 \). Therefore, a
Bonferroni correction was applied for multiple comparisons of means (0.05/7 = 0.007).

To answer the second research question, asking if students in each group feel positive about using online programs and resources, the survey items in the technology category were analyzed in the same way as for the first research question. Item 34, regarding the students’ preference for particular types of technology when learning vocabulary, was analyzed by calculating the percentage of the students in each group who chose each type of technology. The difference between the two groups was analyzed using Fisher’s exact test ($p < 0.007$). All the statistical analyses for the present study were carried out using SPSS Statistics 22.

4. Results

4.1. Student VLS preferences

The first research question asked which VLSs the two groups, lowerclassmen and upperclassmen, used. Table 1 shows statistical analysis for every VLS in each category, and the differences between the two groups. The mean scores per item for metacognitive strategies were generally low and only input-seeking by lowerclassmen reached the mid-point (3.0). The differences between the two groups were significant in both self-management and input-seeking strategies. For cognitive strategies, the mean scores per item were higher, exceeding the mid-point by 0.4 (lowerclassmen) and 0.6 (upperclassmen) for writing rehearsal, indicating students in both groups tend to prefer these strategies. The mean score per item for oral rehearsal among lowerclassmen also exceeded the mid-point, but among upperclassmen was lower with a significant difference between the groups. As for memory strategies, the mean scores per item among lowerclassmen exceeded the mid-point but were lower among upperclassmen, indicating lowerclassmen use memory strategies more than upperclassmen.

4.2. Student use of online programs and resources in vocabulary learning

To answer the second research question asking about the students’ technology use in vocabulary learning, statistical analyses per item were used in the same way as with the first research question (Table 2). The table shows that although lowerclassmen are more positive about using technology, the mean scores per item in both groups indicate that neither group displays a strong tendency for using technology.

Table 3 shows the technology students use when learning vocabulary. More than half the students in either group do not favor using technology for learning and practicing vocabulary. The use of technologies investigated in this study was consistently low and did not exceed 15%, including the use of SNS, which students can use for output of vocabulary terms. Regarding online applications/dictionaries (Item 33), a significantly higher percentage of upperclassmen (26.5%) than lowerclassmen (3.8%) used them. Notable differences were also observed in the use of vocabulary-learning websites (Item 27) and audio recordings/broadcasts (Item 29), with percentages for lowerclassmen being significantly higher than for upperclassmen.
5. Discussion and recommendations

In this section we make five recommendations. Each one is discussed in light of the survey results.

1. Recognize that certain VLS preferences and avoidances are culturally-based.

The first research question attempted to clarify which VLSs Japanese medical school students use when learning vocabulary. Regarding cognitive strategies, writing rehearsal was the preferred VLS in both groups. This was expected because preferences for VLSs can be culturally-based; for example, writing rehearsal is a common strategy for Japanese when learning kanji.22 It is therefore logical that Japanese students will also favor this strategy when learning new vocabulary terms.8 Indeed, this mirrors our findings in a previous study with life science students.11

In contrast, oral rehearsal use was relatively high among lowerclassmen but relatively low among upperclassmen. Schmitt’s Japanese participants of all ages indicated that oral rehearsal was among the most helpful VLSs for consolidating a word’s meaning.2 However, oral rehearsal requires knowledge of phonetic symbols, which are not routinely taught in Japanese schools. Unfamiliarity with phonetic symbols and difficulty in catching the dictionary’s recorded pronunciation thus make it hard for some students to pronounce words.23 Furthermore, the upperclassmen may have decided there is no benefit in being able to pronounce the words since many tests, such as the Computer Based Test (CBT), which they take prior to their fifth year, require knowledge only of meaning and spelling.

2. Explicitly teach memory strategies for better long-term retention.

There were clear differences in students’ perceptions of memory strategies. Lowerclassmen showed a greater preference for these strategies than upperclassmen. Yet, many Japanese students consider these strategies to be complex and time-consuming,11 which may be why upperclassmen avoid these strategies when learning vocabulary within their tight time constraints. Nevertheless, memory strategies are still critical in vocabulary learning. When using them, information processing occurs at the semantic level, leading to the vocabulary term’s retention in the learner’s long-term memory.24 The keyword technique in particular produces faster, more durable learning with positive effects on intermediate and longer-term retention,12 making it worth the extra time and effort. Studies also show this technique is effective for both receptive recall and production.12 However, to utilize the keyword strategy effectively, training is necessary.8


The use of metacognitive strategies was low in both groups, but especially among upperclassmen. As upperclassmen are busy preparing for compulsory examinations such as the CBT and Objective Structured Clinical Examination (OSCE), the students may lose interest in learning English. However, as knowledge of English medical terminology is necessary for both the CBT and longer-term for their professional needs, explicit instruction in metacognitive strategies should help students monitor their vocabulary learning processes and,8 therefore, should be introduced to medical school students. Since VLS use may lead to high self-efficacy, a necessity for long-term, self-regulated language learning,10 training in metacognitive strategy use could benefit medical

### Table 3. Technology use of the students in detail

<table>
<thead>
<tr>
<th>Item</th>
<th>Lowerclassmen (n=104)</th>
<th>Upperclassmen (n=189)</th>
<th>p</th>
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<tbody>
<tr>
<td>27 I use vocabulary-learning websites such as Quizlet, Anki or Flash Card Exchange to learn, review, and test myself.</td>
<td>10 9.6%</td>
<td>3 1.6%</td>
<td>0.002 *</td>
</tr>
<tr>
<td>28 I watch English language videos online (with or without subtitles) to learn or practice new vocabulary.</td>
<td>2 1.9%</td>
<td>5 2.6%</td>
<td>1.000</td>
</tr>
<tr>
<td>29 I listen to English language audio recordings or broadcasts to learn or practice new vocabulary.</td>
<td>14 13.5%</td>
<td>5 2.6%</td>
<td>&lt;0.001 *</td>
</tr>
<tr>
<td>30 I read English language websites, blogs, or news articles to learn or practice new vocabulary.</td>
<td>11 10.6%</td>
<td>15 7.9%</td>
<td>0.521</td>
</tr>
<tr>
<td>31 I utilize Social Networking Services (SNS), such as Twitter or Facebook, to learn or practice new vocabulary.</td>
<td>7 6.7%</td>
<td>10 5.3%</td>
<td>0.610</td>
</tr>
<tr>
<td>32 I use mobile apps or online English language learning games to learn or practice new vocabulary.</td>
<td>5 4.8%</td>
<td>5 2.6%</td>
<td>0.334</td>
</tr>
<tr>
<td>33 I use online or apps dictionaries that also have vocabulary learning functions like list-saving or flash card functions like Eijiro and utilize these functions.</td>
<td>4 3.8%</td>
<td>50 26.5%</td>
<td>&lt;0.001 *</td>
</tr>
<tr>
<td>None</td>
<td>69 66.3%</td>
<td>108 57.1%</td>
<td>0.135</td>
</tr>
</tbody>
</table>

*: p < 0.007 (Fisher’s exact test)
students even after graduation.

4. Investigate suitable uses of technology for medical students’ vocabulary learning needs.

The objective of the second research question was to identify the use of technology among medical school students when learning vocabulary. The results revealed that medical school students do not appear to particularly favor using technology when learning vocabulary, including medical terminology. Again, this did not match our expectations given the growing number of studies showing learners are favorably disposed toward technology for language learning. However, since technology use has been proved effective in many ways, including the use of SNS, where through usage the students can develop their productive knowledge of vocabulary terms, we believe that investigating methods that best fit medical school students’ needs would be worthwhile.

5. Teach how to use online dictionaries effectively.

Interestingly, the use of online dictionaries for learning medical terminology was higher among upperclassmen (26.5%) than for lowerclassmen (3.8%). Dictionary lookup is a useful coping strategy when learners initially encounter unknown vocabulary terms. A learner may notice the term, and after looking it up, utilize other strategies, such as writing the term on a word card or on a vocabulary list. Even though Mizumoto and Takeuchi’s VLS scale excluded dictionary lookup and guessing the meaning of a term from context, research shows both are essential in the initial process leading to vocabulary acquisition and retention.

Despite the effectiveness of using online L1-L2 dictionaries in vocabulary retention, there are also some demerits. Electronic dictionary use is often so quick and convenient that there is a danger that users will be less motivated to find the meaning that best fits the context in which the term appears. While medical school students should be encouraged to use online dictionaries, potential pitfalls must be explained.

6. Limitations

This study has several limitations. First, the data were taken from only two medical universities. A more extensive study with more students and from several medical universities would have provided a clearer image of medical school students’ VLS behaviors.

Second, there were no open-ended questions on the survey regarding VLS use. Using a qualitative methodology to collect the data may have revealed the specific reasons learners have for using or not using a particular VLS, and helped us to understand why technology is not used more.

Additionally, since VLS use changes as learners mature, a qualitative methodology could have uncovered the reasons why upperclassmen and lowerclassmen preferred different strategies. This would have been particularly noteworthy, as the VLS results gathered from the two groups in this study were actually the opposite of those found in Schmitt’s study, in which memory strategies tended to replace cognitive strategies as learners matured.

Furthermore, a qualitative approach using study logs of VLS use or observing learners as they used VLSs may have revealed what they actually do. As Rose notes, successful learning is not dependent on the frequency of VLSs but on the way in which they are used.

Finally, it could be argued that some of the questions used to explore the learners’ use of technology for language learning were too vague. Had they been clearer and more specific about how, when, and why the students used technology, we may have found that the learners were more positive regarding the use of technology to acquire vocabulary and word knowledge.

References
Appendix

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<tbody>
<tr>
<td>1</td>
<td>I have read the information about the study and agree to take part in it.</td>
</tr>
</tbody>
</table>

### Vocabulary Learning Strategies

#### Self-management

1. I regularly review the vocabulary I learned to check if I remember it.
2. I keep a vocabulary book or word list to check the vocabulary anytime I wish.
3. I try to make it a rule to memorize a certain number of words in a specific time period (e.g. ‘10 words a day’).
4. I try to learn extra vocabulary in addition to what I am taught in class.
5. I try to take time for vocabulary learning.
6. I consciously set aside time to study vocabulary to prepare for tests such as TOEIC, TOEFL, or other.
7. I use my own methods for remembering, checking, or reviewing vocabulary.

#### Input-seeking

1. I try to expose myself to English vocabulary by reading or listening a lot.
2. I try to manage the learning environment so as to expose myself to English vocabulary.
3. I try to make use of the media (TV, radio, Internet, mobile phone, or movies) to learn vocabulary.
4. I study vocabulary with the intention of using it.

#### Imagery

*When I try to remember vocabulary,…*

1. I make a mental picture of what can be associated with a word’s meaning.
2. I link my personal experiences to it.
3. I create an image of the spellings or orthographic forms.
4. I use the keyword method (keyword mnemonic technique).
5. I imagine whether the meaning of the word is negative or positive.

#### Writing rehearsal

*When I try to remember vocabulary,…*

1. I write it repeatedly.
2. I write it on a note or a card.
3. I remember not only the meaning but also the spelling of the word by writing it.

#### Oral rehearsal

*When I try to remember vocabulary,…*

1. I say it aloud repeatedly.
2. I vocalize it to remember not only its meaning but also the pronunciation.
3. I say the sample sentence aloud.

#### Association

*When I try to remember vocabulary,…*

1. I associate it with the synonyms or antonyms I already know.
2. I also memorize the synonyms or antonyms of the word.
3. I memorize words similar to it in meaning, sound, or shape, or the related words.

#### Use of technology

1. I use vocabulary-learning websites such as Quizlet, Anki or Flash Card Exchange to learn, review, and test myself.
2. I watch English language videos online (with or without subtitles) to learn or practice new vocabulary.
3. I listen to English language audio recordings or broadcasts to learn or practice new vocabulary.
4. I read English language websites, blogs, or news articles to learn or practice new vocabulary.
5. I utilize Social Networking Services (SNS), such as Twitter or Facebook, to learn or practice new vocabulary.
6. I use mobile apps or online English language learning games to learn or practice new vocabulary.
7. I use online or apps dictionaries that have vocabulary learning functions like list-saving or flash card.
8. Which of the above technology do you use for learning medical terminology? Choose as many as you use.
Japanese doctors in discussion sessions at international medical conferences

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1. Background and Introduction

A number of researchers have described the main body of oral conference presentations (CPs) as being dialogic in nature, or as a co-constructed, interactive forum involving the establishment of a rapport with the speaker’s professional discourse community, necessitating a greater focus upon the interpersonal dimension of speech. However the fact that presentations are largely scripted and controlled by the presenter distinguishes the main body of the presentation markedly from the discussion sessions (DSs) which typically follow. Although some researchers have treated DSs as a mere continuation or extension of the more monologic main body of the presentation, for many non-native English speakers (NNEs) presenters in particular, DSs represent a great psychological and performance leap from prepared, scripted content into the dynamic and unpredictable. DSs not only epitomize the specialized discourse indicative of the professional or academic discourse community, but add interactional challenges that can make negotiating the sessions particularly difficult. This certainly presents, as Hyland states, "an interactional challenge to all but the most accomplished speakers" (p.84).

For non-native English speakers (NNEs) in particular, the immediate application of such metacognitive and metadiscourse skills under the pressure of an expectant live audience of peers can make the sessions particularly daunting. However, DS comments and questions are not entirely unpredictable and speakers can expect that certain discourse patterns will emerge in the sessions. Thus, in order to master DSs, speakers need to develop strategies for both identifying and managing these dynamic interactions. In this paper, I will outline both successful and unsuccessful strategies used in DSs by 110 non-native English speakers at 5 international medical conferences I attended in various Asian locations in 2013-2014. First, I will introduce some of the most typical question/comment gambits used by DS commenters, and will follow this with a discussion regarding which response strategies used by presenters were effective, why they were effective, and which strategies were not.

Question/answer and discussion sessions (DSs) are by far the most anxiety-inducing aspect of performing English-language presentations at international medical conferences for Japanese doctors. In contrast to the body of the presentation itself, which will usually be scripted and thus under direct control of the speaker, post-presentation DSs are often unpredictable, spontaneous, and sometimes, adversative. Managing them successfully requires the ability to think on the fly, to read between the lines, to negotiate and respond in real time, all in an appropriate and/or accurate manner.

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Keywords: Medical conferences, question and answer sessions, discussion sessions, Japanese doctors, conference presentations, strategic competence, pragmatics

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** This research was funded by a scientific grant-in-aid from the government of Japan.
此论文是部分基於2014年7月19日于日本秋野市举行的JASMEE会议中表演的‘战略能力；管理动态的医学话语社区’
to deal with adversative or challenging comments, DSs can be a stressful event for any presenter, but is particularly so when one is engaging the audience using English as a second language. Not surprisingly, Japanese doctors cite DSs as the most anxiety-inducing aspect of a CP precisely because it is perceived to be difficult to manage and control due to its dynamic, open-ended nature. Moreover, most presentation skills textbooks do not target the NNES, operating under the apparent assumption that English proficiency skills will never be an issue.

Some researchers have thus taken a multi-modal approach to analyzing DS interactions, focusing heavily upon both speaker and commenter paralanguage, noting that such skills are rarely taught to NNESs, while others have performed analyses of DSs through intonation and related prosodic patterns. Very few researchers, however, appear to have focused upon pragmatic strategies employed by the speakers in response to questions and comments in the DS despite the fact that strategic competence has been considered a pillar of overall communicative competence for over thirty years.

2. Methods

In 2013 and 2014, I attended five international medical conferences held at five different Asian locations (Seoul, Bangkok, Tokyo, plus Chiba and Miyazaki in Japan) observing the presentations of 142 NNES medical professionals. The majority of these presenters were Japanese (n=77), but 65 presentations, performed by other Asian NNES from Taiwan, China, South Korea, Thailand, Indonesia, and Vietnam, were also observed. While observing these presentations, I compiled detailed notes regarding the common habits and features of both effective and ineffective NNES presenters, including the manner in which they managed DSs.

Of the 142 sessions I attended in total, 104 were parallel sessions (generally lasting 10 to 20 minutes) with the remaining 38 CPs consisting of symposia, keynote speeches, special seminars, or plenaries. This distinction is important in that the majority of young, inexperienced medical professionals presenting at international conferences will likely be speaking in parallel sessions, which are both defined, and limited, by time, the physical constraints of the speaking area (with the central focus being upon the screen rather than the speaker), as well as discourse community expectations regarding the style and content (generally content-heavy research reports on a narrowly-defined theme). Presenters in the other formats tend to be more experienced and effective in most facets of English conference presentations, and thereby often served as paradigms of effective management of DS skills.

Of the 142 CPs attended, 110 involved a DS consisting of questions or comments from the audience (as opposed to singular chair, or null, response cases). Of these, 84 were from parallel sessions and 26 following other presentation formats. When observing how presenters managed the DS, I took the three following factors into account:

· What types of questions or comments were typically asked or made?
· What strategies did presenters use to manage lengthy, adversative, difficult, or awkward questions or comments?
· What caused communicative breakdowns and how did the NNES presenters manage (or mismanage) them?

Answering this question was also informed by subsequent interviews with 8 Japanese presenters.

Although I kept a numerical record of question, comment, and response types for the purposes of producing this paper, my emphasis here is primarily upon expressing some qualitative aspects of DS strategies and management, rather than providing a quantitative analysis. In short, my research question was simply to discover which DS management strategies and approaches for NNESs were effective and which were not.

3. Results and Observations

3.1. Patterns of discourse in questions and comments

Five typical pragmatic functions in DS comments and questions have been noted by Webber, expressed as follows:

Type 1a: information eliciting (facts)
Type 1b: information eliciting (opinions)
Type 2: criticism or attack
Type 3: suggestions
Type 4: comments
Type 5: more than one of the above pragmatic functions

Utilizing this typology, in a study of post-presentation DS interactions at a conference in Hong Kong, it was noted that by far the common responses (total n=61) were those of type 1a (information eliciting: facts; n=38) and type 5 (a combination of the other 4 pragmatic functions; n=20), the latter most commonly made up of combinations of types 1a and 4 (eliciting facts plus comments; n=8) and types 2 and 4 (criticism plus comments; n=9), followed by type 1b (information eliciting: opinions; n=10), with the other types being noted only very rarely (n=2 or less).

In my own observations, although I was not strictly following Webber’s typology, types 3 and 4 (suggestions and com-
ments respectively) were also widely deployed as stand-alone items (n=15 each), as well as in combination with the other pragmatic function types (which may indicate additional cultural or English proficiency factors, since Webber’s subjects were all NESs) indicating a degree of balance across all response categories. Although Webber’s categories are fluid, and thus estimates may be a bit approximate, I identified the following frequencies of Webber’s first 4 types as follows (the total include types used in combinations, thus the number exceeds 110):

- Type 1a (information eliciting - facts) n=51
- Type 1b (information eliciting - opinions) n=25
- Type 2 (criticism or attack) n=35
- Type 3 (suggestions) n=21
- Type 4 (comments) n=37
- Uncategorizable n=10

The pedagogical and practical implications of these results are outlined in the discussion section of this paper.

3.2. Effective DS response strategies

In the discussion sessions I attended I noted several recurring patterns of strategic discourse management emerged, both positive and negative. These were ultimately categorized by the pragmatic function of the utterance, of which 9 strategic patterns were particularly frequent and effective. All strategic patterns listed here were noted on at least 5 occasions and used by speakers originating from at least 3 different countries. These strategic patterns are listed below, along with prominent and/or typifying examples of each, followed by discussion and commentary:

1. Thanking the commenter for criticisms and/or suggestions:

   - That’s an interesting point.
   - Thank you, we’ll take that into consideration in the future.
   - I appreciate your suggestion.

   Thanking the commenter for a critical or adversative comment is widely recognized as a face-saving measure for both the speaker and the audience. As an indirect means of addressing criticism, which in Webber’s study made up a significant 52 of the 130 comments observed, this also has the effect of potentially mollifying and/or deflecting further criticism and is thus an effective strategy when responding to adversative comments.

   Many effective presenters observed responded to criticism and pointed suggestions not with further argument or defense but a simple acknowledgement of the commenter’s point without further elaboration. The commenter, in turn, having made their point, were often sufficiently satisfied that others had simply heard or acknowledged their opinion or suggestion that they demanded nothing further from the presenter.

   This is a noteworthy strategy that novice presenters should keep in mind – that one need not defend or argue each and every flaw pointed out, and that it may be more socially prudent to simply acknowledge the commenter’s point and, in some cases, no further argument or explanation may be necessary, lessening both the rhetorical and interactional burden upon the presenter.

2. Asking for brief rephrasing:

   - So, your question is…?
   - Could you summarize your question please?
   - What exactly is your question?

   A tendency for some NNESs, particularly Japanese, to blame themselves and focus upon their English comprehension shortcomings when the point of the comment or question was not fully understood, was frequently observed, particularly after subsequent interviews with presenters. However, on many occasions, it was actually the commenter who was unfocused, vague, and/or nebulous in their comments, contributing heavily to the subsequent breakdown. This is something that even native speakers of any language will likely experience. At such times, the presenter can, even should, put the onus upon the commenter to summarize or otherwise clarify the utterance. Other members of the audience may also be hoping for a summarization or more succinct rephrasing, so presenters should not be hesitant to make such a request.

   A request for clarification might also be perceived as a challenge by the presenter, especially if the question is difficult to answer. Head-nodding from the presenter during the commenter’s speech is a common indicator as a signal of cognitive assent. A lack of such prosody, or an adversative one such as a visual expression of confusion, should help indicate to the commenter that his/her is not being fully comprehended. Many will take this as a cue to reformulate or summarize without any explicit request to do so from the presenter.

3. Asking for a stylistic adjustment:

   - Sorry, English is not my first language so…
   - Sorry, I didn’t quite understand your point/question.

   At a truly international conference the onus is upon every participant to adjust their English expectations to the reality that a wide variety of international Englishes will be employed and that many participants will not be native English speakers (NESs). NNESs, particularly Japanese presenters, are inclined to think that breakdowns and misunderstandings represent a failure on their part. However, ques-
tions and comments from the floor are not always articulate or well-formed. Often, the obvious limitations of the presenter’s English skills are ignored. However, this can, and perhaps should, be recognized as a communicative failure on the part of the insensitive commenter, not the confounded listener.

One delightfully frank response from a Chinese speaker to an elaborate, sprawling, and highly idiomatic NES comment was a sharp, “I don’t know what you just said!” While somewhat rough in tone, it had the impact of forcing the questioner to modify his wording and readjust his speaking speed. This rather direct strategy seemed to elicit appreciation from other audience members, who, it should be pointed out, were largely made up of NNESSs.

While NNESS presenters should not apologize for having limited English skills at the beginning of their presentations, admitting one’s comprehension limitations in the DS as a means asking for a re-phrasing should in no way be considered shameful or out-of-place. It acts as an instance of communicative repair and should be considered a standard interactive strategy.

4. Elucidating misheard or misunderstood keywords:
   - What exactly do you mean by (vague or confusing term)?
   - Sorry, did we consider what?
   - Sorry I didn’t quite catch the first/last part.

   Often it is only one key word or phrase in the question or comment that is not grasped by the speaker. Rather than responding with, “Sorry, I don’t understand,” which may make it appear as if the speaker can’t grasp the comment at all, the speaker should have the ability to address only the problematic or misheard item, a skill utilized in regular discourse in all mother tongues.

   On one occasion, a Korean presenter’s return question to a commenter, “What exactly do you mean by ‘stance’?”, led to an invigorating discussion about the nature of ‘stance’ within the broader topic, which wouldn’t have occurred if the usage of the term hadn’t been clarified. Again, by asking for clarification, the speaker is actually enhancing comprehension not only for themselves, but also for many others in the audience.

5. Checking/summarizing one’s comprehension of the question/comment and appropriateness of response:
   - So, in short, you’re saying...
   - Have I answered your question?
   - If I understand you correctly...
   - Do you mean X or Y?

   Meaning negotiation of this sort is common in general conversation between native speakers of any given language, so it should be utilized that much more so among speakers of different languages, particularly in a high-pressure public forum where face is at stake. Yet in subsequent interviews with some presenters from Japan, it was expressed that they felt it impolite or unprofessional to check, summarize and confirm their comprehension of the question/comment, claiming that it magnified their lack of comprehension and possibly made it appear as if they were doubting the veracity of the question/comment.

   While the issues of face-saving and face-threatening speech acts loom large in most Asian cultures, it could be emphasized by teachers/trainers that in fact maintaining the face of both the speaker and the audience members might actually be better served if active negotiation of meaning occurs.

6. Evasion:
   - If you’re interested we can discuss this more afterwards.
   - If you’d like to discuss it more please send me an email.
   - Perhaps Professor X can comment upon that.
   - Perhaps we can/should move on to the next question.

   Initially, evasion may seem to be a deceptive tactic. However, hedging (“I think...”), is widely used as a strategy in situations where the presenter does not feel qualified to offer a conclusive response in DS settings. Evasion tactics are readily used when questions asked fall outside the scope of the presentation.

   Moreover, questions often demand detail that is too complex or lengthy to be covered adequately in a short DS. Moreover, if the questioner is serious about the topic and is not simply being contentious, continuing the discussion outside the room or by subsequent email contact could indicate face-saving consideration for the rest of the audience, who may not wish to have all the DS time focused upon one speaker or comment.

   The tactic of asking a senior researcher in the audience to address a question will, of course, depend largely upon the character of, and the junior’s relationship to, that senior researcher. However, for the sake of adequately addressing a legitimate enquiry that the speaker does not feel adequate to discuss, calling upon a more informed colleague to respond can be a legitimate and viable option.

7. Returning the question:
   - What do you think?
   - What would you do/have done?
   - Do you have any ideas about that?

   Often, it appeared that the commenter simply wanted the opportunity to present their own view or explain their own practices, without having a specific question per se. In some cases, returning a question to a commenter who clearly wanted a turn to indulge their views was effective. Rather than focusing upon the presenter’s possible errors or short-
comings and concocting a defense thereof, a legitimate and effective strategy was to simply allow the questioner to offer their approach or opinion. Giving the commenter the floor, the right to take a turn, often had an appeasing effect upon the critical commenter. They should be thanked and no further discussion may be needed.

8. Expansion/reformulation:
What I am saying is...
What I mean is...
Let me explain this another way.
Let me rephrase myself.

Even the most eloquent, articulate speakers will make false starts, employ initially vague or inaccurate expressions, and shift mood or voice during speech, and, as a result, need to elaborate upon or reformulate their utterances. The fact that most speakers readily do so in their mother tongues would imply that NNESs should not hesitate to use such strategies when necessary.

9. Admission of shortcoming and errors:
Sorry, we didn’t research that.
No, we didn’t cover/check that.
No, we hadn’t thought of that.

Often, questions and comments addressed aspects of the research that the commenter felt were deficient or insufficient. In some cases, that speaker chose to directly address this type of criticism (particularly if they felt it was unwarranted or misrepresentative) but, on a number of occasions, simply admitting that a certain area or aspect had not been addressed or covered in research seemed the most succinct course of action.

There may be legitimate reasons why this area was not addressed in the research, in which case the speaker can duly respond that this was beyond the research scope. However, in some cases, the commenter may have a legitimate point about an alleged oversight or shortcoming. In such cases, admitting that, indeed, this aspect may have been overlooked, and subsequently thanking the commenter for bringing the issue to light, appeared to work to the advantage of the speaker, helping them to appear open to, and appreciative of, legitimate and helpful critical comments, without significantly devaluing their own research. The presenter should never bluff in DSs.6

3.3. Ineffective responses and managing breakdown

Three response patterns and behaviors in particular were identified as unproductive ways of managing questions and comments from the audience. These were as follows:

1. Saying “I agree with you” or some variation thereof, to appease the critic, even when it was apparent that the speaker and commenter do not agree with each other.
The speaker may have been using this as a stock response as a face-saving measure, but conversely, this immediate capitulation had the effect of devaluing the speaker’s research presentation efforts, making the speaker appear wavering and indecisive, by immediately seceding academic ground to critics.

2. “…” (no response for several, agonizing, seconds).
On these occasions (n=5, all Japanese speakers), it was apparent that the speaker had not grasped the question/comment adequately and, further, could not retrieve an English strategy to address this breakdown. Post-presentation interviews with two Japanese speakers who suffered such breakdowns revealed that they were ashamed of not being able to comprehend the comment, and, because they felt personally responsible for the breakdown, did not feel it was incumbent upon them to force the speaker to repeat or rephrase the question, and that it would be impolite to imply that the breakdown was the questioner’s fault.

Presenters facing such scenarios need not only to be able to retrieve clarification strategies in English but also to recognize the fact that the questioner/commenter is a co-constructor of the dialogue and thus can be expected to take some responsibility in the repair process as a normative procedure in the conference discourse setting.

3. Responding without clearly understanding the question or comment.
This was noted on an estimated 9-13 occasions (this number being an estimate because it is possible that even though the speakers may fully have understood a question, they may have digressed or offered opaque responses for other reasons). It was noted that this occurred more frequently with other NNES Asian presenters than with Japanese. In the vast majority of these cases (with only one exception) no attempt was made by the speaker to check the suitability or efficacy of their response, which had the upshot of making the presenter seem evasive or otherwise ignoring the commenter’s point. As this can leave an audience perplexed or destroy rapport with the audience, once again the importance of using clarification strategies is paramount.

4. Discussion

Japanese-language guides to presenting in English tend to offer up DS advice in the form of numerous set phrases to be memorized but lacking value in real-world settings.12 However, I would contend that given the pivotal role that formulating situationally-appropriate responses plays in CPs,3 a focus
upon pragmatic strategies, rather than the memorization of set phrases, would have more beneficial applications for Japanese and other NNES presenters managing DSs.

The fact that all of Webber’s question and comment types appeared with some regularity in my own observations suggests that teachers and trainers can, and perhaps should, target these varying pragmatic functions in presentation training and preparation for DSs, as making pragmatically appropriate responses will often depend upon anticipating, identifying, and then addressing the comment/question type. Being prepared for likely question/comment types and being able to accurately identify and interpret the pragmatic intention of a commenter, are skills that can be developed and fostered in training. Learners should not only have a linguistic grasp of strategies such as asking for clarification, evasion, checking and summarizing etc. but also the ability to recognize the scenarios in which that strategy might be best deployed.

The initial challenge for the speaker to respond appropriately in a DS is thus to accurately identify the type of comment or question, not always an easy task for NNESs. However, the gambits can often be understood without being able to decode every word. Many speakers will be able to immediately sense that a speaker is, say, making a suggestion opposed to asking for further elaboration of content, so a decoding of the entire utterance may not always be required in order to respond.

It has also been observed that many questions and comments followed a frame-issue-question sequence, meaning that the framing of an issue, followed by a reference to a slide or part of the presentation content or theme would precede the actual question. This held true for my observations as well and thus provides presenters in DSs with a type of rhetorical scaffold.

Given the dynamic and spontaneous nature of DSs, presentation skills’ teachers and trainers would naturally be inclined to focus upon expanding the speakers’ holistic listening and spoken fluency skills in the hopes that general improvement in these areas will better serve effective performance in managing DS discourse. However, there is also much to be said for developing strategic or managerial skills that can provide, and deal with, the typical discourse frameworks that mark DSs. Holistic English communication skills generally take years of concentrated training and practice to improve, but if and when a targeted focus upon strategies and management is employed, busy in-service speakers can start to utilize effective and practical techniques almost immediately, without demanding extensive extracurricular English training.

In short, a focus on deploying strategies, while never replacing holistic English fluency development, can offer a short-cut to the effective management of DSs. Moreover, the application of these strategies includes gambits in which misunderstood or inadequately comprehended comments and questions can be negotiated by the presenter, and therefore is not incumbent upon an assumed existing fluency in English.

So, while the ability to effectively deploy interactive strategies does not displace the central importance of gradually improving one’s general English speaking and listening proficiency, it still holds a great deal of immediate practical value. However, it should be emphasized to both teachers and learners that in order to deploy such strategic and pragmatic skills effectively one need not already be a proficient English speaker, which should serve as a boon to many Asian NNES conference presenters.

There was, in my observations, no direct correlation between the visceral fluency of the presenter’s English proficiency and the ability to effectively manage the DS. On several occasions, otherwise competent English speakers were unable to manage DSs effectively, while some less proficient English speakers were much more successful in negotiating the session. The effective management of DSs by NNESs was often a result of the speaker’s ability to deploy appropriate interactive strategies in real-time, and was not merely an automatic by-product of their overall English proficiency. Therefore, presentation skill teachers and trainers should strive to impress these strategies upon their learners at any and every stage of the English language development.

There are, however, socio-cultural and environmental factors that might inhibit the development and deployment of these skills. As mentioned earlier, ineffective management of DSs were often the result of misguided attempts at face-saving that, although reflecting culturally legitimate concerns for politeness and respect for peers, ultimately backfired. Novice NNES presenters should keep in mind that DSs are co-constructed real-time dialogues between not only the presenter and the questioner but also the entire audience. Given the central interpersonal function this implies, an inability or cultural reluctance to not ask for rephrasing, clarification, or a failure to check and confirm ultimately inhibits the quality of the discussion, which could be further construed as a violation of audience expectations and thus, ultimately considered as non-polite, and even face-threatening.

In order to overcome this problem, presenters should be trained to avoid viewing DSs primarily as a form of evaluation (or, more precisely, of being evaluated) and more fundamentally regard them as opportunities to negotiate, clarify, and
expand. Teacher/trainers would do well to remind NNES presenters that many in the audience will also likely be NNESs who are sympathetic to the speaker’s lack of English proficiency. Furthermore, teacher/trainers should imprint upon novice presenters that the onus of formulating a comprehensible comment or question is upon the speaker and consequently, that the fault in misunderstandings and miscommunication may in fact lie more with the commenter. Presenters should not be made to feel that they are to be blamed for every breakdown, but, most importantly, if they do, should have the tools to negotiate repair.

5. Summary and Conclusions

Because post-presentation DSs are inherently dynamic and unpredictable they tend to be more anxiety-inducing for presenters than any other aspect of conference presentations, a quality which is magnified for NNESs. What I discovered in the observation of over one hundred presentations at international medical conferences in Asia was that effective management of DSs was often based upon the ability to predict and accurately interpret the type of comment/question made and, thereafter, the utilization of various pragmatic strategies in managing the discussion.

While cultural and face-saving factors must always be taken into consideration, it was noted that ineffective DS management was often based upon a cultural hesitancy to ask commenters for expansions, clarifications, and elaborations, often due to a desire to maintain the face of the commenter, based on limiting assumptions regarding politeness. In fact, the consequent breakdown and miscommunication actually often served to increase a loss of face and further frustrate the commenter and/or audience. This condition particularly afflicted Japanese presenters, and teachers/trainers of Japanese conference presenters would do well to foster the understanding that DSs are co-constructed dialogues that demand the utilization of various interpersonal strategies to enable greater communicative flow.

I hope that these findings and suggestions may influence teachers and trainers of presentation skills in the Asian region in general and Japan in particular such that subsequent DSs will not only be less anxiety-inducing, but also more academically fruitful for all concerned.

References

Developing English for Medical Purposes materials to engage students’ medical knowledge

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1. Introduction

Ongoing needs assessment is an integral component of ESP course development. Particularly important is taking learner perspectives (e.g. self-perception, awareness of target situations, expectations for the lesson) into account when reevaluating and refining existing courses. For those involved in curriculum development in the field of EMP, designing courses that are motivating and relevant for students is of vital importance given the increased importance placed on acquiring proficiency in English to meet global standards of medical education.

The findings of student surveys conducted at Tokyo Medical University in the academic year 2012–2013 showed that while many students rated highly the fact that the university’s EMP course at the time ran in parallel to clinical lectures given in Japanese, some felt the course could be improved if the materials compelled them to engage their medical knowledge in more challenging ways. Students who had returned from the university’s newly launched one-month clinical clerkship program abroad also pointed out in interviews and questionnaires conducted in 2012 and 2013 that while the terminology learned as part of the EMP course provided a sound basis for interacting with their peers abroad, the university’s EMP course could be improved by incorporating the teaching of more functional phrases for communicating in clinical settings.

To respond to such student expectations, a new set of trial materials using case presentations was developed for use in the summer term of 2013. Case presentations were a natural choice, as they are a genre that filled the gap between doctor-patient consultations and journal articles, both of which were already part of the EMP course. It was hoped that case presentations would offer stimulating and relevant content
for the students while at the same time offering opportunities for reinforcing medical phraseology. The decision to use case presentations as the core text was also prompted by the successful use of case presentations in EMP courses at other institutions.\textsuperscript{10,11}

To gather data from students and instructors on whether the new trial materials focusing on case presentations were appropriate for the 4th-year EMP course, a questionnaire survey was undertaken. The aim of the study was to investigate whether the trial lessons would be successful in creating more opportunities for students’ intellectual engagement.

2. Methods

2.1. Participants

A total of 127 4th-year students divided into six groups participated in the trial lessons taught as part of the regular EMP course at Tokyo Medical University in the summer term of 2013. Six English language instructors (including the author) taught one group each.

2.2. Teaching Materials and Lessons

2.2.1. Selection of case presentations

One of the instructors had successfully used Images in Clinical Medicine (ICM) (a section in the \textit{New England Journal of Medicine} devoted to publishing short case presentations featuring images [photos, x-rays, video] of common medical conditions) at another institution, and ICM was chosen as the source of the case presentations for use in the trial materials on the instructor’s advice. Two case presentations were selected—one on a circulatory condition\textsuperscript{12} and the other on a respiratory condition\textsuperscript{13}—to match what had already been taught in the clinical lectures in Japanese. While care must be taken not to burden students with materials beyond their grasp,\textsuperscript{5,14} it was thought using authentic materials as opposed to invented ones would be more stimulating for the students. The case presentations from ICM were thought to be especially suitable for classroom use as they were short (under 150 words) and accompanied by visuals (e.g. photos, X-rays, video) which could be used in the warm-up activity.

2.2.2. Terminology list

An English-Japanese terminology list (see Appendix 1) was distributed before the first lesson on each case report to give students the chance to prepare. In addition to medical terms, the list included phrases commonly used in case presentations, such as “admitted to the hospital with (symptom/medical condition).” The decision to use a bilingual terminology list was based on the belief that the use of two languages would help students activate the medical knowledge they had recently acquired in Japanese.

2.2.3. Worksheet

The two case presentations were taught over four 35-minute segments as part of four 90-minute EMP lessons. Each lesson was centered on a worksheet (see Appendix 2 & 3 for examples) created by the author. The following is an outline of the four lessons:

Lesson 1 (atrial thrombus):
- Warm-up: introduction on case presentation structure
- Focus on the images: short discussion of accompanying photos and echocardiogram
- Focus on the content: listening and answering questions

Lesson 2 (atrial thrombus):
- Warm-up: terminology
- Focus on the language: worksheet activities (identifying nouns and verbs, passive/active voice, reporting findings of diagnostic procedures)

Lesson 3 (whooping cough):
- Warm-up: terminology related to Tdap (combination vaccine)
- Focus on the images: short discussion of accompanying video
- Focus on the content: listening and answering questions

Lesson 4 (whooping cough):
- Warm-up: terminology
- Focus on the language: worksheet activities (adjectives, adverbials of time)

The links to the case presentations were included in the worksheets so students could review the text at home.

2.2.4. Listening activity

As a response to previous student feedback\textsuperscript{7} which showed that students wanted to improve their listening skills and pronunciation of medical terminology, a listening activity was incorporated into the first lesson of each of the case presentations. All groups used a recording of the case presentations read by a British-English speaker (not on the teaching team).

2.2.5. Assessment

As the material was being used on a trial basis, the end-of-term examination did not include comprehension questions on the text, but only terms from the terminology list.

2.2.6. Lesson plans and pre-lesson meetings

To ensure consistency of what was taught in the six groups, a lesson plan for each lesson was sent to the instructors and
pre-lesson meetings were held. As there was some concern over whether the material could be taught by a language instructor alone, it was emphasized that the instructor’s role was to engage the students’ medical knowledge and elicit output in English by asking pertinent questions.15

2.3. Questionnaire Survey

2.3.1. Student Feedback Sheet

The Student Feedback Sheet (Appendix 4) was filled out in class after each trial lesson. It was written in Japanese to allow students to respond without any risk of misunderstanding. In each of the four sections for each lesson, students were asked to indicate the extent to which they agreed or disagreed with three statements about the lesson by marking one of the six response choices. The statements were as follows (author’s translation):

1) I had difficulty following the lesson because the English was too difficult.
2) I had difficulty following the lesson because the medical content was too difficult.
3) It was beneficial as a medical English lesson.

The six response choices were as follows (author’s translation): 1) don’t agree at all, 2) don’t agree, 3) don’t really agree, 4) agree to a certain extent, 5) agree quite a bit, 6) very strongly agree. An even number of response choices was used to counter the reported tendency of survey respondents to select the middle choice to lighten cognitive load.16 Space for comments was provided at the end of the questionnaire to ensure that students felt they could express their personal opinion and classroom experiences in their own words.17

2.3.2. Instructor Feedback Sheet

All instructors received an Instructor Feedback Sheet by email, but giving feedback was optional. All questions were open-ended, asking for any comments the teachers might have on each of the four lessons/worksheets and the two terminology lists. A section for additional comments was included.

3. Results

3.1. Students’ feedback

A total of 125 students filled in the feedback sheet on days they were present. Two students did not turn in the feedback sheet. The three line graphs (Fig. 1–3) show the students’ responses for each of the four trial lessons.

3.1.1. Responses to Statement 1: I had difficulty following the lesson because the English was too difficult
The percentage of students who responded "agree to a certain extent" decreased steadily from 34.7% to 22.5% over the four lessons while those selecting "don't really agree" decreased from 30.6% for Lesson 1 to 46.7% for Lesson 4. Also notable was the decline in those selecting "agree quite a bit," which started at 9.1% and ended at 2.5%.

3.1.2. Responses to Statement 2: I had difficulty following the lesson because the medical content was too difficult

The percentage of those who responded "don't really agree" was consistently high, ending at 54.2% for Lesson 4. "Don't agree" was the second highest response and was always above 20%. Those who expressed strong disagreement by marking "don't agree at all" ranged from 5.6% to 8.5%. In other words, the percentage of those who disagreed with the statement was 72.7% at its lowest and 84.2% at its highest. In contrast, "agree to a certain extent" ranged from 19.8% for Lesson 1 and 13.3% for lesson 4, thus constantly remaining below 20%. "Very strongly agree" was never higher than 1.7% and "agree quite a bit" never higher than 5.9%.

3.1.3. Responses to Statement 3: It was beneficial as a medical English lesson

The percentage of those who responded "agree to a certain extent" was high and consistent, ranging from 48.3% to 55.0% over the four lessons. The percentage of those who responded "agree quite a bit" dropped slightly for Lesson 2, but was never lower than 16.8%. Those who expressed strong agreement by marking "very strongly agree" remained fairly consistent, ranging from 6.8% to 9.2%. This meant that the percentage of those students who agreed with the statement was 75.7% at its lowest and 84.2% at its highest. "Don't really agree" was highest at 20.6% for lesson 2, but remained at around 12% for the other three lessons.

3.1.4. Student comments

A total of 24 students wrote comments for Lesson 1, 10 for Lesson 2, 7 for Lesson 3, and 99 for Lesson 4. The high number of responses for the final lesson is thought to be a result of all instructors encouraging students to write comments. To facilitate qualitative analysis, the comments were grouped into thematic categories which included the following: 1) overall comments, 2) linking with clinical lectures, 3) listening, 4) terminology, and 5) difficulty. Some of the most relevant comments (originally written in Japanese and translated by the author unless otherwise stated) are highlighted below.

Most of the 14 comments on the overall impression were positive and included responses such as: "It was good we got to learn words and phrases that can be used in the clinical setting," "The phrases will probably come into use when making case presentations in the future. Wanted to do more," "I was able to follow the content better than in the regular text because I had to think while listening," "I think that the case report is good, because it is useful as English and Medicine" (shown as written in English by the student). However, one student, clearly with a different view, commented, "The material is not really worth doing in class. It can be done on one's own."

Of the 14 comments on references to the lessons running parallel to the clinical lectures, 11 were positive. Many of these noted that the lesson was a good revision of what had been covered in the clinical lectures. There were two comments to the effect that they had gained some medical knowledge in the EMP lessons. All three negative comments pointed out that the EMP course should be scheduled to trail further behind the clinical lectures until the students had developed a better grasp of the medical content.

Comments on the listening activity were numerous. Of the 22 comments which mentioned listening, 8 noted the value of the listening activity. Another 8 commented on the difficulty of the listening activity, but 4 of these also noted that the activity was beneficial. Two students noted that it was not possible to catch medical terms they had not yet studied. One student pointed out that spelling was a problem even when the word was familiar.

Direct reference to overall difficulty was made by 12 students. One added that despite the difficult terminology, the instructor's explanation made it possible to follow the lesson most of the time. However, another was more ambivalent: "Because there was no explanation of the medical content, there were many things that were difficult to follow, but it may be okay if I think of just the English."

The only comment which specifically referred to the use of images noted that the lesson "was beneficial, as we got to see an echocardiogram and images like that."

Suggestions from the students included more listening and oral activities, terminology quizzes, introduction of related terminology, and more case presentations.

3.2. Instructors' feedback

Written feedback in English was received from two instructors. The two instructors (henceforth Instructor A and B) expressed contrasting views of their experience using the trial materials. Instructor A was, on the whole, positive, commenting that it was good to let the students know about case presentations and that the students seemed to like them more than the instructor had expected. Specifically, the
instructor noted that the terminology list was “helpful” and the inclusion of the structure of the case report in Worksheet 1 was “very helpful.” The instructor pointed out, however, that having multiple worksheets (i.e., a terminology sheet and the trial worksheets in addition to the regular teaching material) was troublesome and sometimes confusing.

Instructor B was much more critical of the worksheets. The instructor expressed unease about incorporating the reading of the echocardiogram in the lesson commenting, “I don’t know about the other teachers, but I don’t know how to read an echocardiogram. Such a video is attractive, but maybe we should start with something easier, e.g., a photo, x-ray, CT.” Among the other points raised were: a) that the grammar activity in Worksheet 2 (finding the subject, changing from passive to active voice) is too easy, as it is something they would have done in high school, and b) that the words in the warm-up of Worksheet 3 would be unfamiliar to the students. As a general comment, the instructor noted that the best principle to follow when teaching was to grade the level of the exercises so that they progressed from being “easy” to “a little difficult” to “a little more difficult” and cautioned that, “What we think is easy is not really easy for them.” The instructor had the following specific recommendations: a) that terminology should be introduced before the listening activity, b) that some of the activity should be done orally rather than in writing, and c) that there should be a listen-and-repeat exercise before the fill-in-the-blanks listening activity.

One notable difference between the two instructors was their opinion on Worksheet 3. Instructor A’s comment that the “students enjoyed the exercise” highlighted this instructor’s appreciation of the students’ engagement with the material in the classroom. In contrast, Instructor B’s comment that, “the words for the warm-up were totally unfamiliar to the students” seems to indicate that the instructor’s primary concern was on whether the exercises were appropriately designed to match the students’ linguistic knowledge.

A comparison of the Likert scale responses of the groups taught by the two instructors showed that a large proportion of students in both groups responded “agree to a certain extent” to the statement that the lesson was beneficial as a medical English session (84.2% in Instructor A’s group; 71.4% in Instructor B’s group for lesson 4). However, while none of the students in Instructor A’s group marked “very strongly agree,” three in Instructor B’s group did. Although a comparison of the two groups should be treated with caution because of the small sample size, it is interesting to note that three students in the group taught by the instructor who was skeptical about the appropriateness of the worksheets strongly agreed that the lesson was beneficial as a medical English session.

4. Discussion

The present study showed that the series of four trial lessons was largely well received by the 4th-year students. Many students embraced the opportunity to engage their intellectual abilities with challenging material from a major medical journal. The majority of students felt they were able to follow the medical content and were able to apply what they had learned in the clinical lectures. Some also commented that the EMP lessons served as a revision of what they learned in the clinical lectures in Japanese. This seems to have prompted them to leave comments that referred to the lessons as beneficial (たのしくなる) and useful (役に立つ). From this it seems clear that the selection of case presentations which dealt with medical conditions that had been studied in the concurrent clinical lectures created opportunities for students to engage their recently acquired medical knowledge in the EMP lessons. These opportunities seem to have elevated their motivation to further their knowledge in both medicine and English.

The responses to Statement 1 indicate that some of the students seemed less confident about their ability to cope with the English used in case reports. However, it became clear from the comments that a considerable number of students who commented on the difficulty of the listening exercise or the content also thought the lessons were beneficial. Positive comments on having been able to learn functional phrases that can be used in clinical settings (実践的, 現場で使える英語) suggest that students found the lessons to be relevant for their future careers.

It is noteworthy that 40% of these students had previously responded in a 3rd-year questionnaire that case reports would be suitable as material in their 5th–6th year. This is a reminder that students’ perception of what might be appropriate as EMP material, and when to tackle it, may change as they accumulate knowledge and progress through their time at college.

While the responses were on the whole favorable, it is also important to take note of the negative comments. The Likert scale responses of the student who wrote, “The material is not really worth doing in class. It can be done on one’s own” was consistent across all four lessons. The student responded “agree to a certain extent” to Statement 1 on the difficulty of English, “do not agree at all” to Statement 2 on the difficulty of the medical content, and “don’t really agree” to State-
ment 3 on whether the lessons were beneficial as an EMP lesson. Taken together, the student’s comment seems to have been based on a combination of the medical content being not challenging enough and the worksheets being too simple.

One specific point on the worksheet worth mentioning is that the grammar focused activities for Lesson 2 were perceived to be too simple or unrelated to the medical content by many and seem to have contributed to the lower rating of the lesson’s relevance as a medical English session, a point also highlighted by instructor B.

What can be learned from this feedback is that there is scope for improvement in communicating the purpose of the lessons for both teachers and students. One essential point that was not sufficiently conveyed was the fact that the worksheets were aimed not so much at reinforcing the students’ grammatical knowledge, but at creating awareness of the linguistic and structural conventions used in case presentations to allow the students to become competent users of the language used in this particular genre. For example, the aim of the exercise in Worksheet 2, in which students had to change sentences from the passive to the active voice, was not to teach a grammatical point, but to draw attention to the convention of using passives to avoid mentioning the agent of the action (e.g. “the round mass was removed” rather than “we removed the round mass”). Similarly, the aim of the exercise in Worksheet 2, in which students had to match diagnostic procedures with findings (e.g. “angiography revealed total occlusion of the artery”), was to focus on the use of technology as the subject in active sentences, another distinctive feature of this genre. These points should perhaps have been emphasized in the pre-lesson meetings and incorporated into the worksheets.

One of the primary challenges for EMP instructors who are language teaching experts and not medical content specialists is to decide how much understanding they should have of the clinical reasoning behind the material. Using material with heavy medical content can be daunting for language instructors, and it is pertinent to note the unease about the lack of expertise in reading an echocardiogram expressed by Instructor B. At the same time, although the survey did not specifically ask about the suitability of the instructors’ level of medical knowledge, it is noteworthy that only one student commented on the lack of explanation of the medical content. The finding that the students were confident that they understood the medical content offers opportunities for instructors to turn to the students as a source of knowledge, thereby encouraging students to demonstrate their medical knowledge in English in ways that are meaningful to them as...

Appendix 1: Excerpt from terminology list for Lesson 3 & 4

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>admitted to the hospital with (symptom/medical condition)</td>
</tr>
<tr>
<td>2</td>
<td>oral glucocorticoids</td>
</tr>
<tr>
<td>3</td>
<td>progressive</td>
</tr>
<tr>
<td>4</td>
<td>associated (symptom)</td>
</tr>
<tr>
<td>5</td>
<td>post-tussive emesis</td>
</tr>
</tbody>
</table>

Appendix 2. Worksheet 3 for the first lesson on “Whooping Cough in an Adult”

**Warm-up activity: Terminology**

Today’s case presentation will refer to Tdap (a type of 三種混合ワクチン). Complete the following sentence using the words in the box.

Tdap is a combination ① **vaccine** for ② **adolescents** and adults that protects against three potentially life-threatening ③ **bacterial** diseases: ④ **tetanus**, ⑤ **diphtheria**, and acellular ⑥ **pertussis** (⑦ **whooping cough**).

<table>
<thead>
<tr>
<th>whooping</th>
<th>bacterial</th>
<th>pertussis</th>
<th>vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>diphtheria</td>
<td>adolescents</td>
<td>tetanus</td>
<td></td>
</tr>
</tbody>
</table>

**Activity 1: Focus on the images**

Watch the video. Can you guess what the patient has?

**Activity 2: Focus on the content**

Listen to Part I of the case report. Focus on the three topics below and jot down the key words for each topic. There is no need to understand every word.

a. How old is the patient?
b. What were his presenting symptoms?
c. What did the medical team notice after his admission?

* The answers to the fill-in-the-blanks activity are shown in cursive font. The layout has been altered for publication.
aspiring medical professionals. How well instructors can utilize the students’ medical knowledge as a resource might be the key to the success of EMP lessons with heavy medical content. Although collaboration with subject specialists will be essential for offering full-fledged content and language integrated learning, this study offers encouraging insights into the possibilities of using material with heavy medical content by the language instructor alone.

Instructor B also raised a pedagogical recommendation which was further brought up by some students—that the activities should be done orally rather than in writing. Such oral practice may be beneficial, especially considering the emphasis placed on acquiring well-balanced English language competencies. To serve as a model for oral practice, instead of having just one recording, two recordings can be made—one delivered naturally and the other delivered clearly at a consistent and slower speed.

While the survey findings of these trial lessons were largely positive, a continued analysis of the effectiveness of a longer course is essential. In the future, a more in-depth interview/questionnaire on the instructors’ needs and perspectives should be undertaken to identify the causes of any

Appendix 3. Worksheet 4 for the second lesson on "Whooping Cough in an Adult"

Activity: Focus on the Language

Part I – Adjectives
Listen to Part I of the case report and fill in the blanks. All the blanks contain adjectives.

a. A 64-year-old man was admitted to the medical service with a presumed asthma exacerbation.

b. His symptoms had worsened during the preceding 3 weeks despite treatment with oral glucocorticoids, leading him to present to the emergency department multiple times with a progressive cough.

[questions c to e have been omitted]

Part II – Adverbials of Time
Listen to Part II of the case report and fill in the blanks. All the blanks contain adverbials of time.

f. The patient's cough abated and his respiratory status improved during the next 5 days.

g. Approximately 1 week after discharge, test results were returned that were positive for B. pertussis.

[questions h and i have been omitted]

* The answers to the fill-in-the-blanks activity are shown in cursive font.

The layout has been altered for publication.

Appendix 4: Student feedback sheet

Student Feedback Sheet

ID: 氏名:

医学英語の授業内容の改善のために。アンケートにご協力ください。
画像と症例報告を使用した教材について伺います。該当する欄に✓を入れてください。
なお、記入されたコメントは評価の対象にはなりません。

Worksheet 1

<table>
<thead>
<tr>
<th>全くそう思わない</th>
<th>そう思わない</th>
<th>あまりそう思わない</th>
<th>ある程度そう思う</th>
<th>かなりそう思う</th>
<th>とても強くそう思う</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) 英語が難しすぎて授業についていけなかった</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) 医学的に難しすぎて授業についていけなかった</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) 医学英語の授業として有益だった</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

その他、WorksheetやActivityについてよかった点、改善点などをご記入ください。

コメントは日本語・英語どちらでも結構です。
ご協力ありがとうございます。

Thank you for responding to this questionnaire.

* The layout of the questionnaire has been altered for publication
inter-instructor differences there may be. A close examination of classroom interactions between students and teachers might also add another layer to such studies. Further research is also needed to find out what aspects of the activities the students found most useful, interesting, or challenging, and why.

5. Conclusion

This study confirms our belief that providing lessons in which students are encouraged to activate their medical knowledge can be the key to devising an EMP course which is both motivating and relevant for the students. If planned appropriately, the use of case presentations can stimulate students to use both their medical and linguistic knowledge in the EMP classroom. It can also introduce students to the language used among professionals in the community they aspire to belong to. The findings also highlight the value of continuous needs analyses for assessing the effectiveness of existing courses and designing course materials that can enrich the learning experiences of students.

Acknowledgements

I would like to thank Kazuyuki Abe, Edward Barroga, Takako Kojima, Naomi Morita, and Kazuko Takahashi (the EMP instructors at Tokyo Medical University in the academic year 2013), especially the two instructors who responded to the questionnaire, and all the 4th-year students for giving feedback on the trial materials. I also thank the faculty of the Department of International Medical Communications of Tokyo Medical University: Jeremy Williams, Professor and Chairman, for his support in devising the lessons and in making the audio recordings; Edward Barroga, Associate Professor, and Takako Kojima, Assistant Professor, for their suggestions in compiling the worksheets. I am also grateful to the members of Tokyo Medical University’s English Speaking Society, who took part in, and commented on, a preliminary trial lesson using case presentations.

References

Learning about legal issues in healthcare through an extracurricular activity

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Extracurricular activities are known to have a positive influence on students’ academic accomplishments. They can be particularly helpful if the curriculum lacks the study of the area(s) or skill(s) that the given extracurricular activity promotes. This paper describes an extracurricular educational lecture held in English at a Japanese health sciences university that provided an opportunity for students to learn about legal issues in healthcare and related English terminology, an area not included in their medical English curriculum. The paper relates the background and the purpose of holding the lecture and examines its effect on students’ learning, through data collected before and after the event. The results suggest that while extracurricular activities of this nature cannot be a substitute for more thorough instruction of specialty-specific medical English, they can play an important role in exposing students to language related to their discipline, and at the same time help create interest and motivation for further language study.


Keywords Extracurricular activities, legal issues in healthcare, medical English, health sciences, healthcare in Japan vs US

1. Introduction

Extracurricular activities are generally school-based or school-sponsored activities that are not part of the regular curriculum. Their purpose is to enrich and extend classroom education. Typical examples of extracurricular activities that support curricular achievements are those held through academic-related student clubs such as history club, forensic club, science club or foreign languages club. In addition, a variety of educational lectures, symposia, seminars, and so on, held on campus but separate from regular lectures organized and administered by the school, can also be a significant source of extracurricular learning. However, not much has been written about such extracurricular events as compared to those organized and managed by students. This paper describes a school-organized extracurricular educational lecture in English held at a Japanese health sciences university that provided a unique opportunity for students to learn about legal issues in healthcare, and related language.

2. The extracurricular educational lecture

2.1. Background

The lecture described here was held at Kagawa Prefectural University of Health Sciences in the western Japanese city of Takamatsu. It was one of several extracurricular educational lectures given by invited speakers that are held on campus each academic year. The undergraduate school has three departments, namely, Nursing (DN), Medical Technology (DMT) and Liberal Arts and Sciences (DLAS), each of which receives an annual budget to sponsor one or more of these events. The speaker and topic selections are left to the sponsoring department. The speakers are mostly teachers/researchers from other Japanese universities or the private sector, while the lecture topics vary depending on the sponsoring department. Thus, the topics may be of general interest when sponsored by the DLAS, or fall into the respective specialty areas of the DN or DMT. Accordingly, the lectures may target students of a particular major and/or school year (such as nursing freshmen), but are generally also open to...
students of other majors and to the faculty at large, and in some instances to the general public. Before the lecture described here, these lectures had always been given in Japanese by Japanese speakers.

The present lecture was sponsored by the university’s DLAS. Two examples of the titles of other educational lectures sponsored by the DLAS (with respective English translations in parentheses) are: *Idenshi kumikae shokuhin to watashitachi no seikatsu* (Genetically modified foods and our livelihood); and *Metabo-seikatsushuukanbyou ni kakomu sanka sutoresu: Mansei enshou kanren wa yuubouna chiryou mokuteki* (Oxidative stress in metabolic syndrome and lifestyle-related diseases: A promising treatment goal for chronic inflammation). In both cases, post-lecture student feedback was obtained (in Japanese) via an open-ended question that asked students to write their comments/opinions. Feedback sheets were forwarded to the respective speakers and the data were not recorded or analyzed by the sponsoring department.

### 2.2. The present lecture

The lecture described in the present paper was given by a visiting US state court judge and was delivered in English. The lecture was made possible through collaboration with a sister-city friendship association between the Japanese town where the university is located and a US city. The title of the lecture was “Healthcare and legal issues in the United States”. This title was chosen to suit the academic and professional qualifications of the speaker and to match the needs of the target class of health sciences majors.

The lecture lasted 60 minutes, including the question and answer session. It was delivered in an interactive manner that encouraged audience participation. Two-way interpretation was provided for questions and answers as necessary. The main areas addressed in the lecture were 1) the common law, 2) medical malpractice, 3) professional duty, 4) standard of care, and 5) insurance.

### 2.3. The students

The lecture was specifically targeted toward the freshman class in the 4-year undergraduate program of the health sciences faculty. The class comprised 90 students, with 70 nursing and 20 medical technology majors. On the lecture day there were 2 absentees in each group, so 86 students attended.

### 2.4. Pre-lecture briefing

The target class was briefed about the lecture a week in advance. This included telling the students about the speaker, the lecture title and its meaning in Japanese, and introducing them to some English vocabulary in the area of healthcare and law. In addition, students were asked to write down in English any questions related to the lecture topic that they would like to ask the speaker. Ten typical questions (unedited) that the students wrote are listed in Table 1.

### 2.5. Post-lecture survey

After the lecture, the students were asked to complete a written questionnaire including the following three questions in English that required a YES/NO response:

Q1. From the lecture, did you learn something new about healthcare and legal issues?

Q2. From the lecture, did you learn any new English words about healthcare and legal issues?

Q3. Do you think that a lecture like this can help you to learn English for health sciences?

A total of 79 students handed in the completed questionnaires. Of these, 78 (99%) answered YES to Q1; 68 (86%) answered YES to Q2; and 77 (97%) answered YES to Q3. The one student who responded NO to Q1 nevertheless responded YES to Q2. All 11 students who responded NO to Q2 answered YES to Q1. Of the two students who gave a NO for Q3, one responded YES to both Q1 & Q2 and one responded YES to Q2. None of the students responded NO to all three questions, whereas 84% (66/79) answered YES to all three.

<table>
<thead>
<tr>
<th>Table 1. Ten typical questions (unedited) written in English by the students prior to the lecture</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I would like to know how to deal with brain death in USA.</td>
</tr>
<tr>
<td>2. How is legal issues about death with dignity in the USA?</td>
</tr>
<tr>
<td>3. In the trial of the case where the patient died of the operation though the doctor used every trick of the trade, is the doctor side still disadvantageous?</td>
</tr>
<tr>
<td>4. I heard that in U.S., there are &quot;nurse practitioner&quot; like semi doctor. So, I would like to know how many legal troubles of it your country have.</td>
</tr>
<tr>
<td>5. How is it thought about surrogate mother birth in the United States?</td>
</tr>
<tr>
<td>6. We have &quot;Universal Health Insurance Coverage&quot;. Is it possible to be realized &quot;Universal Health Insurance Coverage&quot; in USA?</td>
</tr>
<tr>
<td>7. I would like to know about issues of citizen jude system.</td>
</tr>
<tr>
<td>8. I would like to know about the difference between healthcare and legal issues in the USA and it in the Japan.</td>
</tr>
<tr>
<td>9. I would like to know about brain death, organ transplants, insurance, euthanasia, a human killing and artificial insemination in the USA.</td>
</tr>
<tr>
<td>10. I would like to know about the actual condition of malpractice in USA.</td>
</tr>
</tbody>
</table>
questions.

In addition to the above three questions, the questionnaire also asked the students to write their general impression of the lecture in up to 50 words. Ten typical student responses in Japanese (unedited) are listed in Table 2 together with their English translation.

3. Discussion

The extracurricular educational lecture described here was found to have a significant impact on the target class as indicated by the results of the post-lecture survey. In response to the survey questions, most students indicated that they had learned new English words about healthcare and legal issues, and all except one agreed that they had learned something new about the subject. In addition, the lecture inspired the students to think deeply about the subject beforehand and then reflect on it after the event, and they were exposed to specific English language use and terminology both before and during the lecture.

Japanese university freshmen are generally known to have minimal oral communication competency in English. However, the questions written by the students (Table 1) show that they did indeed have the ability to formulate ideas and put them down in writing, even though their listening and speaking abilities may have been limited. Moreover, this suggests that such extracurricular activities can help students to build on their basic knowledge of English through increasing their vocabulary and giving them an opportunity to put their ideas in writing. This would be in agreement with research which shows that extracurricular activities can have a positive influence on students' academic accomplishments.

The questions written by the students, and the post-lecture feedback, indicate an interest in the subject and motivation to learn more about it. This may be attributed largely to the fact that the topic was related to students' future profession. In other words, the problems that they were thinking and writing about were ones that they themselves are likely

<table>
<thead>
<tr>
<th>Table 2. Ten typical impressions (unedited) written in Japanese by the students after the lecture (English translation in parentheses)</th>
</tr>
</thead>
</table>
| 1. 医療と法律の問題を考えることはしばしばあるが、海外との比較をしたりということはなかなかない。新たな見聞の幅を広げるには良い試みだと思います。
   (Although we often think about healthcare and legal issues in Japan, comparing the Japanese situation with that abroad is an opportunity not readily available. I think that it was a new and good attempt to broaden our experience.) |
| 2. 「アメリカにおける医療と法律問題」について真剣にお話ししていただきました。分からない単語が多く出てきたけれど、先生の熱意が伝わって来て、法律問題にも興味を持てたことができ、良い経験になりました。
   (The lecturer talked earnestly about "Healthcare and legal issues in the United States". Although there were many words that I did not understand, the presenter's zeal was conveyed and I could get interested in legal issues as well. It became a good experience.) |
| 3. 話を聞いて、アメリカの医療や法律について学ぶことができました。また、日本との違いについても知ることができ、とても勉強になりました。
   (By listening to the talk, I was able to learn about healthcare and law in the United States. Moreover, I could know about differences between the United States and Japan. I learned a lot from the lecture.) |
| 4. 日本とアメリカにおける医療と法律は異なる部分もあった。いくつかの法律問題の例を挙げて、私たちに考える場面を与えて下さったり、いろいろな考え方を紹介して下さったり、分かりやすい講義内容だった。
   (There are differences between Japan and the United States in healthcare and legal issues. The lecturer presented us with situations to think about and introduced various ways of thinking by giving several examples of legal issues. It was an easy to understand lecture.) |
| 5. アメリカは、数多くの面で日本よりも優れた医療技術をもっているので、そのような国の医療の講義は興味深かったです。
   (Because medical technology in the United States is superior to Japan in a lot of respects, listening to a lecture on healthcare of such a country was very interesting.) |
| 6. アメリカにおける医療と法律問題についての講義を聞いて、これはアメリカだけでなく、日本にも深く関わることなので、しっかりと考える必要がある内容だと思います。
   (I thought that the content of the lecture required serious thinking because it was related deeply not only with the United States but also Japan.) |
| 7. アメリカの医療について知らなかったので今回話を聞いてとても勉強になりました。アメリカの医療について興味を持てるので自分で調べたり勉強したいと思いました。
   (Because I did not know about healthcare in the United States, I learned a lot from this lecture. Also I became interested in American healthcare and felt like studying about it on my own.) |
| 8. とても興味深い内容だったので話を聞くことができやすかった。このような機会はなかなかないのでよかった。
   (Because its content was very interesting, it is good that we could hear the lecture. It was good also because we usually do not have such a chance readily available.) |
| 9. アメリカにおける医療と法律問題について話を聞いて日本とどのような違いがあるかよく分かった。制度が違うと状況もかなり変わるということが分かった。他の国のいいところを日本も見習って日本の医療も良くなればいいと思った。
   (After hearing the lecture on American healthcare and legal issues, I understood well the differences between Japan and America in this area. I understood that when the systems are different, the conditions are considerably different too. I felt that Japanese medicine could improve by following the good aspects of other countries.) |
| 10. 看護師を目指す私たちにとってとてもためになる講義だったと思う。もっと法律について学び、世界的な医療についてもっと知りたいと思った。
   (I think that it was a very good lecture for us who aim at being nurses. It made me want to learn more about law and global healthcare.) |
to face in the future. This is especially reflected by comment 10 in Table 2 where the student states (as translated into English) the following: "It was a very good lecture for us who aim at being nurses. It made me want to learn more about law and global healthcare.”

In the present case, the lecture was delivered by a non-Japanese speaker and on the subject of healthcare in a foreign country, both of which added an international dimension to the event. This made the experience more interesting for the students since knowing and learning about the state of affairs of a foreign country can be appealing to young learners, particularly when the topic is related to their own field of study. Indeed, many of the students’ comments reflect their interest in the lecture stemming from the opportunity it gave them to compare legal issues in healthcare between Japan and the United States (see comments 1, 3, 4, 6, 9 in Table 2).

The international facet of the lecture also made the experience worthwhile pedagogically. An important goal of present day higher education is to raise individuals who are culturally competent and have the ability to interact with people from different backgrounds.6 Toward this goal, an international learning environment can serve to expose students to diverse and multiple perspectives and thereby promote their intellectual and personal development.6 As one student wrote (comment 1, Table 2), "I think that it was a new and good attempt to broaden our experience."

Based on the results of this experience, it is hoped that the university can organize more such lectures, delivered in English and by international speakers, and on topics with direct relevance to students’ future profession. Even though holding the present event in English required a pre-lecture briefing and student preparation of the kind generally not necessary when organizing similar lectures in Japanese, the results show that the effort was worthwhile. In organizing such lectures in the future, it may also be useful to create an opportunity for students to discuss the content of the lecture in one of their subsequent regular medical English classes. This practice would not only serve to link the students’ extracurricular experiences more directly with their curricular studies but also provide them with an additional opportunity to reflect on the lecture and express their opinions and views on the subject orally. Lastly, it is hoped that other Japanese schools of health sciences and allied disciplines can also consider holding similar extracurricular lectures to reap their benefits as described in this paper.

### 4. Conclusion

The extracurricular lecture reported here can be said to have made a small but significant contribution to the students’ knowledge of healthcare and legal issues in the US and Japan, introduced them to subject-specific English terminology and usage, inspired them to think deeply about the topic, and helped create interest and motivation for further study. Despite all these benefits, however, it is important to bear in mind that extracurricular activities cannot be a substitute for thorough and comprehensive study as a part of the curriculum.7 They can be beneficial only as adjuncts to classroom-based instruction. Thus, while the lecture described here may help to fill a gap in students’ specialized English education, it does not exclude the need for a complete curricular course of study in specialized English for health sciences. Therefore, it is necessary to institute in the regular curriculum courses that equip students with English skills related to their study majors.

### References

第18回日本医学英語教育学会
教育講演 (Educational lecture)
日本医学放射線学会の国際化の取り組み
The Japan Radiological Society’s response to globalization
（岡山コンベンションセンター，2015年7月18日）

金澤 右 Susumu Kanazawa
岡山大学築豊医学総合研究科放射線医学教授 Okayama University Medical School
日本医学放射線学会副理事長 Vice president, Japan Radiological Society

日本医学放射線学会は世界でトレードある放射線学会であるが，かつて盛んであった国際活動が衰退傾向にあった。そこで，国際化に優れた他国の状況を参考にしながら，理事会で戦略的な国際化活動を近年行ってきた。それらは第一に学会学術雑誌の英語化とオープン化，第二に学術集会の英語化，第三に他国の放射線学会との定期的交流とその正式な取り決めであるが，いずれも成果を上げつつある。


1. はじめに
放射線医学は，レントゲン博士がX線を開発された1895年に産声を上げました。私どもの日本医学放射線学会は1940年にアジア他国に先駆けて創設され，現在は会員数約9000名であり，世界最大規模の放射線学会の一つです。
私たち日本医学放射線学会には3つのミッションがあります。第一に国民に対し安全で質の高い放射線医療を提供すること，第二に全国の放射線科医に対し研究や教育の場を提供し優秀な放射線科医を育成すること，第三に国や世界の放射線医療体制作りと維持に貢献することです。残念ながら，第三のミッションを遂行するための「国際化」については活動が長く停滞していました。しかし，2010年前後より学会理事会を中心に「国際化」に対するさまざまな具体的試みを開始しました。

2. 国際化に取り組みだした背景
最大の背景は，国際放射線医学界における我々の存在感の相対的低下に対する大きな危機感です。
かつては，日本の放射線科医の海外に対する姿勢は大変積極的で，欧米の一流の国際雑誌における我が国の発表論文掲載はアジアでも群を抜いており，海外留学を希望する者も多数いました。しかしながら近年，国際雑誌における我が国の論文掲載は伸び悩みあるいは減少の一途をたどっており，一方，韓国，中国等のアジア諸国からの論文掲載が目立って多くなってきました（図1）。また，欧米学会でアジア諸国の参加者が激増しているのに対して，我々の若い放射線科医の参加は減少してきており，海外留学希望者も少なくなっています。我々は，多くの諸外国と異なり放射線医学に関する自国語の優れた教科書や雑誌があること，現状の学習・職場環境が比較的良好で，あえて海外にそれを学ぶ必要がないと感じること，インターネットを通じて海外の情報が容易に入手できること，海外生活における日常的リスクが増えてきていることなどがこれら最近の動向の裏事情としてあると思われます。統計等で明らかにされるているわけではありませんが，国際雑誌に投稿しているなんだから問題は皆無ではないと思うのです。我々が国全体で問題になっている「ガラパゴス化」が我々放射線学の分野でもみられているということだと思います。
このような我々が国の最近の傾向を比較すると，アジア諸国は積極的に国際化を進めているように思われます。特に国際意識に優れた韓国放射線学会はさまざまな戦略的視点を
もっと国际化を推進してきました。具体的には、学術誌であるKorean Journal of Radiologyが1を超えるimpact factorを常時獲得してその国際的存在感を増してきたと、アジア諸国を対象に韓国でさまざまな国際会議を開催して自国の放射線医学の優位性を示すこと、アジア諸国における放射線科医を対象にさまざまな教育セミナーを行い放射線科医育成に国際貢献すること、ホームページや電子メールを用いてさまざまな情報活動を英語で行うなどです。彼らの年次学術集会であるKorean Congress of Radiologyでは約70%の発表は英語で成されており、外国からの参加者も増加していると報告されています。

また、前述のKorean Journal of Radiologyは2000年からの出版でありますが、オープン化されたpeer review journalであり、放射線医学のアジア圏での国際英語雑誌の先駆け的立場を占めています。また、impact factorを上げるためのさまざまな戦略的努力を重ねています。それは、雑誌を多く掲載して引用数を増やすKorean Journal of Radiologyに掲載された論文をほかの国際雑誌でお互いに引用するように、引用されにくいとされる症例報告を掲載していないようです。

また、学会事務局活動そのものも、国際学会を取り扱う学会運営会社に委託して、海外との通信や交流を容易にさせています。もちろんホームページは完全に英語化されており、そのところに示されています。韓国では、外科医学や放射線科医学などの大学で放射線科医がほとんど英語であったため、基礎知識が違うというように考えますが、学会で会う若い韓国の放射線科医が非常に流暢な英語で話すので、英語がどの大学に留学したのかと尋ねると、米国留学経験は少ないといわれてびっくりすることもあります。また、彼らの国際化の背景の中には、新鮮化していきたい学術活動や論文執筆において国際的な活動を当たり前にしなくてならないということもあるようです。

いずれにせよ、気がつくと、いつの間にかアジアの学術的トップであった私たち日本の医学放射線学会は、韓国に国際化の進化を後追いする状況になり、今何とかしないと取り返しがつかない状況にあることを認識したわけです。

また、ヨーロッパでは、ヨーロッパ連合（EU）の設立後にヨーロッパ各国の放射線医学会が合併して2005年にヨーロッパ放射線学会(European Society of Radiology; ESR)が結成されました。そして、毎年春にウィーンでEuropean Congress of Radiology (ECR)が開催されており、その共通言語はもちろん英語です。アジアで、そしてヨーロッパで世界的に国際化(英語化)が推進されていました。

3. 国際化のための活動
その1: 学術雑誌の国際化

c）このような状況認識の中で、私たちが一番初めに取り組んだのは私たちの学術雑誌の国際化でした。それは、雑誌の完全英語化、オープン化です。元来、私たちの学術雑誌は「日本医学放射線学会雑誌」で、国際名はNippon Acta Radiologicaでした。大変伝統のある雑誌ですが、抄録のみ英語の和文雑誌で、投稿者数も限定されてしまいました。
一方、日本医学放射線学会の学術誌ではありませんが、東京大学が放射線医学関係の英文雑誌Radiation Medicineを長く出版しており、こちらはオープン雑誌ですが、あまりレベルが高い論文は掲載されず将来の見通しが立たない状況にありました。しかし、理事会での国際化の取組みの話し合いの中から、この2つの雑誌を統合してオープン化した英語の学術雑誌Japanese Journal of Radiologyを出版することが決まりました。当時、完全英語化には反対の意見、すなわち和文論文の提出先を確保すべきではないのか、日本学会が和文雑誌をもたないのはおかしいのではないか、といった意見が理事会内でもありましたが、少数派であり、Springer社と提携して2009年に日本Joumal of Radiologyの出版が始まりました。

この雑誌の特徴としては、放射線科学の総合雑誌として放射線診断、治療、黒医学、インターベンション放射線治療、放射線技術開発といったすべての放射線医学領域を取り扱うことができ、多くの国際雑誌は各領域別になっているのに対して開口が広くなっています。Japanese Journal of Radiologyの出版については、編集委員会は大変な苦労をしながら、投稿や査読で新しいシステムを作りました。また、運営資金的には従来よりは高額となり、財政的苦労もありました。しかしながら、Radiation Medicine時代には年間100前後すらもなかった投稿論文数は急激に増加して、2014年には500を超えるに至りました（図2）。

投稿論文数が多くなると査読が大変になるのはもちろんです。多くの学会員査読者は忙しく査読を引き受けてくれて、出版に遅れが影響が出るようなことはありません。現在、年間もしくは査読でくれた会員には学会誌より優秀査読者賞を差し上げています。また、投稿も最近は近隣アジア諸国だけでなく、イタリア、トルコなどからも多数投稿されています（図3）。これは、後述のそれらの国との学会同士の交流により、各ホームページにお互いの学術誌を掲載され、お互いがそれを自由に読むことができる大きさ影響しているようです。ちなみに2014年の全投稿数は541篇であり、そのうち海外からの投稿数は430篇（73.9%）に上りました。査読の採択率は19.1%です。採択から掲載までの平均日数は2011年に184日であったのだが、2014年には100日に短縮されています。また、impact factorももうなり、2013年は0.742であったのが、2014年には
4. 国際化のための活動　—その2：学術集会の国際化

続いて行ったのは学術集会の国際化です。我々の学会は4月に関催地を横浜に固定して大学放射線学会総会を、秋には関関を固定せず秋季学術大会を開催します。秋季学術大会はどっちかというと教育的な内容が多く、参加者も3000名程度ですが、4月の総会は学術発表センターの内容であり、5000名以上の学会員が参加します。

また、この時期には、Japan Radiology Congress （JRC）として、日本放射線技術学会総会学術大会、日本医学物理学会学術大会、さらに日本ラジオオージ工業会による国際医療画像総会に、CTやMRIなどの画像機器展示が同時開催されるため、会場のバイシマ横浜には2万人以上の関係者が集まります。大量携帯の大きな学術集会の例にあります。この4月の総会を、我々は2012年から2014年にかけての三年計画で国際化することを理事会で決めました。以下のように計画を立て、それを遂行しました。

まず、2012年はすべての発表スライドを英語化することにしました。2013年は、加えて電子ポスターもすべて英語化する。英語での口述発表を推奨する。海外からの招待講演者を30名近くに増やすこととした。2014年には英語での口述発表を30%となることを目指す。抄録集を完全英語化する。学会場の案内を日本語併記するという目標を立てました。

私自身はこの三年計画の最終年である2014年の大会長をさせていただきましたが、2012年、2013年と計画通りに来ましたので、2014年も何かと目標を達成したいと思いました。なかでも懸念されたのが、抄録の完全英語化、英語での口述発表30%ということで、これにより応募演題が減少するのではないかと心配でした。その対策として、演題応募を開始するにあたりて各大学の放射線科教授にこの2点についてぜひご協力いただきたいとのお願いの手紙を送りました。特に若い先生にはぜひ英語での口述発表をすることに励ましていただきたくてお願いしました。また、発表に際しては英語、日本語、どちらでもよい。という選択肢をつくり、どちらで
加入者は海外からの先生の英語講演を一般口演から引き続き聴講できる状況ができ、会場に多くの参加者を引き留めることができました。How to improve your Englishというシンポジウムでは、日本医学放射線学会理事長の木田浩教授、岡山大学脳神経外科の伊達畑教授などから英語上のヒントとなる教育講演をしていただきましたが、会場外に人があふれる盛況でした（図5）。

学会のプログラム・抄録集も完全英語化しました。ただし、利便性を図るために会場の案内などは裏側に日本語版も添えました。また、このプログラム・抄録集の表紙もこの会からオリジナルな表紙に変更して、従来との差別化を図りました。学会場の案内はすべて英語配信として、英語で対応ができるコンシェルジュを配置しました（図6）。

これらの学術集会の国際化は、まず、我が国の放射線科医、特に若い放射線科医が国内にいながらにして国際化に親しむことができる一の目標ですが、もちろん、その次の方針としては、RSNAやECRと同様に諸外国からの参加者を増やすことが目標です（図7）。徐々にではありませんが、その成果が上がったりつつあり、2015年には50名を超える海外からの一般参加者がありました。

5. 国際化のための活動
--その3：海外の学会との定期的交流

3番目の活動は、海外との学会との定期的交流です。従来行ってきた世界最大の放射線医学会である米米放射線学会（Radiological Society of North America; RSNA）との合同会議だけでなく、ヨーロッパ放射線医学会（ESR）やアジアでは韓国、トルコ、ヨーロッパではフランス、ドイツ、イタリア、スペインなど各国の放射線医学会理事会と交流会議を重ねています。具体的には、世界中の放射線科医が集まるRSNAの学術集会が行われる11月のシンガポール、ヨーロッパの放射線科医の集まるECRの3月のウィーンなどで、各団体、各国放射線医学会と定期的に会合をします（図8）。RSNAとECRの際には、日本医学放射線学会専用のオフィスを会場に借りて、会議環境を整えています。

会議では、お互いの現状を毎回紹介した後に、さまざまなexchange programについて審議され、覚書（MOU）が交
われられています。内容としては、お互いの学術雑誌のホームページにおける紹介、教育講演の交換、学術ポスターの交換などで
す。教育講演の交換では、お互いに1〜2名の講演者を毎年相互に派遣して、滞在費・参加費は招待側が受け持ち、旅費は派
遣側が受け持つという相互平等の原則を貫
いています。これにより、日本医学放射線
学会総会時には必ず数名の海外講演者が
確保されることとなり、会の潤滑な運営に
役立っています。交換プログラムについても検討議題に上がりますが、スポンサーの確保が現状では困難であ
り、あまり活用されていません。しかし、これ
らの定期的交流は海外の現状を知る上だけ
でなく、我が国の現状を知ってもらうことも
有効であり、さらに優秀な若手放射線科
医を我々側から派遣して講演してもらう
ことにより、我々の放射線医学の高いレ
ベルを知ってもらうことにもなります。そ
のほかに、ECRでは、会場内に日本医学
放射線学会のブースを設けて、私たちの学
会活動の紹介を行っています。
これらの定期的交流を継続推進するため
には、それを担当する人材が必要で、現在
日本医学放射線学会では、国際担当理事を
アジア、ヨーロッパ、アメリカの各々1名
ずつ計3名でおります。これらの理事はそ
の優れた英語力を生かして精力的に活動してくれています。
また、代議員会なども国際交流活動について代議員に報
告するようにして、国際活動を会員に周知することにして
います。

6. 最後に

私たちの国際化の取り組みはやむに已まれの状況で始ま
りました。しかしながら、3つの活動にそれぞれ目標を置
きながら活動することにより、ある程度の成果を上げるこ
とができました。もちろん、途中であることに変わりなく、
今後も努力を重ねつつおります。

「国際化」には、反対する勢力もあるように思いますが、
国際化が進む世界全体の現況の中では、反対する理論的根
拠は明らかに消失しています。しかし、我々国では、私た
ち日本人的「英語力」が大きな障害になっているように思
います。というより、我々国特有の「恥の文化」が、英語
でコミュニケーションする機会を自ら失わせているように
思います。日本医学英語教育学会が、今後このような状況
をぜひ解決していただく一つの大きな力になっていただける
と期待しています。

謝辞
講演の機会を与えてくださった第18回医学英語教育学
会大会長の伊達 教授に深甚の感謝の意をささげます。また、私のつたない講演を熱心に聞いてくださった日本医
学英語教育学会会員の皆様に心から感謝申し上げます。
第18回日本医学英語教育学会
教育講演 (Educational lecture)
グローバル化の中のミャンマー医療支援
Medical support to Myanmar in the age of globalization
（岡山コンベンションセンター，2015年7月19日）

木脇 敬裕  Yosihiro Kimata
岡山大学大学院医療 Crafts 研究科形成再生外科
Okayama University Medical School

岡山大学は現在までに100名近いミャンマー人を短期長期研修や訪問などで受け入れてきた。実臨床に関しては、多数の科が現地での医療の実践とともに医師の指導を行っている。これらの国際的医療支援の中心的スキルとなるのは、やはり英語であるが、海外で医療支援を経験すると、言葉の問題だけでなく食事を含めた生活習慣、宗教、歴史などいろんな課題に遭遇せざるを得ない。ミャンマーの医療支援を通じて、英語の必要性ならびに次世代の医療人にとってのグローバル化とは何かという点についてお話する。


1. はじめに

1988年8月8日は、ミャンマーでアランディーニャンバーである5474566575なる国民の民主化運動勃発の日である。その後、それの鎮圧した軍事政権の支配はさらに強まり、大学の閉鎖、国際教育・研究のネクサなどが長期間続き、その結果教育水準の低下、研究の劣化とともに、保健医療を含めた医療環境が改善されることなく今も続いています。岡山大学は、各国が支援を取りやめる状況で、共同研究や医療支援を継続して行い、現在までに100名近いミャンマー人を短期長期研修や訪問などで受け入れてきました。実臨床に関しては、形成外科、脳外科、整形外科、麻酔科、消化器内科、乳腺外科など多数の科が、現地での医療の実践とともに医師の指導を行っています。

これらの国際的医療支援の中心的スキルとなるのは、やはり英語である。その一方、グローバル化の推進を目指している日本の若い医師の言葉の問題が大きく感じられる。さらに、海外で医療支援を経験すると、言葉の問題だけでなく食事を含めた生活習慣、宗教、歴史などいろんな課題に遭遇せざるを得ない。その観点からみると、英語は必要なスキルであるが、真のグローバル化とは異なることも実感として感じられている。

ミャンマーの医療支援を通じて、英語の必要性ならびに次世代の医療人にとってのグローバル化とは何かという点について少しの経験を踏まえてお話する。

2. ミャンマーの医療状況

Health in Myanmar 2013によれば、死亡疾病の上位は感染症であり、特にAIDSはここ数年上昇傾向で大きな問題になっている。一方、生活環境における安全対策の不備や、急激な経済発展に伴う都市の交通状況の悪化などにより自傷は先進国と比較して圧倒的に多く罹患率のトップである。乳児・妊娠婦死亡率もアジアで最も高い状況にある。これはいまだに営業の自然出産に伴う周産期の合併症、乳児の感染症や劣悪な栄養管理に伴うものである(図1)。2013年度の医療費は、日本が38.5兆円と一人当たり30万円を超えるのに対し、ミャンマーは1400億円一人当たり2300円である。総GDPは福井県に相当する程度であり、経済成長が見込めるミャンマーであるが、保健医療という観点からみると非常に大きな課題が立題される。

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3. 岡山大学を中心としたミャンマー医療支援

このような労働的な保健医療を改善するためには、衛生、水などの基礎生活分野、インフラを含めた社会基盤整備、環境分野、医療に関する法整備やシステム構築など、幅広い支援が必要になる。しかしこれらの支援をすべて行うことは経済面で不可能であり、やはりミャンマー独自の経済発展が不可欠であることを言うまでもない。その一方、支援において重要な点は、最終的に自立できるような体制の構築である。その大きな柱は教育であり、人材育成である。

この点に重きをおいて岡山大学ではミャンマーに対する医療支援を25年以上にわたり行ってきた。その一つに、演者らが中心となっている形成外科領域の人材育成と手術支援がある。ミャンマーの人口は約9000万人に及ぶが、形成外科医師は8人しかいない。外傷による顔面四肢の変形や先天異常などのほとんどが未治療の状態である。このような患者さんの救済のために、ミャンマーの形成外科の若手医師を短期に当科に留学させ、現地で一緒に手術治療を展開している。過去6年間の現地ミッションで300人以上の手術治療を行い、5人の形成外科医を育ててきた。

一方、さらなる大きな展開は、JICAと6大学（千葉大学、新潟大学、金沢大学、岡山大学、長崎大学、熊本大学）との連携による大型の医療人材育成プロジェクトである。基準医学と臨床医学の領域で、4年半にわたり60人の医師と8人の放射線技師を日本で研修させる内容で、2015年4月から開始された（図2）。

4. 国際支援における英語の必要性

さて、このような医療における国際支援を展開していくためには、両国の共通言語が当然欠かせず、ミャンマーでは英語が主体となる。ミャンマーは英語が植民地時代から長く、ほとんどの領域で英式の教育環境が導入されている。特に英語教育は5歳から開始され、小学校5年で日本の中学校3年生レベルと言われている。2年間の高校教育はすべて英語で行われ、大学入試をすべての教科で英語で行われる。ミャンマー教育省は、日本と同様に国際化を大きな目標としている（図3）。現在、医療系人材のほとんどが、日常生活や専門領域で不自由なく英語を使えるよう能力を育っている。

したがって、ミャンマーの保健省や医科大学、医療系大学等、教育と会議、講演なども当然英語が共通言語となる。

では日本の医学部『学部と卒後』英語能力向上のための教育の改善は必要？

YES!

英語の授業を増やす
定期的な英語の試験(TOEICなど)
さらに高度な英語教育を提供
授業を全て英語にする
試験を全て英語にする

図2 JICA/国立6大学ミャンマー医療支援

図3 ミャンマーの英語教育環境

小学校（5年間）：5才から
中学校（4年間）
高校（2年間）
全て英語の教科書!!

16歳で大学

Medical School（6年間）

国際化を大きな目標!!

図4 英語能力向上のための教育の改善は必要？

図5 日本の医学部教育
患者さんのほとんどは英語が理解できないが、その通訳を現地医療人が行い、最終的に英語でやり取りすることになる。つまり、国際医療支援を実践するにあたって、英語がその基本的ツールであることを強く実感させられることになる。同時に当方自身はもちろん、留学生の受け入れや現地での医療指導などにおいて、学部学生や卒業後医師の英語力の不足と英語能力向上のための対策の必要性を痛切に感じている。現在、来国などに本邦留学生の減少が続いているなど、文部科学省ならびに日本全体でも英語を中心としたグローバル化の育成と各大学のカリキュラムの改善が求められている。

5. 日本の医学教育における英語教育

この状況下で、日本の医学部の学部学生や卒業後医師に対して英語能力向上のための教育改善が必要である（図4）。しかし、日本の医学教育は医学の発展による情報量の増加、より実践的な能力の確保、多様な領域の知識の必要性などから、教養課程の短縮が行われている。さらに、卒業後も専門医制度、指導医制度、医療安全、医療倫理など非常に多くの卒後教育システムに隔され、余裕がなくなる状況になっている（図5）。これらの状況は留学希望者をさらに減少させることになり、かつ英語を積極的に学ぶ姿勢や環境整備もできにくいことにつながってくる。

6. 効果的な英語教育の一案

では、国際支援も含めて英語能力を強化するために効果的な方法はないだろうか。一般社会における英語能力の向上の目的は、ビジネスチャンスの獲得にある。しかしこのためには、かなりの努力と時間を必要とする。ただし、医学部学生や卒業生に関して言えば、専門領域の業績作り、専門分野の発表や留学、そして専門領域の国際支援である、すべての領域において英語能力の向上が必要であると考える。すなわち、専門分野に絞った目標設定を行い、それを実践する方法がよいのではと思われる。さらに、英語を使わざるをえない場を、学生や医師に提供することも一案である。そこで国際支援や本邦への留学生受け入れなどが大きな力を発することになる（図6）。個人的な意見はもちろんですが、正しい文法を身につけるとか、縦書きの発音をするとか、他人を気にして手紙を言うという、というより専門分野
に関する表現力と理解力を向上させることや、またその場
に飛び込む上（図7）ということが良いきっかけになると考え
ている。採用者は、留學生を受け入れる際にも担当者を決める
接遇させることが、強制的な場を与えることになる（図8）。

我々のミッション名はMJPLAS (Myanmar Japan Plastic
Surgery Mission) であるが、その参加延べ人数はこれまで
に55人に及ぶ（図9）。現在は人数を抑えているが、他施設
の形成外科医のみならず、看護師或は学生の参加希望者も増え
ている。その目的は、他国で医療体験、ポランティア体験、友達形成などであるが、二次的なものとして他国
の文化を知ることになり、最終的には日本の文化を自分自
身で調べて認識するようになる。

自国文化の認識と理解度を深めることは、日本文化を活
かすためのグローバル化にとって最も重要な点であろう。

7. グローバル化の危機感を与える

ミャンマーは、アウサンスーチーの選挙勝利とともに
急激な民主化と経済成長が期待されている。最大都市ヤン
ゴンではすでに巨大なショッピングセンターの出現、ホテ
ル建設のラッシュ、若者の女性のファッションの変化、携帯
電話やパソコンの普及など、まさに進化国文化が急激に
入る状況である（図10）。すなわち、ミャンマーでさ
えも知識や裕福な人は、世界中で最新知識を情報を受け
的に瞬時に得られるようになっていた。まさに、グローバル
化の時代の突入で、優秀な人は最新知識を常に収集し、最
新技術を開発し、職種に関係なく国境のない時代の到来を
意味していると考えられる。しかもこれらのすべてが英語
ベースで動いているということを認識させざるを得ない（図
11）。

世界中がこの動きにあり、しかも英語ベースであるとい
う情報を受け取るとして学部学生や卒後の医師達に伝えてい
くことも、英語能力のアップにつながるものでは思って
いる。

8. 最後に

ミャンマー医療支援の経験から、英語の必要性ならびに
次世代の医療人にとってのグローバル化とは何かという点
について話をしてきた。あとで、英語はあくまでも道具
であり、目的ではないということ。そして効果的な能力
向上には専門領域から始めることが、国際医療支援や留
学生受け入れなどの英語の場を提供することなどの案を提示
した。グローバル化の危機感を与えることなども重要であ
ると思われる。そして、その根本には日本語を基本とした
日本文化の再認識と、考える力や議論する力の向上が重
大であると考えている（図12）。

謝辞

本学会会長の伊達 敦先生には、本学会での発表の機会
を与えていただき、ありがとうございました。厚く御礼申
し上げます。
第18回日本医学英語教育学会
シンポジウム：病院に外国人患者を受け入れるために
Symposium: How can we prepare ourselves to accept growing numbers of international patients at our hospitals?

外国人患者に優しい病院：りんくう総合医療センター（大阪府）の現状
A foreign patient-friendly medical center: Rinku General Medical Center (RGMC), Osaka, Japan
(岡山コンベンションセンター，2015年7月18日)

in English

English Medical Interpreters Available Today

Hoy está en turno intérprete español

 rộng dịch

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1. سريくう総合医療センターの医療通訳サービス

سريくう総合医療センターは大阪府南部にあり、3次救急医療にも対応する地域の基幹病院である。また西日本唯一の特定感染症指定医療機関であり輸入感染症にも対応可能である。関西国際空港の対岸に位置する当院には訪日・在日の外国人患者受診が多い。当院では有償ボランティア登録通訳士（約60名）および国際医療コーディネーターによりスペイン語、英語、ボルトガル語、中国語、タガログ（フィリピン語）の通訳サービスを無償で提供している。また米国、ブラジル、中国の医師免許を有する日本人医師達が必要に応じて外国人患者の対応にあたる。外国人患者受入れ医療機関認証制度（Japan Medical Service Accreditation for International Patients; JMIP）が2012年に厚労省の支援事業として開始となり、当院は2013年に国内初のJMIP認証病院の一つとなった。以前から必要に応じて翻訳した同意書や説明書等があったが、翻訳者数の確保や追加、院内表示英語仮訳の追加のみならず、病院内英語メニュー、広報発信等に多言語誘導ブック作成など新たに取り組むべき事項も多かった。新たに作成した外国人患者対応マニュアル・フローチャートが役に立ち、その後外国人患者対応がスムーズに運ぶようになった。
ボランティア活動として、日本人医師が所属する外国に赴任して、外国人患者の通訳、日本の医療機関の訪問や、日本の医療機関のスタッフが通訳をして医療機関を訪問しようと考えています。この活動を通じて、日本での医療機関の見解を増幅し、日本の医療機関の診断や治療を円滑に行うことができます。日本国内では、多くの日本医師が、義ぎ湯水を活用し、外国人患者の通訳を必要とする医療機関を訪問しています。この活動を通じて、日本の医療機関の活動を円滑に行うことができます。
表3 JMIPの評価項目 Rating categories of JMIP

I. 受入れ項目 Preparedness to accept foreign patients
1.1 外国人患者に関する情報と受け入れ体制 Information in foreign languages
1.2 医療費の請求や支払に関する対応 Billing system, etc.

II. 患者サービス Patient services
2.1 通訳（会話における多言語対応）体制の整備 Interpreters, language assistance
2.2 通訳（文書での多言語対応）体制の整備 Translations / foreign documents
2.3 院内環境の整備 Providing friendly environment to patients
2.4 患者の宗教・習慣の違いを考慮した対応 Consideration to religions / customs

III. 医療提供の運営 Medical provision management
3.1 外国人患者への医療提供に関する運営 Management of medical services for international patients
3.2 説明と同意 Informed consent

IV. 機構体制と管理 Person(s) in charge / Office and safety management
4.1 外国人患者対応の担当者または担当部署の役割 Person(s) in charge / Roles of the International Department
4.2 安全管理体制 Safety management, medical errors, disaster control, etc.

V. 改善に向けた取り組み Efforts to improve services
5.1 関内スタッフへの教育・研修 Staff education / classes / training
5.2 外国人患者の満足度 Patient satisfaction

ド作成など新たに取り組むべき事項も多かった。新たに作成した外国人患者対応マニュアル・フローチャートが役に立ち、その後外国人患者対応がスムーズに進むようになっ
た。医療費未払い防止対策、外国人患者対策等計画、文書
翻訳依頼方法などもJMIP委員会をきっかけに作成すること
となり、さまざまなシステムが整った。

申し込みからJMIP認証の流れは以下の通りであった（図
4）。申し込み→契約、書面調査、訪問調査、中間報告、最
終判定、審査結果通知。訪問調査は書類調査、合同面接
での150分の質疑応答、中間審査調査など2日間に行われる。
JMIP認証を取得することができたが、未整備だった
夜間休日の通訳体制の整備は今後も課題となっ
た。これまでも国際診療科のみが外国人患者対応をしていたが、
JMIP受審準備を通じて病院の各部署が以前よりも外国人
患者に対して積極的に対応するようになった。

3. 米国退職軍人メディカルチェック
当院は2012年から米国退職軍人メディカルチェック指
定病院となっており、米国医師免許を有する筆者が担当し
ているが、日本国内なのでむろん米国医師免許は必須では
ない。音声によるやり取りも含むオンライン講習などを通
じて指定医となる。また、プライバシー、性的暴力、精
神的問題などについてのオンライン講習の受講要請がある。
オンライン講習を最後まで進むと、その内容に関する小テ
ストがあり、一定以上の正答率が必要である。小テストを
クリアするまで繰り返しテストを受けることとなる。

保険制度も同様日本と異なり、米国では患者オペレ
タというとされる公的医療保険が義務づけられるようにな
るまでは、公的医療保険は高齢者のためのMedicareと低所得
者および身体障害者のためのMedicaidののみであったが、
米国において、軍人および退役軍人への医療保険制度は非
常に手厚い制度である。米国内では退役軍人は退役

図4 申し込みから認証までの流れ Accreditation process of
JMIP

図5 米国退職軍人の健康診断フォーム Questionnaire form
for veteran's medical examination

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軍人病院を訪れるが、米国外に在住する退役軍人が障害補償を図る機関である退役軍人局に申請した場合には、在住地域近くの当院のような指定医療機関を訪れ診療や診察、検査を受ける。

処方を含めた治療は行わせず、次診診療を予約しない。保険診療ではなく、自費診療である。当院指定の診療等費用に加えて診察・診療項目数により一定額が後で米国から病院に支払われる。診断、診察、検査項目は、あらかじめ通知される指定項目のみである。退役軍人局は指定病院からの情報を基に障害補償につき決定を行う。日本国内の指定医療施設は関東、九州、沖縄などにあり、りんくう総合医療センターを含めて5カ所ほどある。

関西には米軍基地がないため関西に在住する退役軍人は少なく、大阪府に当院を訪れる退役軍人は米軍基地のある山口県岩国市が多くあり、次に多い場所は沖縄である。時々関東やその他の地域からも訪れる。遠方から来ることになるが、交通費の個人負担はない。大半は、除隊後も在日米軍基地辺り地域に在住し基地関連の仕事をする日本人妻をもって退役軍人である。国内の指定医療機関である診療所や病院のうち当院が最も規模が大きく、可能な診療も多いと聞いている。

テキサスにある会社、Veterans Evaluation Services (VES)が退役軍人局、在日退役軍、当院と連絡をとり、スケジュールを調節する。心エコー、呼吸機能検査、単純X線、心電図などVESを通じて指定される検査を当院で施行する。CT・MRI検査はこれにくいには一度も依頼がなかった。こちらの判断で検査を追加することもない。

訴え、診断名や器官名に細分化された数多くの障害補償質問票 (Disability Benefits Questionnaire: DBQ)があらかじめ作成されている (図5)。筆者は内科系指定医なので、耳鼻科、眼科、精神科関連の詳細な診療を含むDBQを行うことはないが、外傷や手術後に含まれる関節痛などの整形外科の問題はほとんどの場合に含まれる。循環器系、呼吸器系、消化器系、内分泌代謝系など内科学系すべてに加えて皮膚科、耳鼻咽喉科、泌尿器科の範囲DBQも含まれ、難治する場合もしばしばある。

診断名、これまでの画像・血液検査結果、疾患の経過、手術・処方を含む治療内容、診察所見などに詳細にDBQシートへの記載を要求されるが、本人に詳細に質問しても、退役軍人が正確な診断名、診断結果、治療内容を覚えていたことはまれであり、記載は不十分となりざるをえない。過去の医療情報として300ページを含むスキャンされたPDF書類をオンライン上で見ることが可能である。しかし、「除群して基地内の診療所でX線撮影されたが骨折を認め軍病院処方のうえ通過見学とした」。「胸部通気術で夜間に救急外来受診時心電図異常を認め通過見学とした」などの判断が困難な手書きのカルテのコピーや、X線検査の読影結果、医療とは直接関係のない判読不能手書きカーボンコピーされた米軍の書類などがランダムに含まれており、膨大な資料の中から必要な情報を得るのは至難の業である。書類は診療科別でも時系列でもなく、下送りされただけにスキャンされている。入退院サマリーや診断名、病歴、検査結果、処方内容等がまとまっている書類は、やっとの思いで記載し提出した後の、しばしば詳細記述を求める場合もあり、軍での職務と症状や疾患との関連を尋ねられる。疾患が職務のために発生したのか、軍での職務のために民間業務の場合よりは、症状が悪化したのか、症状が軍での職務との関連性は50％以上か50％未満かと問われても、科学的で回答することは困難である。本人に所属部署と職務内容を尋ねながら、軍で軍の職務に詳しくない筆者が多質問した程度で、その軍の職務における疾患に対する影響の理解が十分とは言えない。

退役軍人の訴えや診断名に基づき、診問と診療を行いDBQシートに記載後、オンラインで提出する。内容は人それぞれ異なるが、毎回複数のDBQがあらかじめVSSを通じて指定されている。例えば一人の退役軍人に①高血圧、②糖尿病、③脳痛、④呼吸器系、⑤膝、⑥背痛、⑦足首、⑧頭部、⑨腕の問題がある。それぞれのDBQシートは約12ベージュで構成される。筆者による診問・診察に2時間、リハビリスタッフによる関節可動域測定や筋力テストなどに1時間、オンライン入力に2時間程度かかる。数十分の装具をつくって一日の中の軍行や激しい身体訓練時に生じた外傷既往を一つずつの多い。また、戦闘機の座席下の騒音性聾聾、軍用車両格納庫による一酸化炭素中毒後遺症高次脳機能障害、戦争体験によるPTSD、枯落症などの有難い事例例もある。

筆者が記載するDBQシートが補償内容に影響するため、彼らの訴えはしばしば誇張されており、話の内容もしばしばバイアスがかかる客観的ではない。このような、診療所見を含む診療内容が軽微または正常範囲であるにもかかわらず、症状や訴えは激しいという記載になる傾向がある。この点に関してVSSより追加説明をしばしば求められ、難治することも多々ある。このように時間がかかり苦労する点も多いが、英語で診察することは筆者にとっては楽しみである貴重な機会であり、今後も継続していきたい。
1. Introduction

The number of non-Japanese-speakers visiting Japan is increasing and is expected to rise even more rapidly over the coming years. Many such individuals speak English as a first or second language. As a consequence, it is important that Japanese hospitals and health-care institutions can adapt to accommodate a potential rise in the number of English-speaking patients. This paper will outline a number of key issues relevant for individuals or groups involved in the delivery of health care or medical English education. Topics discussed will include useful medical expressions, common phrases and question patterns, structuring patient encounters, and techniques for improving communication.

As a native English speaker living in Japan, I also have personal experiences that have highlighted to me the importance of promoting medical English education among Japanese health-care professionals. A number of years ago I was admitted to a hospital in Tokyo as a surgical patient. I was suffering from abdominal pain, fever, and malaise and had correctly diagnosed myself with acute appendicitis. I was very grateful for the care that I received prior to, during, and after my admission; however, on many occasions I experienced first-hand the challenges and frustrations of cross-cultural miscommunication. I believe that the health-care providers who could communicate with me in English aided my recovery, both physical and mental, and greatly strengthened my positive perceptions of the health-care system. I also believe that the importance of this should not be underestimated and, therefore, that effective medical English preparation and practice can be hugely beneficial.

In my presentation I aim to outline a number of key issues relevant for individuals or groups involved in the delivery of medical English education within Japanese health-care institutions. One of my key objectives is to allow participants to discuss possible considerations that may be relevant to them as educators or facilitators. I will also provide some suggestions for session content and a number of examples of potentially useful expressions.
2. Preparation and considerations

It is relatively easy to say that Japanese health-care institutions will benefit from developing English communication skills among their staff. However, it is often much more difficult to implement this effectively. Furthermore, different institutions have different needs, so it is prudent to carefully consider how best to implement any new training programmes or educational initiatives.

Figures 2 and 3 highlight a few of the possible considerations that may be relevant to your institutions. The list is by no means exhaustive. Session content is often one of the first considerations, and this can vary greatly depending upon the institution, instructors, participants, and their needs. The content will also vary with the participants’ roles within the institution, including, but not limited to, whether they are doctors, nurses, medical students, interpreters, allied health-care professionals, or administrative staff. As an example, doctors may benefit from medical interview and physical examination training, whereas administrative staff may have very different needs. I believe that almost all participants, regardless of their role, can benefit from practising basic techniques such as those outlined in Figure 4. This may be a good starting point for many institutions wishing to increase the medical English proficiency of their staff. Consequently, I have dedicated the next part of this presentation to introducing a number of expressions and ideas that could prove useful in improving these fundamental components of medical English communication.

3. Examples and suggestions

As shown in Figure 4, there are a number of fundamental topics which most Japanese health-care providers will need to be able to cover when meeting non-Japanese-speaking patients and will most likely benefit from practising. Teaching formal and polite greetings, such as those shown in Figure 5, may at first seem elementary, but it is often a good starting point. I often begin by having participants practise role-plays with basic phrases provided to increase their confidence before progressing to more advanced conversations and phrases. Of course, many of these phrases will also require some explanation. For example, the phrase “Nice to meet you” is perfectly acceptable for use with a patient who is comfortable, pain-free, and smiling. However, a patient who is angry, upset, anxious, or in obvious pain may become
annoyed if a doctor or nurse uses that same phrase.

Self-introductions usually come next and the importance of using clear, polite, and appropriate phrases should be emphasised. In addition to providing a name, role, and purpose, encouraging participants to obtain verbal, written, or implied consent is important.

The next slide highlights some of the key demographical information that should be obtained from most patients who visit a hospital or clinic. Obtaining a patient's full name, date of birth, country of origin and marital status is important both medically and legally.

Teaching participants simple health-related questions, such as those shown in Figure 8, is not something that can be taken lightly, as such questions cover a wide range of important topics, such as the chief complaint, history of present illness, past medical history, family history, and social history. In this slide I have chosen to focus on a small selection of questions for the chief complaint. Open questions are often the most appropriate, as they allow the patient to speak freely about their concerns and symptoms.

The final slide that I wish to share with you today (Slide 9) focuses on teaching participants phrases that help them to avoid misunderstandings and reduce problems associated with verbal communication. It is impossible to provide phrases that will cover every possible conversation eventuality, but if we can offer a number of tools that can be used in a range of different situations, then I feel this will provide greater benefit to participants.

4. Final remarks

I hope that this presentation has been useful in reviewing some of the considerations for integrating more medical English teaching initiatives into health-care institutions in Japan. In addition, I hope that as educators we can continue to work together on such initiatives and provide high quality educational opportunities for Japanese health-care providers.
Nell L. Kennedy 先生を偲んで

日本医学英語教育学会の発足時から、長年にわたり理事および学会誌編集長として多大な貢献をされた植村研一先生の第1回受賞者でもあったケネディ先生は、昨年（2015年）10月15日に76歳で天に召された。

ケネディ先生の追悼文をお引き受けしたもの、彼女とのお付き合いは17年間の学会メンバー、理事、共著者、そしてその間の師、友人としてであり、その他のことはよく知らない。35年間ケネディ先生と同居してきた東京に伺ったところ、最初は座間の米軍キャンプの学校で教えるために1年契約で来日したのみで、そのような経緯で日本に永住することになったのか、何から思えば知らないことばかりであるが、私自身が彼女の交流の中で学んだ貴重なこと、感じたこと、人ととなりを紹介することで彼女への追悼文にしたい。

出演
ケネディ先生との出演は、メディカルビュー社の『アセプトされる医学英語論文を書こう！』の翻訳を依頼されたことであった。この書のFOREWORDにも記したが、ケネディ先生は長年にわたりの日本人医師、科学者の英語論文の添削をしてきた経験から、日本人の稿子を書かない間違い、またよくわからずやまだ習慣的におかしてきた間違いなどに対し、的確な説明と共に正しい表現・記述方法を大変わかりやすく説明された。学会の理事会でもしっかりとした意見を言い、厚い信頼を得ていた所からの仕事が依頼で、おおいて感謝してお引き受けしたものの、未経験の私にとっては思い手掛ける経験であり、試練であった。

ケネディ先生の人となりを一言で申し上げるならば、大変優しく誠実で暖かい人柄であった。学会発表前の不安やある私に、いつも「大丈夫！私がついているから」と、その言葉がどれほど心強かったか！また、仕事に関しては、非常に論理的、科学的で、正確な表現の追求には妥協を許さない方であった。医師からの論文添削などは、その領域の論文を片手で読み、内容に関するこ

とも含めて的確なアドバイスや表現のチェックをされた。「「いかがげることはないの？」「が彼女

の信条で、日常生活はほとんどどの時間を論文読みに費やしていたそうである。

学会誌編集長と日本語の副編集長として
ケネディ先生は本学会の第2代学会誌編集長であり、私は副編集長として主に日本語の面でサポートする立場であった。彼女が編集長であった期間に学会誌に投稿した方は、詳細なチェック、アドバイス、多様な表現の提案など、驚くほど丁寧な添削が戻って来て、誇り、恐れ、経験を

お持ちの方が多くいらっしゃることと思う。編集長として、本学会の学会誌のレベルを上げたい。学会誌掲載にふるわぬ論文を載せたい、そのためには曖昧な表現ではなくきちんと科学的にスッキリ書いてほしいと願う気持ち、一つ一つの投稿原稿に真摯に向き合い、長い時間をかけて添削する作業につながっていた。そんな彼女にも弱い点があり、疑問を持つ論文、あるいは掲載するにあたって、ある条件を要求しなければならないような場合、なかなかストレートに言えない。そんな時、彼女から私に、貴女のこと日本語で伝えてほしいと依頼があった。

共著者あるいは訳者として
通常、書き終えてからの校正は4・5回ではないかと思うが、ケネディ先生の場合、おそらくこれで最終原稿？と思ってからも幾度となく繰り返される校正。書き終えてからの何十回ものチェック（本人曰く「20回のチェックが必要」）には本当に驚いた。彼女はとにかく妥協を許さない！よりよい表現、誰が読んでも理解できる余地を与えない表現を追求して何度も何度も推敲を重ねる。そして、表現、英語はもちろんのこと、スペース、バランス、バックエージョンにも厳しい。ダッシュの長さ（ｍダッシュとnダッシュの使い分け）も正確で、日本語らしい表現にもこだわった。英語で "Mr.XX" と書かれていたのを「××氏」と訳したところ、日本語では「××さん」とは言わない。「○○さん」と言
いまですか？また "black and white" を「黒白」と誤読した。日本語では「黒白」より「白黒」と言うのが自然でしょう？

どんな本も完璧にはできないのはわかるが、少しでも完璧に近づけたい、と言うのがいつも彼女の姿勢であった。編集者、出版者としては、時間的な制約もあり、出版上昇が原稿から順に送ってほしいと要望するが、彼女の「まだ見直したいし、全体が出来上がってから構成を変えるかもしれないから未だ完成だと思っている」とある意味では出版社泣かせの著者であった。あまりに改訂版の原稿が多いので、受け取る側もきちんと整理していなかったか改訂版の順序を間違えたりしてしまう。前回の訂正部分が直っていない！との叱りを受けたりすることも多々あるのかが、その要望のメールの長さも尋常ではない。

1ヵ月の訂正の説明が長い長い英文で毎日山のように届くのである。本のレイアウト、右のページに来るべきもの、左のページに来るべきものに関しても全てチェックされる。そんな中で、あの本が出来上がってるか何か指摘をを見つけた瞬間だったとおっしゃっていたが、それでもあの本が出来上がるまでにやり取りした原稿の量は半端ない量であった。

他にも、ケネディ先生と協働した本は数冊あり、その一人、平野美津子先生がメインで書き始めた菱田との共著の本にケネディ先生のアドバイスをお願いしたところ、大変貴重な意見を多くいただきベージの高い著者が出来上がったものの、主張を曲げない彼女の話し合いは時には凍り付いたり、雪解けでホッとしたり…

そんな折、彼女が体調を崩して入院したことがあった。仕事の都合で一緒に見に行けなかった平野先生と私は、それぞれ札幌の病院まで飛んだ。入院して以来本当に元気をなくして伏せていたケネディ氏が私たちの顔を見るなり、いっぱいに病床を止め、いささか仕事の話に夢中になり、お世話をしていた河田さんを驚かせた。

癌の再発がみつかって以来、徐々に体力も衰えて就任は辞任され、学会の出席もままたくなくならなくなったが、それでも仕事への情熱は全く衰えることなく、「アクセスとされる…」の改訂版を書きたい、まだ私から伝えたいことがあるから新しく本を書きたい、と言われ続けていた。

残念ながら体力的に彼女の希望は実現されなかったが、彼女の仕事に対する真摯な姿勢を受け継いだ本学会会員が益々活躍することを天国から見守っていることと思う。

菱田 治子
Journal of Medical English Education
前副編集長（日本語担当 2004～2008）

略歴
1939年 米国テキサス州生まれ
1964年 米国テキサス州立大学教育学部卒業、同大学院ジャーナリズム科専攻
1968年 来日、神奈川県座間の米軍キャンプの学校の教師として赴任
1970～73年 毎日新聞記者
1970～80年 クリスチアニュティトウディ誌(ワシントンDC)アジア、ミクロネシア地域記者
1972～85年 北里大学医学部非常勤講師、相模女子大学非常勤講師
1993年 北里医学ジャーナルおよび国外投稿英語医学論文校閲
1986年 米国コロンビア大学フィックス大学医学博士号取得
2008年 麦農学園大学獣医学部教授 オオバイ
2008年 メディカルイングリッシュ研究室

所属学会 日本医学英語教育学会（1998.7～）
理事（2001～2009）
学会誌編集長（2004～2008）
全国語学教育学会
国際英語教育学会
国際聖書学会
Nell L. Kennedy 1939–2015

Nell was born on September 8, 1939, in Titus County, Texas to Forest and Valree LaPrade. After attending a local high school, she entered East Texas University, from which she graduated in 1964 with a BA in English. Nell had a strong desire to continue widening her education, however, and later returned to study at a number of different universities, finally gaining a PhD in Education Psychology in 1984.

Nell started her teaching career as a high school teacher in 1963 and, five years later, transferred to Japan to teach at the Zama American High School. She studied Japanese in Tokyo and, in 1971, became a journalist for the Mainichi Daily News and Christianity Today, Asian edition. From 1972 on she taught at Japanese universities, moving to Hokkaido in 1986. There she began working at Rakuno Gakuen University, where she became a pioneer of English for Medical Purposes in Japan, trying out her new ideas on veterinary students, as a reward for which she was made a full-time professor in 2004. Nell retired in 2005, but continued working at Rakuno as a part-time professor until 2008.

Nell authored numerous books, some of them with the founder of JASME, Professor Uemura, with whom she collaborated closely, conducting many seminars and workshops. The books she authored are now recognized as having moved the field forward, and many young Japanese biomedical authors owe much to her efforts in helping them overcome the considerable hurdle of getting published in international English-language scientific journals. One testament to this is the fact that many such authors would travel from all over Japan to write under her guidance, even though perhaps affiliated to another university altogether.

Throughout her life, Nell manifested an interest in her Christian beliefs, and she was an active member of her Church group in Sapporo. Her academic work and her work with fellow worshippers provided Nell with a full and fulfilling life, which she participated in and to which she contributed.

Nell joined JASME at its inception, was an active participant in the society’s activities from day one, and was the first recipient of the Kenichi Uemura Award. She was a member of the executive council, and was appointed second editor of the Journal of Medical English Education in 2004. Unfortunately, ill health forced her to resign, both as an executive member and editor-in-chief in 2008.

During her time as Editor, Nell converted the publication into a respectable international scientific journal. When she started, the journal had two titles, and no criteria for accepting submissions. Nell removed one of the titles, established its present title, and wrote the first set of Instructions to Authors. She also created a reviewing process that ensured that all accepted papers would be published at, or above a certain standard. Nell personally read over each submission and sent the authors detailed comments that led to substantial improvements. When Professor Yoshioka and I visited her in 2008, she was already in poor health, yet she spent a number of hours with us, explaining in detail the minutiae involved in editing the journal. She also endowed me with a thick file of notes, comments and partially edited papers. Although she used her com-
puter extensively and mailed her friends and colleagues regularly, Nell was of the pre-computer age. Back home I went through a great many documents in which, immaculately inscribed in red ink, were her notes. Both instructive and helpful, they were never over-critical or insulting.

Even after her retirement from JASME activities, Nell continued to show an interest in the work of the society and the journal, and would let Mr. Eguchi at the JASME office know whenever she felt things were not up to her demanding standards.

For the last ten years of her life, Nell Kennedy battled with cancer, which, at times, left her in a weak and unstable condition. I remember her final appearance at the JASME executive meeting in Tokyo, where Prof. Patrick Barron and I had to support her since she could not walk on her own. Yet Nell was a fighter. With the help of her friends and her church group, she made a partial recovery, and was able to enjoy the last years of her life.

We shall all remember Nell Kennedy as a kind, helpful and bright person, who contributed to the field of medical English education and enriched the lives of all those who knew her.

RIP

Reuben M. Gerling
Former Editor-in-chief
Journal of Medical English Education
(2008–14)
投稿申請書
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下記の論文を日本医学英語教育学会誌Journal of Medical English Educationに投稿します。なお、他誌への類似論文の投稿はいたしません。また、採用された場合、本論文の著作権が日本医学英語教育学会に帰属することに同意いたします。

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February
2016
Vol.15
No.1

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