

# Journal of Medical English Education

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# *Journal of Medical English Education*

Vol. 7, No. 2, July 2008

*Journal of Medical English Education*, the official publication of The Japan Society for Medical English Education, was founded in 2000 for the purpose of international exchange of knowledge in the field of English education for medical purposes. For citation purposes, the registered name of the Journal replaced the dual name that had appeared on the cover before Vol. 6 No. 1. The *Journal of Medical English Education* is a continuation of Medical English, Journal of Medical English Education and is the registered name of the Journal.

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# Journal of Medical English Education

The official journal of the Japan Society for Medical English Education

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植村研一

Kenichi Uemura, M.D.

### 1. Article categories and *Journal* aims

*Journal of Medical English Education*, the official publication of the Japan Society for Medical English Education (JASMEE), is interested in articles on English education for medical purposes, including *clinical medicine, nursing, rehabilitation, dentistry, laboratory technician work*, research, and *international medical activities* such as reading and writing medical papers, making oral presentations, participating in forums, seminars, symposia, workshops, international conferences, and continuing professional education. Categories are *Special Article, Original Article (research), Original Article (teaching methods), Short Communication (research), Short Communication (teaching methods), and Letter*. The Special Article is by invitation from the editor or is the address by a guest speaker or symposium participant at the annual JASMEE conference.

### 2. Preparing the manuscript

- 2.1. Articles may be submitted in English or Japanese.
- 2.2. The manuscript should be prepared on either Macintosh or Windows/DOS (preferably Windows XP).
- 2.3. Use Page Layout *25-to-26 lines per A4 page, 12-point typeface* of a common font such as Century or similar. **Margins:**  
**Left** 30 mm; **Right** 25 mm;  
**Top** 30 mm; **Bottom** 25 mm.  
Maximum length: 20–24 pages, including the Title Page, text, figures, tables, and References.
- 2.4. *Number all pages consecutively*, beginning with the Title Page as p. 1 and including each page that has a Table or Figure.
- 2.5. Submit the manuscript in normal Page Layout *without the tracking protection tool*.
- 2.6. Do not use footnotes, op cit, or Ibid.

### 3. Title Page

Order of information on the Title Page:

- 3.1. A concise, informative title, centered near the top of the page. The 1st line of the title ought to be slightly longer than the 2nd line. Avoid abbreviations and formulae where possible. For example, *instead of SLA, write Second-language Acquisition*. A subtitle is seldom necessary, as the key information

can usually be included in the base title.

- 3.2. Authors' names and affiliations. In the order agreed upon by the authors, write the full names without academic degrees. Use asterisks to designate authors from more than one institution, as in 3.3 below; the asterisk goes **after** the author's name and **after** the comma. Example: Jun SUZUKI,\* Arnold PALMER\*\* and Helen KELLER\*
- 3.3. Full names of the *institutions* and *departments* where the research was done, City, and Prefecture (State and Nation if outside Japan). If authors are from different institutions, put one or more asterisks **before** the institution name. Example:  
\* ABC Medical University, English Department, Nanai, Hokkaido  
\*\* XYZ Medical University, School of Nursing, Gunma
- 3.4. *Keywords*. A maximum of six keywords or short phrases that would help in indexing the article.
- 3.5. *Corresponding author*. Name of the author (with job title, e.g., Professor, M.D.) who will handle correspondence throughout the editorial process; name the university and department affiliation, full address, telephone and fax numbers, and e-mail address.
- 3.6. *For all authors*, give the e-mail address, telephone and fax number.
- 3.7. If part of the paper was presented orally or as a poster at a meeting, then at the bottom of the Title Page put *the title of the meeting, sponsoring organization, exact date(s), and the city where the meeting was held*.

### 4. Abstract

- 4.1. A maximum of 250 words (about one A4-size page). May be in 11-point typeface if necessary, to contain the Abstract on a single page.
- 4.2. State the **background** in one or two sentences (see 6.3 below), **objective** of the investigation in one sentence, then describe the **Methods** (study design, study population, protocol) in the past tense; **Results** (main findings or major contribution) in the past tense; and finally the **Conclusion** (or recommendations) in the present tense. Be con-

crete and avoid saying merely, "... was investigated" or "This paper describes ...."

## 5. Text

- 5.1. Use either American or British English, but do not mix the two.
- 5.2. *Indent* the first line of each new paragraph.
- 5.3. *Abbreviations* should be kept to a minimum and spelled out at first mention, giving the full term first, followed by the abbreviation in parentheses. Example: *English as a foreign language (EFL)*. In both humanities and natural science, *e.g. (for example)* and *i.e. (that is, namely)* are preceded and followed by a comma. Standard metric units (*mm, cm,  $\mu$ L, L, mg*) can be used without definition but must be accompanied by a numeral; symbols and metric units do **not** take a period. Common units such as *sec, min, h* (units of time do not use the plural form) are used only in combination with a numeral. Example: *The test was 80 min long*. But **not** "*The test took several min.*" **not** "*For most students, an h was enough time.*" Abbreviations requiring a period are those that could be confused with an existing word, such as **in.** for *inch*, were it not for the period.
- 5.4. **Reference citation.** Cite each reference as a superscript number matching the number in the References section of your paper. The superscript citations usually appear, without parentheses, at the **end** of the sentence, the **end** of the paragraph, or the **end** of a quotation. If more than one is used, the superscripts are separated by a comma but no space. The superscript goes **after** the comma or period.
- 5.5. Author-and-date citation in parenthesis, i.e., the Harvard system, known also as the American Psychological Association (APA) system, is **not** used in this *Journal* now.

## 6. Arrangement of the article

- 6.1. Divide your article into clearly defined and/or numbered sections. Subsections may be numbered 1.1 (then 1.1.1, 1.1.2) etc.
- 6.2. Each subsection should be given a short heading. Subsections are helpful for cross-referencing within the paper. Instead of just saying, "... as mentioned above," we try to guide the reader by saying "... as

*shown in 1.1.3 above*" or "*as aforementioned (1.1.3)*," or "*as explained under explained above.*"

- 6.3. **Introduction.** First, give the general topic, or territory, of the research in one or two sentences. Example: *How to help students hone their English listening skills is a standing concern of teachers, and especially for those teaching medical students*. After that, explain your rationale and lead up to the problem the paper is addressing, then state *the objective of your research or of your classroom approach*. References are necessary in the Introduction, but subheads are not (if you think subheads are needed, your Introduction is probably too long).
- 6.4. **Methods.** In the past tense, briefly describe your study design or classroom trial. Tell explicitly what was done, how many students were involved, what academic year they were in, what materials were used, how much time the study took (from when to when, if appropriate). Subheads are helpful in lengthy Methods.
- 6.5. **Results. (Results and Discussion** may be a single division of the paper, depending on author's preference.) Although each result is stated in the past tense, the discussion and generalization of the results are in the present or present progressive tense.
- 6.6. **Conclusion.** The Conclusion is usually the last subdivision or final paragraph of the **Discussion**, but a separate Conclusion is permissible. The conclusion is **not** a repetition of the Results but a (present-tense) generalization derived from the results.
- 6.7. **Acknowledgments.** If you express appreciation to someone for help with the data collection, analysis, manuscript, or for a grant, a brief Acknowledgments section is appropriate between the main text of the paper and the References.
- 6.8. *Figure legends, tables, figures*—in that order—may be collated at the end of the article, provided the text is marked to indicate the approximate location where each figure and table is intended. At the TOP of each **table**, number the tables consecutively according to their order of mention in the text and make a short title for each. Place table footnotes immediately below the table. Vertical lines are not necessary inside the table except in special cases. For figures embedded in the text, put the fig-

ure number and legend **beneath** each **figure**.

## 7. References

**7.1.** Switch off any automated Reference Manager, such as EndNote, ProCite, or other software you may have used, thus allowing editors to make stylistic conformation of the References if necessary.

**7.2. a. Preferred order:** *Citation order (the Vancouver method, modified slightly)*. List the references in *the order cited in your text*, putting the **family name** of the authors first, followed by the initial or initials of the person's name without punctuation (Examples 7.9 below).

**b. Alternative order:** *Alphabet and number*. The references may be listed *alphabetically*, provided the entries are also numbered consecutively. Although the citation order is preferred, *Journal of Medical English Education* currently allows either style as a way to meet the needs of the unique JASMEE blend of social science and natural science scholars.

**7.3. Journal article** (Example 1 below). **Author(s). Year. Article title. Journal Name Volume (Issue number, optional) page numbers.** The article title is written in *lowercase* except for the first word and proper nouns. In the *Journal Title*, the first letter of each word is in *uppercase*, and the *Journal Title* is italicized. The full *Journal Title* is preferred. The word "Vol." does not appear but the volume number is in **boldface**, followed by a non-bold colon, then the page numbers. Notes : **5**(1): 64–65 but NOT 64–5. / p. or pp. is NOT used in *Journal* entries.

**7.4. Book** (Example 2). **The Book Author(s) or Editor(s). Year. Book Title. City: Publisher's Name, p. number** (optional if several scattered portions were used).

**7.5. Book chapter** (Example 3). **The Chapter Author(s). Chapter title. In: Editor Names (Eds.) Year. Book Title. City: Publisher Name, pp. numbers.** The chapter title is written in lowercase except for the first word and proper nouns, and is followed by *In: Book Title*. In the *Book Title*, uppercase is given to the first letter of each word except prepositions and articles, and *the Book title is italicized*. Page numbers for the full chapter are designated by **p.** or **pp.**

followed by the numbers. Caution: pp. 128–136 but NOT pp. 128–36.

**7.6.** Journal *articles* or book *chapters* having 7 or more authors may list the first 4 authors followed by et al.

**7.7.** Japanese references. **Preferred:** If your article is written in English, then in your References put the Japanese author names in Roman characters and paraphrase the title of the Article referred to. At the end, say *In Japanese* (Example 5). **Alternative:** Currently, the References may use either Japanese or Roman characters; even if you write the reference in Japanese characters (Example 6), enter it into the single list of References either by citation order or by alphabet and number.

**7.8.** Numbered references to personal communications, unpublished work, or manuscripts "in preparation" or "submitted" are unacceptable.

### 7.9. Examples:

1. Gledhill C. 2000. The discourse function of collocation in research article introductions. *English for Specific Purposes* **19**: 115–136.
2. Sinclair JM. 1991. *Corpus, Concordance, Collocation*. Oxford: Oxford University Press. p. 78.
3. Nylenna M and Hagve TA. Small journals and non-English language journals. *In*: F. Godlee, T Jefferson (eds). 1999. *Peer Review in Health Sciences*. London: BMJ Books. pp. 112–121.
4. Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, and Richardson WS. 1999. Evidence-based medicine: What it is and what it isn't. <[http://www.cebm.net/ebm\\_is\\_isnt.asp](http://www.cebm.net/ebm_is_isnt.asp)> (Accessed December, 2004).
5. Hishida H and Hirano M. 2003. Teaching material using Web site information on nursing. *Medical English* **4**(2): 41–44. In Japanese.
6. 井上真紀, 佐藤利哉, 神田和幸. 2004. コミュニケーションから見た看護事情の改善の必要性. *Medical English* **5**(1): 51–58.
7. SAS Use's Guide. 1989. 4th edn. Vol. 1, Version 6. Gary, NC: SAS Institute.

## 8. Submission of the paper

**8.1.** A manuscript will be considered for publication with the understanding that it is being submitted solely to the *Journal of Medical English Education*



and that all pertinent sources of support and information have been acknowledged. Submission of an article implies that the work has not been published elsewhere (except perhaps as an Abstract in a conference Program or Proceedings) and that the work does, in fact, belong to the author(s) named on the Title Page.

- 8.2. Submit the manuscript by e-mail attachment to <[jasmee@medicalview.co.jp](mailto:jasmee@medicalview.co.jp)>.
- 8.3. If the manuscript cannot be sent by e-mail attachment, then send the file on CD or MO disk accompanied by three sets of the printed manuscript, to:

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**Medical View Co., Ltd.**

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Tokyo 162-0845, JAPAN

Phone +81-3-5228-2274 Fax +81-3-5228-2062

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

These materials will not be returned unless a return envelope and sufficient postage are provided by the author(s).

- 8.4. The "Transfer of Copyright" must be signed by all authors and sent to the JASMEE office (8.3 above) by regular post. The *Consent of Submission* form appears near the end of this *Journal*.
- 8.5. The authors are responsible for obtaining written permission to reproduce materials that have been published or that involve the property or privacy of anyone other than the authors. Infringement or violation of rights includes the use of copyrighted materials such as figures or tables, the use of photographs that may identify an individual, and quotation of unpublished results or private communications.

## 9. Japanese Articles

When writing an article in Japanese, follow the English Guidelines in addition to providing English in 4 places: (1) Just beneath the Japanese title of the article, provide an **English Title**, (2) put the **Author Name(s)** in Roman characters under the Japanese Name(s), (3) name the **Institution and Department** in Roman characters just below the same author affiliations in Japanese, (4) provide the **Abstract** in English only.

## 10. Student submissions

- 10.1. Articles prepared by students will be considered on a limited basis. All manuscripts are subject to the Guidelines for Authors, and the Title Page must include the name of a teacher, possibly a co-author, who will serve as the contact person throughout the editorial process. Provide e-mail addresses and telephone and fax numbers where the Editors might reach someone for consultation even after the student author has graduated.
- 10.2. Articles by student associations such as WJEMA must include a Title Page listing a teacher and/or other contact person with e-mail addresses and telephone and fax numbers where the Editors might reach someone for consultation even though the student author may have graduated.

## 11. Review of Manuscripts

All manuscripts except Special Articles will be evaluated by 1 or 2 reviewers assigned by the Editors.

## 12. Proofreading

Galley proofs of accepted manuscripts will be sent to the authors shortly before publication of the *Journal*. Typographical errors and errors in the data will be corrected upon return of the proofs, preferably by e-mail attachment or fax, to the JASMEE Office.

## 13. Reprints

Reprints are available free of charge for 20 copies or fewer when ordered with the returning of the proofs. The cost of copies exceeding the first 20 will be charged to the author(s).

\* *Guidelines for Authors* in both English and Japanese can be downloaded from the following webpage (本ガイドラインならびに日本語投稿用のガイドラインは、下記のホームページでもご覧いただけます):  
<<http://www.medicalview.co.jp/jasmee/journal.shtml>>

## Messages from the departing Editors

### We Welcome New Editors at the Helm

---

This issue of the *Journal* marks the transition from retiring editor to new editor.

This timely transition, I believe, launches new and exciting possibilities for JASMEE members as well as for the *Journal* itself. The realization of new possibilities, however, requires challenge, and challenge requires a curious blend of commitment, cooperation, and courage on the part of every writer. The right blend is produced by unwavering effort and, on occasion, the rare gift of serendipity and the even rarer gift of a trained mind that can seize the moment and turn the serendipitous happening into a positive force.

One of the adventurous possibilities, for example, is that at some point in the future the *Journal of Medical English Education* will qualify for and attain coverage in *Current Contents* and maybe also in the *Social Science Citation Index*. That is one of my visions and ideals for growth of the *Journal* in both quality and quantity, but especially for growth in academic quality. Is Japan ready for that? Is our publisher ready for that? For now, both questions can only be answered, "No, not yet." Is JAS-

**The true goal is to broaden the field  
where YOUR research article can  
carry new knowledge and join the  
worldwide ranks of new knowledge  
and thus improve medical education  
around the world.**

MEE ready? No, not yet. But before an affirmative answer can be given to the first two questions, JASMEE must make the pivotal move, for JASMEE is the kingpin than can make it all happen. Only JASMEE can raise the bar and make possible the citation opportunities afforded by those coveted citation indexes of academic progress. But the goal is not merely to be cited. The true goal-the vision-is to broaden the field where YOUR research article can carry new knowledge and join the worldwide ranks of new knowledge and thus improve medical education around the world.

New possibilities are rarely achieved by a quantum leap but rather by increments.

One of the ideal increments for the near future of the *Journal* might be to add from six to eight assistant editors; some could be shaping the forthcoming issue while others would be readying the next issue and the next. Such a core of editors in addition to editorial interns would contribute measurably toward narrowing the time between submission and publication.

Another ideal could be to open a "letters-to-the editor section" where ideas could flow from reader to author and vice versa as an enrichment opportunity for all the readers.

A third pragmatic increment would be a regular Question/Answer column to handle



confusing usage and rhetoric matters that confront us in both teaching and writing.

Retiring editors usually write about the glories of past issues of their journals and about the historical hurdles the journals had to overcome. So when our new Editor-in-Chief, Professor Reuben Gerling, asked me to write a greeting for this transitional issue, I wrestled hard with the conflict between what has been achieved and what has yet to be achieved. I was only the second editor-in-chief in the life of the *Journal*, after all, so if any gold standards have been set in place, the gold remains to be fully tried and tested. If you have ever tried to walk in the footprints of a giant such as your father when you were a child, then you might understand why I would dare anyone in JASMEE to try to walk in the gigantic footprints of my predecessor, Dr. Shizuo Oi, who was the founding editor! A brilliant man of gargantuan achievements, my predecessor

**Prof. Takeo Hikichi led a pleasant-looking man over to where I was sitting a few minutes before that first annual conference opened in Hamamatsu ("This is Dr. Uemura, our president," he said). Little did I know then the wonders of meeting so many scholars of like mind and zeal for reaching upward and ever upward toward the worthy goals of this Academic Society.**

**You have all proven that you hold the power and accept the responsibility to make a real difference in education.**

certainly left a legacy the *Journal* can look backward to with pride and he forged a journal we can look forward to with hope.

I owe a debt of gratitude to my coworker Professor Haruko Hishida, whose dedicated, sacrificial, and time-consuming work has kept us all sane. She was the *Journal's* first Associate Editor, so she took a multiplicity of roles and, as we made decisions jointly, I called on her often to take care of tasks that overlapped what I should have done myself. I am exceedingly grateful also to every writer, to the assistant editors (both the named and the anonymous, who knows who he is), the publisher, the Board of Directors, reviewers, editorial advisers (yes, spelled with an e), and the oh-so-many JASMEE members who took gargantuan strides that kept the *Journal* on course. Thanks to each one of you, this official flagship publication of the Japan Society for Medical English Education is well on its way forward. You have all proven that you hold the power and accept the responsibility to make a real difference in education. One of the main responsibilities of an editor is to ensure that the high standards of written English commu-

nication are maintained. This task is compatible with that of the medical sciences, where only the highest standards can make an unequivocal difference. So, when I recognized the scope of my assignment as editor of your *Journal*, the publication that started as the brainchild of Dr. Kenichi Uemura, I confess to being a sentinel of grammar and rhetoric and to being unrelentingly tough on genre structure, and I deeply appreciate the overwhelmingly warm cooperation and eager spirit with which everyone took every matter in hand and dealt with it professionally and creatively. I am proud of you.

I can truthfully say that seeking out the publishable material and editing this *Journal* was one of the most rewarding and exhilarating experiences of my many years in academia and journalism. When Professor Takeo Hikichi, formerly of Fukushima Medical

**Editing this Journal was one of the most rewarding and exhilarating experiences of my many years in academia and journalism.**

School, introduced me to JASMEE ("Why don't you come and give a presentation," he said) and led a pleasant-looking man over to where I was sitting a few minutes before that first annual conference opened in Hamamatsu ("This is Dr. Uemura, our president," he said), little did I know then the wonders of meeting so many scholars of like mind and zeal for reaching upward and ever upward toward the worthy goals of this Academic Society. Thank you, Professor Hikichi.

We wish the very best to Professor Gerling now, our new Editor-in-Chief, and to Dr. Toshimasa Yoshioka, Deputy Editor (or Associate Editor) as they steer the *Journal* to new heights.

**Nell Kennedy**, Former Editor-in-Chief

## Messages from the departing Editors Associate Editor を終えて

日本医学英語教育学会の学会誌編集部をケネディ先生と一緒に引き受けして始めたのが Vol.5 No.1 August 2004 からでした。学会誌の発行が遅れていたため、まずは定期的に発行することが使命でした。その後はケネディ編集長がこの学会誌をより良い、レベルの高いものにするため様々な尽力をされました。学会誌に英語で投稿された経験のある方は、どなたもケネディ先生の丁寧なコメントとメールのやり取りによる熱心な指導に、多くを学ばれたことと思います。正しい論文の書き方を知っていただきたいというケネディ先生の熱意は並々ならぬもので、この学会誌の編集に掛ける時間とエネルギーは圧倒されるものでした。投稿規程の改訂、“Continuing Professional Education”、“Call-out”等様々な提案をし、学会誌を充実したものに努力を日々されていました。副編集長としては査読をお願いしたり、日本語の投稿原稿に対して査読者との意見調整をしたり、編集長の意図を上手く執筆者に伝えるお手伝いをしたりという仕事でした。先回の Vol.7 No.1 February 2008までケネディ先生と仕事できたこと、そして当学会誌のために多少なりともお手伝いできたことを本当に嬉しく光栄に思い、次の編集部のゲーリング先生、吉岡先生に無事にバトンタッチできてホッとしております。学会誌が益々発展していきますことを心より願っています。

聖路加看護大学・英語

菱田 治子

## Message from the incoming Editor

### **Nell Kennedy: Thank you and Farewell**

---

Nell Kennedy was one of the founding members of JASMEE and very quickly joined the executive council. She took over from Professor Oi as editor of the journal and worked hard to make the journal better and more interesting.

Nell's understanding of medical writing as well as the many hours that she put into editing and revising the material she received served to make the journal a first class venue for papers on subjects relating to medical English education. She received a journal with two names, and gave it its present standard name, she wrote up the guidelines for contributors and made sure that all papers conformed to her guidelines. She coaxed, cajoled, advised and encouraged writers and thereby not only made sure that the papers were of improved quality, she also gave the authors a chance to improve their writing.

Now Nell is retiring from her old, well padded lair at Rakuno and is settling to write a book. We are all sure that this will be as much a masterpiece as her previous writing. We wish her all the best and hope that she will remember us so that we continue to benefit from her long experience and wealth of knowledge. At the same time we are faced with the task of running the journal, making it more successful and helpful to the members of the association and to the EMP public in general. So, god speed Nell, and all the best.

The editors would also like to express the deepest appreciation to professor Hishida for the hard and conscious work she has done in editing and preparing the Japanese language side of the journal. We wish her all the best and hope to benefit from her experience and knowledge in the years to come.

**Reuben M. Gerling**, English Editor

## Perspectives

### 日本医学英語教育学会誌の編集について

このたび日本医学英語教育学会誌の編集組織が改変されました。

これまで酪農学園大学 Nell L. Kennedy 先生と浜松医科大学 菱田治子先生が担当理事として編集が行われてきました。ここまで本誌を発展させてきていただいたことに心より敬意を表したいと思います。今般理事会で、日本大学 Reuben M. Gerling と東京女子医科大学 吉岡俊正が編集責任者となりました。会員・読者の皆様におかれましては、どうぞよろしく願いいたします。

新たに編集責任者として任命されましたので、編集の基幹となる本誌の在り方について私見を述べさせていただきます。医学英語、English for medical purposes (EMP) は世界に共通の医学教育テーマのひとつです。しかし、英語を母国語とする国、英語が母国語ではないが医学教育を英語あるいは英語の教材で行う国、と日本は大きく異なります。現実の教育、臨床が母国語で行われているのが日本の特徴です。英語は国際共通言語として使用され、最新の医学・科学の理解には必須であることは言うまでもありませんが、日本の言語環境での実際の教育には困難を伴います。一方英語を母国語としない国あるいはその国民に英語による医療を行う場合は、英語はコミュニケーションの道具です。英語を母国語とする国を含め、信頼と相互理解に基づくコミュニケーションは国によって異なる文化・習慣・倫理などの背景を意識し理解して可能となります。英語によるコミュニケーションは

単なる語学ではなく専門家(医師)として国を超えてコミュニケーションを行う技能や態度も含まれ医学英語の目標のひとつとなります。日本における医学英語教育の課題は、日本だけに当てはまるのではなく同様な言語環境にある国を含み国際的に一般化できることもあります。

このような視点から日本医学英語教育学会は国際的にも広がりを持つ可能性のある医学教育情報交換の場であり、学会誌である本誌が英文と日本文の両方の論文を掲載する意義も高いと思います。本学会は英語教育を本務としている教員・研究者と医学教育・医療実践を本務とする教員・研究者が協働して良い医学英語教育を目指す場でもあります。本誌は立場の異なる英語教育者のプラットフォームとしての意義も高いと思います。

次に、編集責任者間で編集組織・編集方針について検討した結果を述べさせていただきます。

編集組織として一般の科学論文誌と同様な組織を構築します。すなわち編集責任者のほかに何名かの編集委員を設け編集員が投稿された論文を担当し査読による評価を行い、編集委員会で採択を決定します。編集委員は別に査読者を1もしくは2名指名し編集作業を行います。従来は編集委員が直接著者と編集・校正のやり取りを行っていましたが、編集部(メジカルビュー社)がロジスティクスを担当します。

外部査読者を導入することで論文の客観的

評価が行われることが期待されますが、一方で投稿された論文が不完全であると査読が行わないで、何度も著者と編集者が応答を繰り返した上で不採用となってしまうことがあります。投稿される論文は、投稿規程に沿って作成されているだけでなく、日本文・英文を問わず、文章・構成・論旨・根拠が明確であることが査読・編集作業が円滑に行われるために必要です。論文内容について規定はありませんが、仮説あるいは問題点に対する検証・検討・分析・評価が行われた原著論文、多くの根拠に基づく包括的な総説、単なる報

告ではなく新たな教育の試みとその評価などが会員・読者にとって価値のある学会誌となると思います。また、編集あるいは論文に対するレターなども充実させたいと思っています。

皆様のご協力をお願いします。

日本医学英語教育学会会誌

Japanese Editor

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## Perspectives

### EMP in Medical Education

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#### Medical Education

As a discipline medical education came to the fore about thirty years ago and has been gaining strength ever since. It is now possible to gain higher degrees in centres such as Maastricht, Dundee and McMasters. These centres also provide shorter courses for interested persons. The discipline deals with such areas as curriculum planning, students' evaluation, teaching methods and outcomes. Much of the published work is about studies of students' attitudes, description of courses and evaluations of outcomes. Outcomes, together with integration are key elements in the success of medical education. There are medical education associations in most major countries and a number of international associations. There are also numerous publications for papers dealing with medical education.

#### The Need for EMP

English is the major international language and the foremost language of medicine. Although the Japanese system requires material in Japanese that material is, in fact, mostly translated from the English either as it is or as material collated from various sources. The latest information regarding advances in the field are presented at conferences and published in journals, all of which is most often in English. An increasing amount of information

is available on the internet, again in English. In fact, quite a few journals release on the Internet pre-publication views of their latest issues. This means that to be a medical practitioner one needs a certain amount of English. The only question is, how much and of what kind.

#### Swings of ESL

The teaching of foreign languages is, of course, very old. The way language is taught can be divided into two basic ways, teach the language by explaining it in the speaker's original tongue and translate as much vocabulary as possible; this is referred to as 'reading translation'. The other method calls for a 'hands on' approach in which the learners are asked to use the language rather than to explain it, sometimes referred to as the 'direct method'. Historically the practice has been moving like a pendulum from the one to the other. People used the language but complained that they did not know what they were doing so explanation and translation took over. Then learners realized that they could not string up a simple sentence when they needed to converse, and that they could not write a proper paragraph and the 'do it, don't talk about it' squads took over.

## **Why EMP**

There is no doubt that learning the rudiments of a language is the correct way to go. However, university students should be familiar with that part and if they are not, there is little chance that they will suddenly learn it. A language is invariably a tool and it must be used. The more one uses it the better one becomes. There may be some esoteric merit in asking learners to practice English by conversing about sushi in New York City, but relating to their own field of study may be more productive. EMP concentrates on providing the means and ways to access a tool that will be crucial to the students' success as doctors.

## **EMP and Medical Education**

Advanced medical education places much importance on curriculum integration and on outcomes. Including EMP in the curriculum enhances the whole scope of these two factors. When students are asked to do some of the core material in English they get a chance to approach that material in a different language and therefore to improve their understanding. They are allowed to work on the material beyond the limited scope of the tight curriculum and are given a chance to peruse references in their original setting. This deepens understanding and improves interdisciplinary comprehension, all of which is bound to improve outcomes.

**Reuben M. Gerling**, English Editor

## Abbreviations and Acronyms Occurring in Studies on English Education

This list is a quick reference for readers whose academic field may not be the study of English education but whose work puts them in contact with such terms. Caution: The list is not a free license for authors to bypass the writer's etiquette and responsibility to spell out the full meaning when the term is first used in the main body of a paper.

Abbreviation	Full Expression
1. CALL .....	Computer-Assisted Language Learning
2. CARS .....	Create a Research Space
3. <b>COBUILD</b> .....	<b>COLLINS Birmingham University International Language Database</b>
4. DDL .....	Data-Driven Learning
5. <b>EAP</b> .....	<b>English for Academic Purposes</b>
6. EEP .....	English for Educational Purposes [now almost obsolete, replaced by EAP]
7. <b>EFL</b> .....	<b>English as a Foreign Language</b>
8. EGAP .....	English for General Academic Purposes [e.g. listening and note-taking, academic writing, reference skills, seminars, discussions]
9. EGP .....	English for General Purposes
10. ELP .....	English for Legal Purposes
11. ELT .....	English Language Teaching
12. <b>EMP</b> .....	<b>English for Medical Purposes</b>
13. EOP .....	English for Occupational Purposes [e.g. doctors, hotel staff, airline pilots]
14. EPP .....	English for Professional Purposes English for Pharmaceutical Purposes [of recent origin]
15. <b>ESAP</b> .....	<b>English for Specific Academic Purposes</b> [e.g. medicine, law, engineering, economics]
16. ESL .....	English as a Second Language
17. <b>ESP</b> .....	<b>English for Specific Purposes</b>
18. EST .....	English for Science and Technology
19. EVP .....	English for Vocational Purposes
20. IELTS .....	International English Language Testing System (UK)
21. ITA .....	International Teaching Assistant
22. L1 .....	First language/mother tongue
23. L2 .....	Second language/medium of communication
24. NS .....	Native Speaker (of English)
25. NSS .....	Non-native Speaker (of English)
26. <b>PBL</b> .....	<b>Problem-Based Learning</b>
27. PERC .....	Professional English Research Consortium [based in Japan]
28. RELC .....	Regional Language Centre (Singapore)
29. TEFL .....	Teaching English as a Foreign Language
30. TENOR .....	Teaching of English for No Obvious Reason [e.g. for children unaware of any particular need for English, sometimes equated with EGP]
31. <b>TOEFL</b> .....	<b>Test of English as a Foreign Language</b>
32. <b>TOEIC</b> .....	<b>Test of International Communication</b>
33. TSA .....	Target-Situation Analysis

Boldface indicates terms sometimes found in *Journal of Medical English Education*.

This list was compiled by the editors.

# Approaches to Teaching Oral Presentation Skills<sup>1</sup>

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For the medical profession, the need to deliver and comprehend oral presentations in English is increasing. Effective structuring of a presentation is an essential skill for presenters, since it creates coherent discourse and aids audience comprehension. This paper describes how recordings of real presentations can be used to raise students' awareness of the importance of discourse structuring. Micropresentations are introduced as a way of helping students to extend their linguistic range and incorporate discourse structuring techniques into their presentations. Using language derived from authentic data was found to be effective in helping students to improve their presentations and bring them closer to genre mastery.

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**Key Words:** authentic materials, discourse community, discourse markers, English for Specific Purposes, guest lectures, oral presentations

## 1. Introduction

International conferences now play a central role in communication among members of discourse communities with oral presentations being one of the main ways results are reported to the community.<sup>1</sup> This is particularly true for the medical profession.<sup>2</sup> For this reason, the need for proficiency in both delivering and comprehending oral presentations in English is increasing. The importance attached to presentations as a means of transmitting research findings, as well as the increased mobility and internationalization of the scientific community means that the genre of the oral presentation is one that the medical profession, scientists and researchers need to master if they are to establish successful careers.

Applied linguists have focused primarily on the genre of the research article, ignoring spoken academic English because of its complexity, the difficulty of accessing data, and the time and cost involved in researching it.<sup>3</sup> In recent years, however, there has been considerable inter-

est in spoken academic discourse, which is now reported as a field in its own right.<sup>4</sup> This is mainly because it has become more researchable with the establishment of a number of corpora of spoken academic English, such as the Michigan Corpus of Spoken Academic English and the British Academic Spoken English Corpus. For teachers of presentation skills interested in obtaining data from authentic sources, advances in technology have meant that presentations can be recorded more easily, transferred to and stored on computer, and used to create a database of structures, lexis and techniques that can be used in teaching and the production of materials.

In Japan, there has been a slow, but steady growth in English for Specific Purposes (ESP), as well as the development of an ESP community with several special interest groups forming, and a number of conferences dedicated solely to ESP.<sup>5</sup> One of the main attractions of ESP is that it holds promise for more effective and genuinely useful English programs.<sup>6</sup> The potential of ESP has been noted by the Ministry of Education, Culture, Sports and Technology which has stated the need for a clearer link between the classroom and real life, and special emphasis on the relevance of classes to real needs.<sup>7</sup> The strongest claim for the importance of ESP in Japan has been made by Evans and Squires who state that at universities here, ESP will become the norm and not the exception in years to come.<sup>8</sup>

The above factors account for the increasing number of presentation skills programs at medical schools, uni-

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<sup>1</sup>A shorter version of this paper was presented at the 10th annual JASMEE Academic Conference, July 15, 2007, Tokyo.

versities, institutes, and laboratories here, as well as the appearance of more materials aimed specifically at the teaching of presentation skills.

## 2. Presentation Skills Programs

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It is probably fair to say that, in spite of new research on the genre of oral presentations and the development of teaching materials, the quality of presentation skills programs and their outcome remains mixed. Banks, for example, in a survey of French scientists, reports that many scientists had a poor opinion of the English training they had received.<sup>9</sup> This, I believe, is widespread among the medical profession, scientists and researchers around the world.

At many medical, dental and science universities in Japan, English language programs stop after the second year and cover only general English. ESP programs, although increasing in number, are still the exception. At postgraduate level, students are expected to give oral or poster presentations in English with little or no training in the necessary skills. To compensate for this, they develop strategies to survive the presentation, which, in the long term, do not help them become good presenters. It is, for example, not unusual for students to prepare a script for their presentation and memorize it. The problem is that this will conform more to the genre of the written research article than the conversational oral presentation that has become the norm among most experienced presenters at international conferences today.<sup>10</sup> Students are not taught the crucial difference between the two genres and consequently deliver presentations that are inappropriate.

The skills involved in giving a generically appropriate presentation are complex and not easily acquired, especially by L2 learners. This means that without instruction in the linguistic norms of oral presentations, young members of the discourse community who are non-native speakers face severe difficulties, and the process of becoming a fully-fledged member of the discourse community who understands the rules of the genre and can function successfully within them is delayed.

Teachers with qualifications and experience in ESP are still in a minority, and it is usual for teachers of general English to take charge of presentation skills programs. Additionally, even qualified and experienced teachers face problems in acquainting themselves sufficiently with the content of the target material they teach. Although team teaching is becoming more common in

ESP programs, this remains a significant problem. Depending on the time available, teachers generally make schedules so that participants give one or two presentations over the course of the program which probably lasts for one semester. Ostensibly, this meets the needs of novice presenters: they can practice their presentation in a situation that is close to that of an international conference, and receive valuable feedback from the teacher, as well as their peers. However, in terms of output, giving one or two presentations is not enough to master the genre, or indeed to make significant progress. The problem is that the presentation itself is the main objective for students and teachers, becoming a necessary hurdle to be cleared, and what happens before and after is largely ignored. In terms of output, which we know to be essential in developing fluency in a foreign language, doing one or at most two presentations is not enough to improve fluency.<sup>11</sup> This means that in standard presentation skills programs, where the delivery of a single presentation is the main goal, there is not enough specific practice of microskills at a lower order to develop confidence and fluency.

In many cases, students are not presented with linguistic descriptions of what happens in oral and poster presentations at international conferences, and consequently have nothing to model their presentations on. This is understandable, as up until recently, knowledge of the mechanisms of oral presentations was limited and to a large extent teachers did not fully understand or have access to data on the norms of the genre they were teaching.

## 3. Shortcomings in Commercially Available Teaching Materials

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Few teachers, unless they have considerable experience of teaching presentation skills and plenty of supplementary materials, are willing to teach without a textbook. Good teaching materials, however, are in short supply and fall short on a number of points.<sup>12</sup> Presentation skills textbooks generally contain examples of mini-talks or presentations on which students are expected to model their presentations. In most cases, they contain examples that, while they look like the real thing, are idealized, unrealistic and over-emphasize some aspects of the genre.<sup>13</sup> Examples are usually read from a prepared script and do not have any of the hesitations, repetitions or other characteristics of realistic spoken English. They also contain explicit discourse markers that signal the

introduction, main body, topic transitions and conclusion of the presentation. It is common, however, for teaching materials to overuse discourse markers, with the average number per 1000 words in model presentations being considerably higher than in real presentations.<sup>14</sup> Model presentations are also shorter and more coherent with information broken into smaller chunks and, as such, are not accurate representations of reality.

In short, textbooks that focus on presentation skills remain largely unchanged in approach and do not reflect the implications of studies that have focused on the language of presentations at international conferences.<sup>15</sup> Additionally, they do not reflect the findings of modern corpus linguistics that are beginning to make an impact on textbooks aimed at students of general English. Such textbooks make use of corpus data on language usage to present the language as it is actually used, featuring strategies from authentic situations.<sup>16</sup>

#### 4. Accessing Authentic Data through Guest Lectures

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From the above discussion of problems associated with commercially available teaching materials, it is clear that for students to improve their presentation skills, they need at some stage in their training to be provided with models of real presentations or, at least, quasi-realistic data on which they can model their own presentations.<sup>13</sup> One way to access such authentic data is to make use of guest lectures. At my place of work, there are, on average, six or more guest lectures a year. With the permission of the presenters and the departments concerned, recordings of the lectures were obtained. Using an IC voice recorder, a good quality recording can be obtained that can be transferred to computer and copied to CD. It is also possible to achieve similar results using a cassette recorder. Multiple copies can be made, so that each student has a copy of the presentation. These can be used in class, or as homework, with students transcribing sections of the presentations and analyzing them. Obvious targets for transcription and analysis are introductions, conclusions, transitions between sections, summarizing, focusing, introducing graphics, forward and backward movement, use of rhetorical questions, handling questions and so on. Students should work only on short, specified sections of the guest lectures under the guidance of the teacher. Although this exercise will help to improve students' listening ability, the aim of the activity is not the development of listening skills, and stu-

dents are not expected to transcribe the lecture in its entirety. Teachers will need to support students, so that an accurate transcription of key parts of the presentation is arrived at. A final script for the presentation should be made available to students. This will involve the teacher in carefully transcribing the recorded presentation. The CD and the script act as a resource pack for students to refer to and use as a model. It can also be used in the class by the teacher to focus students' attention on language, structures and techniques used in the guest lecture.

#### 5. Is There a Standard Oral Presentation Model?

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In all, 6 guest lectures were recorded, 3 by native speakers and 3 by experienced, near-native speaker presenters. Analysis of the presentations showed that while displaying a variety of features in common, the genre does not exhibit the kind of uniformity of structure and expression evident in written medical and scientific papers. In other words, there is no single model that can be said to represent the genre, a finding supported by the work of McDonald.<sup>12</sup> Some presentations had large numbers of discourse markers while others had relatively few. In general, non-native speakers made a more conscious effort to structure their presentations and guide their audience with the use of explicit discourse markers. This result matched the findings of a study that compared interactive discourse structuring used in presentations given by both L1 and L2 speakers. It was found that interactive discourse structuring was most frequent among L2 guest speakers and less frequent among L1 guest speakers.<sup>3</sup> However, in a study conducted in Jordan that compared lectures on the same subject given in English by a teacher whose first language was Arabic with those given by a native speaker, the lecture by the native speaker was found to be more interactive, showing numerous examples of chunks to signal boundaries and direction, as well as paraphrasing expressions.<sup>17</sup>

#### 6. Interactive Discourse Structuring in Authentic Data

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The function of discourse markers is to guide the audience through a speech event, by helping them create a mental map. In other words, presenters use them to inform their audience about what is to come and how this connects to what has been said and will be said. Such



interactive discourse structuring plays an important role in creating coherent discourse, and is known to have a positive effect on comprehension.<sup>3</sup> When discourse markers are missing, listeners experience difficulty in understanding the message.<sup>18</sup> Given the importance of discourse markers in the delivery of a successful presentation, teachers need to consider how they can raise students' awareness of them, provide authentic examples, and create tasks and interaction where they can be practiced. The recorded guest lectures were analyzed for examples of discourse structuring. Here are some examples of how presenters structured their presentations.

**Backward movement:** This is just to remind you of what I said about ...

**Changing direction:** Now, let me switch to my analysis of the data.

**Forward movement:** I'll show you that data in the next section.

**Focusing:** What I'd like to concentrate on here is ...

**Introducing a section:** In this section, I'd like to talk about ...

**Repetition:** So, one of the first symptoms is tremor, so tremor in the hands, in the limbs. You see them trembling.

**Simplification:** Normally, the transmitters are metabolized - er broken down. In other words, ...

**Skipping:** I won't go into details.

**Summarizing:** I'd like to go over the main points again.

The above examples of discourse structuring are often characterized by formulaic expressions called chunks. Chunks have been acknowledged as playing important roles in scientific discourse and at the same time posing difficulties for novice members of the discourse community.<sup>17</sup> Data from the recorded presentations show numerous examples of chunks, suggesting that they are typical of the informal, conversational style of presentation. It is interesting to note that Japanese presenters rarely use these kinds of chunks, preferring instead a much more formal style that is closer to that of the research article. The problem is, however, that the more complex the information presented, the more the audience needs discourse structuring to guide them. For this reason, students need to realize that sentences such as those above are powerful tools that can make their data more accessible and will significantly improve their presentation.

## 6.1 Rhetorical questions

Rhetorical questions are organizational devices that indicate the desire for a shared discourse. They are used as a means of introducing a new topic, have the effect of lessening the distance between the speaker and the audience and are a device used frequently by experienced presenters. There were numerous examples of rhetorical questions in the recorded presentations. Students, however, were reluctant to use rhetorical questions in their own presentations, suggesting that novice presenters have difficulty in developing genre awareness and are reluctant to extend their range of linguistic choices.

## 6.2 Personal pronouns

Analysis of the presentations showed frequent use of 'I', 'we' and 'you', with 'we' being the most commonly used personal pronoun. In the literature, 'we' is reported as occurring three times more frequently than 'I' or 'you'.<sup>19</sup> Presenters used 'I', 'we' and 'you' to create a sense of joint effort and belonging. Instead of using the passive, native speakers use a high proportion of personal pronouns followed by an active verb. Non-native speakers, however, use the passive frequently and personal pronouns rarely. In a comparison of presentations given by Bulgarians and native speakers involving ten native speakers of English and twelve Bulgarian English speakers, it was found that 'I', 'we' and 'you' were only used half as frequently by Bulgarians as native speakers of English.<sup>20</sup> Rowley-Jolivet reports similar results with native speakers using passive sentences in presentations in 8.3% of clauses, whereas non-native speakers use them over half as much again.<sup>21</sup> It is probable that non-native speakers are uncomfortable using personal pronouns and prefer the passive, since they feel it lends authority and formality to their presentations. The problem is, however, that this creates an impersonal effect closer to the research article than the interactive oral presentation, and results in a less interactive presentation.

## 6.3 Lexis

There was considerable uniformity in the use of lexis in the presentations recorded, particularly in introductions. Common patterns in introductions were as follows: talk about, focus on, give a review, give some background, consider. In general, presenters used informal collocations such as 'take a look at' or 'have a look at'. This is in contrast to non-native speakers who prefer the formality of observe, investigate etc. The lexis of oral presentations is an area that needs further research and

description, particularly since phrasal verbs and three word lexical bundles pose particular problems for novice presenters, and the teaching of these items requires more attention.<sup>3</sup>

#### 6.4 The need to teach discourse structuring

It is probable that the above linguistic features come naturally to native speakers and near-native speakers, and are not used in a conscious way to create a coherent discourse. The same cannot be said for non-native speakers who are novice presenters. For this reason, it is important to raise students' awareness of the existence and importance of such features and to give them plenty of opportunity to practice. The fact that non-native speakers who are novice presenters do not generally exploit such structures means their presentations lack organization, and this has a negative effect on clarity and rhetorical impact.<sup>21</sup> Additionally, there is a need for non-native speakers to make more explicit use of discourse markers to compensate for other problems relating to pronunciation and grammatical accuracy.<sup>22</sup>

When novice presenters analyze authentic presentations given by experienced native or near-native speakers, they get the opportunity to consider the basic linguistic structure of the genre. This helps them to appreciate the difference between the written mode of the research article and that of the oral presentation. It also provides them with a database of structure, lexis and techniques from which they can develop their own presentations. Students are encouraged to use these examples in their own presentations, but are not under pressure to conform exactly to the model. For teachers, accessing authentic data is an essential part in the process of teaching presentation skills, writing materials and reflecting on the skills we teach.

### 7. Micropresentations as a Way of Developing Fluency

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For course designers and teachers, one of the main challenges is creating the right kind of interaction and tasks so that acquisition takes place and fluency is developed. One solution is pair and small group work, both of which have proved to be effective in classes based on the principles of communicative language teaching. In a presentation skills program, micropresentations of approximately 3 to 5 minutes can be used in the same way as pair and small group work and achieve comparable results. The aim is to give students the chance to break

down a complex task, such as their main presentations, into smaller more manageable parts that can be practiced in each class. Students can, for example, practice giving an introduction, explaining graphics, describing an experimental set up, giving a conclusion and so on. They can also be encouraged to introduce interactive features of the type listed above into their presentations. In this way, they can be familiarized with a wide range of appropriate structures and also given the confidence to use language they would otherwise avoid or that they might not be aware of.<sup>20</sup>

Micropresentations work best in groups of 20 students or less, but can be used in larger groups, particularly if students are given sufficient guidance and appreciate the benefits of the task. Students are assigned to groups of between 3 to 5 people to deliver their micropresentations and handle questions. They should be encouraged to stand and put keywords, data and diagrams on a whiteboard or pieces of paper, and also to speak without notes. Members of the micropresentation groups should ask questions, thus making the tasks as interactive as possible, since when students interact amongst themselves acquisition-rich discourse is more likely to ensue.<sup>11</sup> This kind of interaction fosters acquisition, since when a communication problem arises learners are engaged in negotiation for meaning.<sup>23</sup> My own experience is that micropresentations give students greater opportunity to ask questions and enter into meaningful discussions than in full presentations, as they are less pressurized. This kind of practice is crucial in preparing them for what they will encounter in real presentations.

While micropresentations are in progress, the teacher circulates and takes notes. After the activity is over, the teacher offers feedback to the group as a whole from the points that have been noted. Typically, these would be on pronunciation, lexis, structure and how best to use the target structures from the guest lectures. In a presentation skills program, micropresentations can be scheduled between full presentations. In a 90 minute class, I envisage 30 minutes being taken up with one full presentation, including Q and A, and feedback from peers and the teacher, leaving the remainder of the class for micropresentations and teacher fronted introduction of target language and techniques from the guest lectures. The main advantages of micropresentations are summarized below.

- a. A complex oral task is broken down into smaller more manageable steps that can be easily practiced.

- b. Students get the opportunity to practice speaking in every class.
- c. Increased interaction amongst students promotes motivation, acquisition and fluency.
- d. Students can try out language and techniques from the guest lectures in a relaxed and supportive atmosphere and extend their linguistic range.
- e. Students get regular feedback and advice from the teacher.
- f. Giving control of the discourse topic to the students ensures interaction and language acquisition.

## 8. Toward an Ideal Presentation Skills Program

What should an ideal presentation skills program look like? Firstly, it should provide participants with authentic or at least quasi-authentic input that accurately reflects the norms of the discourse community they aspire to join. One way of achieving this is to use guest lectures or actual presentations from international conferences as a model. Another is to access data from corpora of spoken academic English. From these authentic sources, a linguistic description of the language of presentations can be built up that students can use. Secondly, for the reasons listed above, students should be given every opportunity to practice at the level of micropresentation at the same time as they prepare for a full presentation. It is also imperative that an on-going needs analysis is established, as well as program evaluation, and planning. The production of teaching materials directly relevant to the needs of the students is also of crucial importance. The program itself, although most likely taught within the English department, should also involve staff from other departments who are responsible for teaching content courses, so that multiple perspectives are taken into account in all program planning decisions. Exchanging information and informing each other of what can and should be done, and how it can be achieved, is an important part of establishing and maintaining an effective program in a joint enterprise involving ESP teachers, teachers in specialist departments and students. In this way, programs can be developed that really meet the needs of novice presenters and assist them in making the massive jump from presenting in class to presenting at international conferences.

## 9. Conclusion

Research on spoken academic discourse provides information on interactive discourse structuring and other linguistic features, as well as the norms of the genre, all of which can be used in presentation skills programs and teaching materials. Additionally, there is considerable opportunity for teachers to conduct action research projects using data from guest lectures and online corpora to create programs that are up-to-date, relevant, linked directly to what actually happens at international conferences, and which provide explicit linguistic descriptions of the extensive set of formulaic expressions commonly used in interactive presentations. Creating active links between specialist science departments and English departments that involve all teachers whether scientists, medical professionals or teachers of ESP, will help to develop effective programs, increase the number of stakeholders and compensate for the compartmentalized learning in Japanese universities which restricts opportunities for exchange of information. Teachers need to spend time designing tasks at microlevel that allow students to try out and acquire the use of such expressions, as this will give them the confidence to use structures and lexis they are unfamiliar with. In this way, students can move from reading or memorizing a prepared script to dynamic, interactive presentations that will hold the attention of their audiences, make their research both more accessible and convincing, and meet the norms of the discourse community. For students, increased genre knowledge will result in improved communicative competence and ultimately better oral presentations.

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[Teaching Method]

# Introducing the Medical Humanities to Japanese Medical Students through the English-for-Medical-Purposes Class

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As medical science advanced in the twentieth century, medical schools increasingly focused their curricula on the science of medicine—medical knowledge and technique. This focus came at the expense of the art of medicine—the human dimensions of medical care. To restore the human element to the study of medicine, more and more US medical schools have been including the study of the medical humanities in their curricula. Through the medical humanities, particularly literature, students reflect on such themes as the physician-patient relationship and the experience of illness and thus develop empathy and skills in communication, observation, and analysis. In recent years, the interest in the medical humanities has spread beyond medical schools to the broader medical establishment, featuring in journals devoted to the medical humanities, in medical journal special columns, and in conference workshops. But in Japan, the study of the medical humanities is comparatively overlooked. English-for-medical-purposes teachers can compensate for this area of neglect by using materials from the English medical humanities in discussion classes. Such a class and the materials used in it are herein described. Through the course, students not only develop speaking, listening, reading, and writing skills in English, but also become familiar with the field of medical humanities and have the chance to reflect on the human side of doctoring.

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Whilst the medical humanities enjoy an increasingly important place in US medical school curricula, they remain a neglected area of study in Japan. English-for-medical-purposes (EMP) teachers can fill the gap by introducing English-language works from the medical humanities into their discussion classes. In this paper, I will describe what the medical humanities are, what pedagogical purpose they serve, and some ways in which they are implemented in US medical school curricula. I will then outline an EMP class I teach based on English-language medical humanities materials and will finish by introducing some of those materials.

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## 1. Twentieth Century Gains in the Science of Medicine Came at the Expense of the Art of Medicine

In the *Cecil Textbook for Medicine*, Lloyd H. Smith describes the physician as “the advocate of the patient as well as the adversary of disease.”<sup>1</sup> This characterization neatly encapsulates the concept of medicine as both science and art. To fight disease as its “adversary,” the physician needs medical knowledge and technique—the science of medicine. To act as each patient’s “advocate” by doing what is in that patient’s best interests for achieving a cure, the physician needs human understanding, or “human faculty,” as Smith calls it. This human faculty includes “the ability to listen, to empathize, to inform, and to maintain solidarity with the patient throughout adversity.” These are the non-scientific aspects of medicine, the intangibles that constitute the second part of the medicine equation—the art of medicine. Few would argue that scientific knowledge and skill are essential for effective medical treatment. Because treatment begins in



the clinical encounter, however, one might also argue that the quality of what transpires during that encounter is equally essential for the effective outcome of treatment. As the adage goes, “Listen to the patient. He will tell you the diagnosis.”<sup>2</sup> Yet, whilst the twentieth century saw tremendous attention paid to the science of medicine, with great advances made in medical knowledge and in diagnostic and therapeutic technique, the latter years of that century also brought criticism that these advances were made at the expense of the art of medicine.<sup>3,4</sup> Some even wondered if medicine had lost its humanity.<sup>5,6</sup>

## 2. Restoring the Art of Medicine to Medical Curricula through the Medical Humanities

### 2.1. The medical humanities

To redress the imbalance between emphasis given to the science of medicine and that given to the art of medicine, there has been an increasing push in the last thirty years to include the study of the medical humanities in the curricula of US medical schools. The humanities are those disciplines that explore what it means to be human and include literature, theater, poetry, philosophy, ethics, history, music, visual arts, film, sociology, and anthropology. The medical humanities are those that examine the question from a medical perspective. They offer insight into the human experience of illness by making us consider questions such as “What is suffering?”, “What does it mean to be a doctor?”, and “What is my responsibility to others?” In doing so, medical humanities help nurture the human dimensions of medical practice.

### 2.2. Benefits of studying literature and medicine

Literature has provided a particularly rich source of material from which to study such questions. Indeed, the field of literature and medicine is now recognized as a subdiscipline of literary studies.<sup>3</sup> Why this happy union? Firstly, the sheer number of literary texts that deal with medical issues provides a rich source of materials for study. (Witness the size of the *Literature, Arts, and Medical Database* maintained by the New York University School of Medicine.<sup>7</sup>) This abundance is thanks in part to the natural affinity that medicine and literature have always shared, stretching back to the ancient Greeks whose god of medicine, Apollo, was also their god of poetry.<sup>8–10</sup> The long list of physician-authors also attests to this affinity: Sophocles, Francois Rabelais, John Keats,

Leo Tolstoy, Anton Chekhov, Arthur Conan Doyle, Sinclair Lewis, Tezuka Osamu, William Carlos Williams, Richard Selzer, and Michael Crichton, among others. Secondly, in its richness and complexity, literature conveys the human experience of illness more powerfully and more authentically than can the standardized and impersonal case history.<sup>2,4,9</sup> By studying literary works about illness, therefore, students understand more deeply the human experience of illness and thereby develop empathy for their patients’ plights. By reflecting on the nature of the physician-patient relationship, they appreciate more the importance of physician-patient communication. By reflecting on the moral and ethical dilemmas and the physical strains that challenge the physician’s work, students become more self-reflective, more self-aware. Thirdly, through the very act of reading, students develop skills that will help them become both better readers and better doctors. For the skills required for reading—observation, analysis, interpretation, problem-solving—are the same as those required for doctoring.<sup>3</sup> Fourthly, medicine shares a further affinity with literature in that narrative is also an important feature of medical practice: oral (e.g., history-taking and clinical conferences) and written (e.g., case histories, progress notes, and referral letters) descriptions of illness events form an everyday part of the physician’s work. By applying literary theory to the study of such medical narrative forms, students can evaluate more accurately the physician-patient interaction and the way in which medical information is conveyed.<sup>3,10–12</sup> Indeed, recent literature and medicine scholarship has increasingly inclined toward the narrative aspects of medicine.<sup>13</sup> Finally, some would even bring the affinity as close as to claim that literature *is* medicine by pointing to the cathartic value of reading/writing, or to claim that medicine *is* literature: “It is not only the practice of medicine that is informed by literary understanding—by poetry—but that poetry is created in the practice of medicine.”<sup>9</sup> And: “We carefully listen with our minds to the words of Sophocles and Camus so that we may better hear the poetry of our patients.”<sup>8</sup>

### 2.3. Some ways in which the study of literature has been implemented in medical curricula

Since Literature and Medicine was first offered as a course at Pennsylvania State University College of Medicine in Hershey in 1972, it has spread so that approximately one-third of US medical schools now include literature or other humanities study in their curricula.<sup>14</sup>



Courses take various forms including pre-clinical courses, seminars during the clinical years, reading groups for practicing physicians, and journal groups in which members keep journals and share and discuss their writings at meetings.<sup>11</sup> Students in literature courses study short stories, poems, essays, and drama. In broader medical humanities courses, film or the visual arts are also included. Typical themes include the physician-patient relationship, ageing, death and dying, disability, minorities and culture, and AIDS.<sup>3,14</sup> Often the teacher guides the class through discussion of aspects such as plot, character, use of metaphor, and narrative stance.<sup>11</sup> For assignments, students may keep journals in which they reflect on readings or class discussions, or they may write their own short stories, poems, or recollections of their own or family experience of illness.<sup>15</sup> They may prepare a photo essay of a house call or a presentation set to music.<sup>15</sup> In this way, they reflect on the medical experience not only through the work of others, but also in the creation of their own work. They may be asked to rewrite a narrative from the perspective of a different character in the story, thereby opening up their imaginations to the experience of others and developing empathy.<sup>14</sup> Or the course may be built around readings unrelated to medicine in order to focus on strengthening analytical skills. For example, in a course on the works of Sir Arthur Conan Doyle, students work through the process by which the detective-sleuth Sherlock Holmes solves murder mysteries and thus learn problem-solving skills in an indirect, if not entertaining, way.<sup>16</sup>

The phenomenon is not confined to medical schools. Some professional societies offer workshops in literature and medicine at their annual meetings, whilst some medical journals include special columns in which medics write about their work or patients write about their experience of illness (the “pathography”—literally, ‘writing about suffering’).<sup>3,11</sup> Increasingly, universities are also publishing journals devoted wholly to the medical humanities.<sup>17</sup> Not to mention the books written by doctors, by patients or their relatives, even by students. One of these, *On Doctoring*—an anthology of medical literature—was distributed through the Robert Wood Foundation to all incoming medical students in the United States between 1995 and 1998.<sup>11</sup>

In all of these creative ways, then, the study of the medical humanities in medical schools and hospitals is helping to promote the humanization of medicine, bridging the gap between knowing the facts about disease and understanding the patient’s experience of illness, training

doctors in the art of medicine so that they have a more holistic view of the patient.

### 3. Medical Humanities in Japan

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What about the place of the medical humanities in Japan’s medical schools? Nakamura and Ashida reported on a course they taught using English literature to encourage students to think about medicine from the psychospiritual aspect.<sup>19</sup> In that paper, they also reported on the large number of medical humanities syllabi posted on the Internet by US and UK medical schools. In contrast, they found no such information from the Internet postings of Japanese medical schools, a finding which seems to support their observation that the “psychospiritual aspect ... is currently deficient in the medical and nursing schools in Japan.” Indeed, in my own experience, I have yet to meet a Japanese physician or student who understands the term ‘medical humanities’ in English upon first mention.

### 4. Teaching Medical Humanities to Japanese Students through EMP Classes

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English-for-medical-purposes (EMP) teachers in Japan have a tremendous opportunity, then, to fill this neglected area by introducing English works from the medical humanities to their students. Not only is there an abundance of materials but since many of the materials come in the form of short stories, poems, or essays, they are of a length that is usually not too burdensome for students to read.

#### 4.1. Example of a course

In my own teaching, I use medical humanities materials in a third-year EMP discussion class. The course is a year-long elective and usually has an enrollment of seven to twelve students. It meets once a week for a 75-minute period. A typical class begins with students summarizing the story or movie assigned that week, and then proceeds with discussion of questions posed by the teacher and, sometimes, by the students themselves. As a lead in to discussion, students take turns writing up on the blackboard one word describing the emotion they were left with after reading the story/watching the movie. They then each explain why they felt that emotion before proceeding to the more specific discussion questions. Since the works often deal with real-life medical encounters, the content is immediately appealing to students

and provides many points from which to jump into discussion. Because the stories tell the experiences of ordinary people just like themselves (often the writer is a medical student or a physician describing an event from his or her student days), and not with more generalizable, esoteric debate issues (“Should euthanasia be legalized?” “Is abortion ethical?” “Should doctors always tell the truth to patients?” and so on), the impulse to discuss, to debate informally, is keener. In spite of themselves, students are using English to talk about some issue that is important to them. Besides the assigned readings or movie-viewing each week, students must keep a class journal, writing at least one page a week about the assigned reading or movie ahead of or after class. In this way, the journal helps students assemble their thoughts about the reading or movie in writing. In addition, the inclusion of the journal assignment makes this a course in which students can use all four skills of speaking, listening, reading, and writing.

#### **4.2. Examples of medical humanities materials and excerpts of student comments**

Finally, then, I will introduce some of the writings and movies that I use in my teaching and students’ journal comments about them. I will also outline some accompanying discussion questions or activities for use in and out of the classroom.

##### **4.2.1. Imelda<sup>20</sup>**

In this classic short story, physician-author Richard Selzer recalls the autocratic chief professor of plastic surgery of his student days. The professor’s secretive surgery to repair the harelip of a patient after she had died on the operating table, which the student discovers and later acts impulsively to conceal in an attempt to save his professor’s reputation, raises many questions. Just as the author struggles to understand his professor’s behavior, so too do students. Was it arrogant pride that drove the professor to commit this “unrealistic” act, or was it a sincere commitment to fulfill his duty to his patient even after her death? The story offers no easy answers, and students are reminded of the mysteries of the human heart and also of the burden of responsibility that is at the core of every physician’s work. During discussion, students’ opinions of the professor’s behavior vary widely, perhaps explaining why they consistently rate this as one of the best stories of the course.

Student journal comment: “What doctors treat every day, is life. And so heavy it is, no more can doctors bear

the burden sometimes. There is also one doctor-author in Japan, Keishi Nagi. He used to treat cancer patients in end-stage, and however he tried, he could not save many lives. He was very diligent and dedicated him to his work everyday, but gradually he was lost and he got depression in the end. Only by writing novels, he seemed to be getting over a little. When thinking about him, and reading this masterpiece Imelda, I cannot help thinking how difficult it is for doctors to keep balance between always being humane and sensitive to people’s pain, and still bearing that heavy task. I think that is one of the doctors’ deepest agonies which exists in every country, every period.”

##### **4.2.2. Intensive Care<sup>21</sup>**

The author of this short story recounts her residency on the ICU of Bellevue Hospital and how it was colored, for good or for bad, by a one-of-a-kind, larger-than-life attending physician. The shock of his subsequent suicide leads her to remark that medicine is “a dangerous profession,” inevitably overwhelming physicians at times with its constant barrage of physical and emotional challenges. Faced with a medical community that has little patience for those who do admit to needing support, most physicians have no choice but to suffer in silence, thus denying themselves the “intensive care” they would so readily give their own patients.

Student journal comment: “As the author pointed out, the doctor is really challenging jobs, not only academically, but rather psychologically. We at some point have to face our powerlessness and accept that we cannot always cure patients. And even we know that we are not omnipotent, we have to strive to treat patients as much as we can. I think that what is important in this kind of situation is to never forget the goals we have set before one enters the medical school. If one’s will is strong enough, I think he or she somehow survives through obstacles of life.”

##### **4.2.3. First Do No Harm<sup>22</sup>**

This movie depicts the harm that results when physicians insist on uncertain scientific methods over known unscientific methods to treat their patient, thereby violating the fundamental ethical principle of its title. The patient, 4-year-old Robbie, has epilepsy. But when the movie opens, Robbie has yet to suffer his first epileptic seizure. We see a normal, healthy little boy who enjoys a happy home life with his parents and two older siblings. Their life is turned upside down when he suffers two epileptic seizures but does not respond to conventional

medications. As his doctors struggle to find a way to control his epilepsy and deal with the severe side effects of one ineffective epilepsy drug after the other, we see the condition of this once happy-go-lucky child deteriorate to that of a zombie-like state. We witness, also, the toll Robbie's illness exacts on this once close-knit family as they deal with the physical and emotional pressures of caring for him and at the same time face financial ruin from the debts incurred paying for his medical fees. In the end, the only treatment option the doctors can offer is brain surgery and with that the risk of probable brain damage and even of death. Refusing to accept that nothing else can be done, Robbie's mother (played by Meryl Streep) decides to conduct her own research into epilepsy and in doing so, learns about the ketogenic diet. Pioneered by the Johns Hopkins University Hospital in the 1920s, the treatment consists of two to three years of a rigidly controlled diet of fat-based foods and has a complete recovery rate of one in three patients. Despite fierce opposition from Robbie's chief physician, who derides the evidence for the ketogenic diet as "anecdotal," Robbie's mother manages to have him discharged from the hospital so that she can fly with him to Baltimore and to Johns Hopkins, where the therapeutic effects of the diet are immediately evident in Robbie, eventually leading to his complete recovery.

This is a very popular movie with students. Discussion topics include what ethical principles Robbie's physicians violated, and why they did so. Students can also respond to the comment of a retired physician in the movie that "so many in our profession choose not to look beyond drugs and surgery" or to Meryl Streep's character's complaint, "What could have gone so terribly wrong with this medical system? We gave them our son, our trust, damn near our home. Instead of giving us the simplest information, they abused Robbie and almost destroyed us all." In addition, as a pre-viewing task, students may investigate epilepsy and report their findings in class. As a broader activity, students may investigate a therapy from alternative medicine and report it in class.

Student journal comment: "I couldn't leave my eyes from the screen during the movie. ... The problem I felt in this movie was the attitude doctors took towards patients. They must have cold blood! Why can't they encourage patients or their family? Why don't they respect family's will? I felt sad at that point. ... I thought it would be difficult to see children with serious diseases not getting better, having terrible episodes, suffering from diseases or medication. Am I able to stand such

tragedies? But if I want to be a doctor, I must endure sad scenes and keep encouraging patients."

#### 4.2.4. Miss Evers' Boys<sup>23</sup>

This movie examines the Tuskegee Syphilis Study, which took place in the region around Tuskegee, Alabama between 1932 and 1972. For much of that period, the experiment's objective was to study the course of untreated syphilis in its research subjects—600 black, largely illiterate, male sharecroppers. The movie's opening titles describe the experiment as "arguably the most infamous biological research study in US history." Infamous because the subjects were not informed of the real purpose of the study; rather, they were deceived into believing that the liniment rubs and vitamins that they were receiving were treatment for their "bad blood." Infamous, too, because despite the discovery of penicillin as a cure for syphilis in 1947, the subjects were left uninformed and untreated until 1972 when a newspaper leak finally put an end to the experiment. By that time, only 127 out of the original 400 non-control subjects were still living.

The 'Miss Evers' of the title refers to Eunice Evers, a black nurse who participated as a member of the study's medical staff throughout its 40 years, aware of its true nature, but concealing it from her patients ('Miss Evers' Boys'). The movie's structure is intertwined around flashback scenes depicting the circumstances and characters of the experiment as it unfolds over the years and scenes in which a now elderly Miss Evers faces a government investigatory committee to answer questions about her role and responsibility in the affair.

Students find this movie gripping both to watch and to discuss. It offers plenty of scope for activity both in and out of class. As a pre-viewing activity, students can research and then report in class about the historical facts of the Tuskegee Experiment as well as about syphilis. Concerning the story, students can discuss Miss Evers' motivations for staying with a project that violated the medical ethical principles of non-maleficence ('First, do no harm'), autonomy (the right of patients to be correctly informed about their illness and to make their own choices about treatment), and faithfulness (the duty of doctors to preserve the bond of trust with patients by not lying to them). Patients can discuss Miss Evers' sincerity when she declared before the court, "If the study weren't done, they [the patients] would have got no care at all!" and later, "They were susceptible to kindness. I loved those men. I gave them everything I had."

Student journal comment: “I absolutely can’t forgive that they didn’t give patients chances to have penicillin. ... I think if she [Miss Evers] was caring her patients from the bottom of her heart, she could do something! If the system she belonged to was wrong, her guiltiness would grow hard as she tried to hide it. It’s awful that she stand her job for 40 years. I heard from this experiment, poor black people won’t accept treatment for HIV and cause many death by AIDS. The tragedy is continuing even now.”

#### 4.2.5. *Wit*<sup>24</sup>

*Wit* is a movie based on the Pulitzer-prize winning play by Margaret Edson. Its main character, Vivian Bearing, is a professor of English literature specializing in the poetry of John Donne. Strict and uncompromising, she has the respect of her colleagues and students but little else in the way of warm, meaningful relations with them, or indeed with anyone. The movie opens with a scene in which Vivian’s physician is telling her that she has stage IV metastatic ovarian cancer. He recommends an experimental form of treatment involving very strong doses of chemotherapy. Vivian agrees to the treatment and in doing so, must go from being the one in charge to being totally dependent on her doctors and the medical staff. Now, we follow her as she surrenders herself to the indignities of hospital life and as she suffers the agonies of an increasingly aggressive chemotherapy, which, she comes to realize, is not curing her in spite of everything. As she confronts her death, she reviews her life and sees her rigid pursuit of knowledge and heartless treatment of her students and those around her as a reflection of the cold, impersonal treatment of her now by her own doctors, for whom she represents a fascinating case for research rather than a very ill, very scared patient. Her lifelong confidence that knowledge was all that counts shatters as she admits to herself that knowledge is of no use to her now. Instead, what she really needs is a human touch, the simplicity of kindness. Admitting this, the walls of her pride and self-reliance come tumbling down, and she can finally open herself up to the kindness of that human touch, extended to her by one of the nurses. Reconnected with her humanity, she is no longer alone in her suffering and can meet death with peace and dignity.

This is a difficult movie for students. Vivian’s philosophical musings as she ponders the meaning of her life, all the while quoting from the poetry of John Donne make for very challenging listening for Japanese stu-

dents, so a subtitled or captioned version of the movie is essential. That said, whilst student discussion may not extend to identifying Vivian’s experience of terminal cancer as a “journey to grace,”<sup>25</sup> the movie does offer plenty of opportunity for students to discuss Vivian’s experience of medical care—the indignities inflicted on patients (Vivian’s undergoing a pelvic exam by a former male student of hers, for one), the officiousness of a mechanical and uncaring medical staff, the coldness of her physician and his subordinates for whom she is just a case and bedside manner little more than an afterthought. Students comment on the “beauty” of this movie’s depiction of a woman confronting her own death, and thus appreciate the delicate work of art that it is. In spite of the challenges posed in terms of language and thematic content, it is a worthwhile movie to share with students.

Student journal comment: “It is said when we’re medical student, we’re sensitive to patients’ mind, but many students forget that mind becoming doctor. I really don’t want to be like the doctors [in the movie], especially the young doctor. I think he should be a researcher rather. Medical staff should be who can care patients’ mind as well. To be such a doctor, I won’t forget anger I felt when I watched the rudeness [of the medical staff] in the movie. I got angry when he tried to revive her although she’s in DNR.”

The other works studied in the course are two collections of essays, *Kitchen Table Wisdom*<sup>26</sup> and *The Soul of a Doctor*,<sup>27</sup> and the movies *The Motorcycle Diaries*<sup>28</sup> and *The Sea Inside*.<sup>29</sup>

## 5. Conclusion

In US medical schools, the medical humanities, in particular literature, are increasingly recognized as important in developing students’ human faculty so that they can become skilled in the art of medicine. In Japan, medical curricula give less attention to the medical humanities. EMP discussion classes can be the place to introduce Japanese medical students to English medical humanities. Teachers can draw from the many resources available to design courses that develop all four English skills of reading, writing, speaking, and listening. Whilst improving their English skills, students also reflect on the human dimensions of clinical practice. Thus, such a course contributes to developing students’ human faculty so that they can become physicians who serve their patients not only by their knowledge of science and technique but also by their skills in the art of medicine.

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# コア・カリキュラムとリンクした医学英語教育 *Cecil Textbook of Medicine* による英語教員と医学教員との チーム・ティーチング

## Medical English Education Coordinated with the Core Medical Curriculum: Team Teaching between English and Medical Faculty Using *Cecil Textbook of Medicine*

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**Background.** Although the instrumental importance of English is generally well understood in the field of medicine, English education is disproportionately concentrated in the first two years at most medical schools in Japan. Because such English courses are generally not coordinated with content-area courses, students tend to be left with unrelated and quickly forgotten facts and technical terms. In order to develop students' academic proficiency in English, English education needs to be integrated into the core medical curriculum.

**Objective.** The present article proposes the idea of integrating English and medical education in the advanced years of medical schools in Japan.

**Methods.** The Faculty of Medical Sciences at the University of Fukui introduced team teaching between English and medical faculty into one of its advanced English courses. Using *Cecil Textbook of Medicine*, the students learned in English the content-area material concurrently studied in the core medical curriculum.

**Results.** The students gained proficiency in both English literacy and content-area knowledge. They also reported high level of satisfaction with the course.

**Conclusion.** These results demonstrate the benefits of integrating English and medical education. This finding has pedagogical bearing on curriculum planning, materials development, and course content.

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**Key Words:** team teaching, English for specific purposes, *Cecil Textbook of Medicine*

### 1. 序

平成3年の大学設置基準の大綱化により一般教育と専門教育の区別規定が取り払われた結果、多くの大学で専門教育を充実させるという名目で英語を含む教養科目の単位数を削減する傾向が一般化している。全国の医学部において

も英語教育の実質時間数が減少するとともに、低学年への傾斜が強まっている。医学における英語の重要性や英語の6年間一貫教育を唱える声もあるが、現実には英語教育を早く終え、専門教育を早期から始めようとする趨勢になっている。本学医学部が平成10年に全国14医科大学に対して行ったアンケート調査<sup>1</sup>によると、必修の教養英語単位数の平均は6.48単位であり、大学設置基準で英語8単位必修であった大綱化前と比べ1.52単位減少しており、しかもこれらの科目の63%が1年次に集中していた。選択単位を含めると、大綱化以前の14大学における教養英語の最大習得可能単位数は平均14.7単位であったが、大綱化以降は同7.88単位に減少している。また、「カリキュラム上「医学英語」を銘打った必修科目を2年次以降に開講している大学が6大学あったが、履修すべき時間数は平均わずか35.2時間

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(大綱化前の単位に換算して1.56単位)であり、担当者も半数が外部講師であった。

以上のように、我が国における医学部英語教育は、教養英語の縮小と中途半端な専門英語(医学英語)の導入とに特徴づけられており、世界で活躍しうる人材の育成という観点からも極めて不十分と言わざるを得ない。このような問題意識を受け、本学医学部では、英語科目の1年次から4年次までの継続履修を可能とする新カリキュラムを平成15年に導入した。具体的には、1年次から2年次前期にかけて「話す・聞く・書く・読む」の4技能を強化し、2年次後期以降は英語教員と専門教員が協力する形で医学書の読解や症例報告・医療面接の訓練等を行っている。

進展する国際化の中で医学における英語の重要性はますます高まっている。英語を1・2年次生に対する単なる教養科目に終わらせず、3年次以降も継続させることの意義については、多くの医学関係者が認めるところであろう。一方で、医学教育モデル・コア・カリキュラム(コアカリ)導入や教員人件費削減の流れの中で、教員の負担は確実に増している。医学英語教育の充実を謳うのであれば、その効率のかつ効果的な教育法の確立は急務である。本稿では、そのような教育法を探る試みとして、筆者が昨年より3年次後期に実施している英文医学書読解の授業(必修科目・受講生100名)を紹介する。英文医学書の読解は医学英語学習の基本であり、授業の実施も比較的容易である。多くの大学において実現可能な教育モデルを提示することにより、今後の医学英語教育を展望する手掛かりを提供したい。

## 2. 方法

### 2.1 教材と授業日程

教材選択の上で、最も重要な点は専門科目との関連性である。3年次を迎えた医学生にとって、医学(あるいは国家試験)と直接関わらない英語科目は、言わば「余分な」科目である。英語の重要性は認識しつつも、専門科目の勉強が忙しい中、英語の勉強は必然的に後回しとなる。モチベーションもなかなか高まらない。そこで我々は、リーディングの教材を専門科目の内容とできる限り関連づける方策を実施することにした。具体的には、教材の内容を同時期に開講されている専門科目のそれと一致させたのである。3年次後期には、コアカリのC項目に相当する科目群が配当されている。我々は授業開講を前に担当者(後述)を集めた会議を開き、まず定評のある医学書でありコアカリC項目の内容を網羅している *Cecil Textbook of Medicine* (22nd ed.)<sup>2</sup> を教材として選定した(*Harrison's Principles of Internal Medicine*<sup>3</sup>も候補に挙がったが、翻訳が出ているということで採用は見送られた)。次に、コアカリの時間割を参照しつつ、各週におけるテーマを決定していった。授業の全15週における内容は、下記の通りである。

第1週	ガイダンス
第2週	ゲスト・スピーカーによる講演
第3～4週	Atherosclerosis(「コアカリ」循環器系)に対応)
第5～6週	Sarcoidosis(「コアカリ」呼吸器系)に対応)
第7～8週	Pancreatitis(「コアカリ」消化器系)に対応)
第9週	中間テスト
第10～11週	Glomerular Disorders(「コアカリ」腎・尿路系)に対応)
第12～14週	Diabetes Mellitus(「コアカリ」内分泌・栄養・代謝系)に対応)
第15週	期末テスト

学生の関心を引くテーマを教材として選択することは、英文読解の授業では従来から行われてきた。今回の授業ではそれを更に一歩進め、専門科目で学んだ内容を、英語の授業でもう1度学び直すという方式を採った。既に1度学んでいる内容なので、学生は英文を比較的容易に読み進めることができる。また、英語の授業が専門科目の復習ともなるので、学生は英語力を強化しつつ専門事項の理解を深めることができる。学生による授業評価を見る限り、彼らのモチベーションを上げようとした我々の試みは成功したようである(授業評価の詳細は後述)。

### 2.2 担当教員および事前の準備

本授業は高度な専門知識を必要とするので、基本的に医学専門の教員による担当が前提となる。藤枝<sup>1</sup>によれば、「専門医学英語の教育は専門医学の教員(チーム)の担当が望ましい。医学の専門的知識のない教養教育の英語教員は分を弁えるべき」とのことである。教員の負担を考えた場合、テーマごとに担当者を変えるというのが現実的な方策となる。一方で、これは英語の授業であり、英語を教えることに慣れていない医学教員が不安を感じることも十分考えられる。具体的な教育方法を提示・説明し、彼らの疑問や不安を払拭させることは英語教員の重要な役割である。

本授業では、病理学講座の先生方に協力を依頼した(1テーマを1教員が担当)。互いの情報交換を密にするために同一講座に依頼したものであるが、別の方法も可能であろう。授業前の準備・打ち合わせは極めて重要である。手順としては、まず筆者が1週分の課題文(3ページ程度)を読み、重要と思われる事項に対する学生の理解度を問う英語の設問およびその模範解答を10組程度作成する。医学書等で専門知識を補いながらの作業となるため、この部分で最低2時間は必要となる。次にそれを担当の医学教員に見てもらい、医学的見地から修正を加える。不必要と判断された設問は削除され、見落とされていた重要事項があればその時点で設問と解答を新たに作成する。この部分に要する時間は毎回30分程度である。完成した設問は宿題として課題文のコピーと共に配布し、学生には授業で各自の解答を発表

させる。なお、発表の際、ほとんどの学生が発音の誤りを犯す。発音の矯正は、英語の授業の大きな目的の1つであるため、医学教員は、設問および模範解答の正確な発音(およびイントネーション)を事前に英語教員と十分確認しておく必要がある(この点については、発音機能のついた電子辞書の活用も一案である)。また、*Cecil Textbook of Medicine*には表面的な記述が多い。学生のより深い理解を促すための資料は、医学教員の責任で準備することになる。

### 2.3 授業の形式

まず、sarcoidosisの授業で実際に使用した設問と模範解答を表1に示す(*Cecil Textbook of Medicine*, pp. 549–551に対応)。なお、学生は設問部分のみを宿題として配布される。

これらの設問は課題文の重要事項の理解をその記述順に問うものである。設問に解答することにより、学生は課題文をただ漫然と読むのではなく、その重要部分を効果的・集中的に学習することができる。また、解答を英語で作成することで、作文力・要約力の訓練が可能となる。更に本

授業では、設問および解答を正しく読み上げる練習を自宅で行うことを学生に課している。医学用語の発音に少しでも慣れてもらうのがその目的である。

実際の授業では、まず筆者が10分ほど単語テスト(配布済みの単語リストから筆者が英語で10語を読み上げ、学生は和訳を解答用紙に記入する)を行った後、医学教員と交代する。医学教員は、設問ごとに1~2名学生を指名し、設問と解答の読み上げおよびそれらの和訳を行わせる。発音や解答に誤りがあればその都度指摘し、最後に模範解答の提示(PowerPointによる)とその和訳および医学的な解説を行う。参考資料は適宜使用する(図1にsarcoidosisの授業で使用した資料の一部を示す)。通常、授業開始後70分程度で解答の解説がすべて終了する。その後、筆者が再び教壇に立ち、語学的観点から必要な指導(主に和訳に際しての文法的な説明)を10分程度行う。なお、医学の非専門家として講義中に難解に感じた箇所があれば、この機会に医学教員に必ず確認し、学生の理解を促進するよう心がけている。授業の最後に、次週の課題文および宿題を配布し、解

表1 授業で使用する設問および模範解答(sarcoidosis)

Q1: How is calcium metabolism altered in patients with sarcoidosis?	A1: Macrophages within granulomas produce calcitriol, which results in increased calcium absorption from the intestine, leading to hypercalciuria with or without hypercalcemia.
Q2: How is the level of ACE increased in patients with sarcoidosis?	A2: ACE is produced by epithelioid cells and macrophages within granulomas in addition to that normally found in the lung.
Q3: How is the diagnosis of sarcoidosis confirmed?	A3: By the finding of well-formed noncaseating granulomas in one or more affected organ systems or tissues, with appropriate additional studies to exclude other causes of granulomas.
Q4: In what circumstances is an invasive procedure for diagnosis deemed unnecessary?	A4: When a patient has asymptomatic bilateral hilar lymphadenopathy.
Q5: What are the characteristic features of sarcoidosis seen on a chest radiograph?	A5: They are lymphadenopathy, usually involving both hila in a relatively symmetrical fashion as well as the right paratracheal region, and involvement of the pulmonary parenchyma.
Q6: In what circumstances is CT generally recommended?	A6: When the findings on plain chest radiography are atypical or if there is a need for better definition of mediastinal lymph node involvement.
Q7: What are the most common sites of diagnostic biopsy in sarcoidosis?	A7: They are the pulmonary parenchyma, intrathoracic lymph nodes, and skin.
Q8: What are the three methods of biopsy of the pulmonary parenchyma?	A8: They are transbronchial lung biopsy, endobronchial biopsy, and bronchoalveolar lavage.
Q9: What conditions obligate immediate therapy?	A9: When there is significant ocular, myocardial, or neurologic involvement.
Q10: For what purpose are corticosteroids used?	A10: To acutely suppress the manifestations of sarcoidosis.
Q11: How good is the prognosis of sarcoidosis?	A11: Approximately two thirds of patients experience resolution of their disease, whereas 10 to 30% have chronic or progressive course.

答の際の注意事項を伝達する。

本授業における医学教員の役割は、基本的に模範解答の提示と医学的解説のみである。負担は通常の講義に比べて軽く、発音に少々不安のある教員でも、発音の指導を英語教員に任せるなどすれば十分対応が可能である。また、医学教員から見た英語の重要性や学習のコツ、苦労話などを交えれば、学生に貴重な示唆を与えることもできよう。本授業を担当した教員は皆、英語の授業に新たなやりがいを感じたとのことであり、反応は一様に好意的であった。

## 2.4 試験問題

試験は、中間試験および期末試験の2回である。出題および評価は筆者が行う。出題内容は、課題文の穴埋め問題 (cloze test)、学習済みの設問に英語で解答する問題、和訳した設問に日本語で解答する問題、およびその他の問題と多岐にわたる。なお、課題文は資料として試験時にコピーを配布する。

穴埋め問題の目的は、試験前に課題文全体に再度目を通すことを学生に促すためである。試験範囲は15ページ程にもなるので、あまり細かい事項を問う問題は避けるべきであろう。学生の負担を考え、事前に試験範囲を限定しておくことも一案である。

設問に英語で答える課題は既に授業で1度実施されている。試験では、資料の抜き書きではなく、要約の力を試す問題を選んで出題している。

和訳した設問に日本語で解答させる問題には、日本語による記述の精度により学生の真の理解度を判断する目的がある(英文資料の参照が可能なので、英語による解答のみで学生の理解度を判断することは難しい)。英文の医学書で得た知識を日本語で正確に記述することは医学生にとって不可欠な能力であり、それは十分な内容理解が伴って初めて可能となるのである。なお、課題文を参照せずに解答できるようになれば更に望ましいが、学生の負担を考慮し、そ

のような試みは行っていない。表2に中間試験の設問と模範解答を示す(穴埋め問題は省略)。

## 2.5 評価法

評価の割合は、単語テストと宿題が合計で30%、中間テストと期末テストがそれぞれ35%ずつである。宿題の量は膨大なので、評価は、未提出が0点、不可が1点、可が2点の3段階としている。他人の宿題をそのまま写して提出している学生もいると思われるが、結局宿題を理解しなければ定期試験に合格することはできないので、その旨を授業で指摘するだけにとどめている。最終的に60%を下回った学生は再試験となるが、昨年度は医学教員が英語を初めて教えるということで教員・学生双方に緊張感があったためか、再試験該当者は皆無であった。

## 3. 結果

### 3.1 学生による評価

本授業に対する昨年度の学生評価(5点満点)は、講義内容に関しては平均4.12点(医学科全開講科目平均4.10点)、教材に関しては平均4.03点(同4.00点)であった。なお、同年度前期に医学関連の英文記事を教材とする医学英語クラスが2年次生を対象に開講されたが、同科目の学生評価は講義内容が平均3.74点、教材が同3.64点であった。同じ英文読解クラスでありながら、前者の評価が後者を大きく上回っているのは、前者の授業内容が専門科目と密接に結びついてきたためであると思われる。授業評価の自由記述欄に記された多くの意見も、この見方を裏付けるものであった。その代表的なものを下に示す。

- ・医学系の授業で学んだことを英語でやるので、英語力もつくし、授業内容も復習できるしで良い取り組みだと思いました。
- ・ちょうど今コアカリで同じ内容の勉強をしているので、

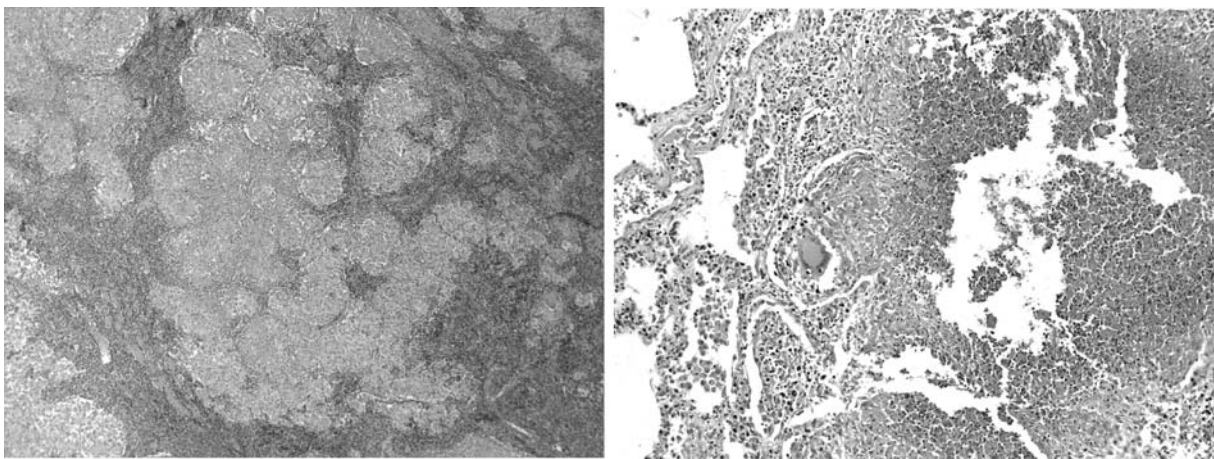


図1 サルコイドーシス(左)と結核(右)の病理組織像(福井大学医学部腫瘍病理学領域 法木左近准教授 提供)

サルコイドーシスには、その特徴である非乾酪性肉芽腫が顕著に見られる。



理解を深めたり、切り口の違うところからの勉強としてとても参考になりました。

- ・昨年までの英語と違い、今の講義に沿った内容なので高いモチベーションで臨むことができた。

### 3.2 問題点

本授業の最大の問題は、受講生が 100 人を数え、語学のクラスの特徴であるきめの細かい指導が難しいという点であろう。宿題を添削して返却したり、学生の多くが何らか

の発言・発表の機会を持れば教育効果も更に高まるであろうが、その実現は現状では困難である。

また、医学書には事実を淡々と記述する傾向があり、複雑な構文やひねった表現が使用されることはほとんどない。英文医学書の読解が、語学的に高度な読解力の涵養に必ずしもつながるものでないことは認識しておくべきであろう。

更に、設問への解答をメインとする授業は単調になりがちである。興味深い資料やエピソードを織り込むなど、学生の関心を引きつける努力が教員には要求される。

表 2 中間試験の設問および模範解答

Q1: LDL はある名称の省略形である。元の名称を英語で記しなさい。
A1: low density lipoprotein
Q2: In diabetic patients, what substances promote the development of atheromas or plaques and how?
A2: Various glycosylated proteins and local growth factors can stimulate the proliferation of the fibromuscular component of the mature atherosclerotic plaque. And so-called subclass B form of LDL has markedly enhanced atherogenicity.
Q3: 安定狭心症がどのように引き起こされるのかを説明しなさい。
A3: 安定狭心症は、心筋における酸素需要が増大し、狭窄した冠動脈の酸素供給能力を上回った場合に引き起こされる。
Q4: How is calcium metabolism altered in patients with sarcoidosis?
A4: Macrophages within granulomas produce calcitriol, which results in increased calcium absorption from the intestine, leading to hypercalciuria with or without hypercalcemia.
Q5: "production of the enzyme by epithelioid cells and macrophages within the granulomas (Biochemical Changes の項の第 2 パラグラフ)"の the enzyme が指している語(句)を記しなさい。
A5: ACE もしくは angiotensin-converting enzyme
Q6: 無症候性両側肺門部リンパ節腫脹の患者さんに侵襲的手法による診断を試みる必要性が低い理由を記しなさい。
A6: その患者さんがサルコイドーシスであることはほぼ確実であり、侵襲的手法のリスクやコストを考えるとその必要性は低いといえる。
Q7: Sarcoidosis の診断に CT を用いるべき状況を 2 つ挙げなさい。
A7: 1. 単純胸部 X 線写真による所見が非定型の場合 2. 縦隔リンパ節の病変をより高い解像度で撮影する必要がある場合
Q8: List two types of genetic defect that may cause familial pancreatitis.
A8: 1. an arginine-histidine substitution at 7q35 2. mutations in the pancreatic trypsin inhibitor gene
Q9: Describe the relationship between cathepsin B, trypsin, and acute pancreatitis.
A9: Cathepsin B activates the conversion of trypsinogen to trypsin, which then catalyzes the conversion of many proenzymes to their active forms, causing major systemic complications of acute pancreatitis.
Q10: 高トリグリセリド血症のある急性膵炎の患者さんを診断する際に注意すべきこととその理由を記しなさい。
A10: 高トリグリセリド血症によって見かけ上低下している血清アミラーゼ値を正確に測定するために、血清を希釈する必要がある。
Q11: Table 145-1 を参考にして、急性膵炎の診断に、血清アミラーゼ値よりも血清リパーゼ値の方が有用である理由を記しなさい。
A11: 血清アミラーゼ値はマクロアミラーゼ血症や耳下腺炎の際にも上昇するが、血清リパーゼ値は正常値を保つ。

## 4. 結論

本授業に対する学生評価(5点満点)は平均で4点を上回っており、今回の試みが学生に好意的に受け止められたものと解釈できる。定評のある医学書を、コアカリ科目とリンクさせながら読み進めることにより、学生は、医学の知識を更に深めると共に、英語文献読解における貴重な自信を得たようである。また、当該取組を通じて、英語教員と医学教員が協力して英語科目を担当するノウハウをある程度確立できたものと考えている。英語の学習は、継続して行うことが極めて重要である。本稿が、3年次以降の専門医学英語教育を実施する上で、多くの大学の参考となることを願っている。

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# A Crucial Element in Health-Care English Conversation

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The present piece outlines a simple method for improving the efficiency and effectiveness of patient/staff communication in English. The method involves addition of certain phrases, words, and interjections to staff members' questions and statements which will convey politeness, friendliness, and reassurance to the patient. By doing so, it is believed that a greater degree of trust and willingness to cooperate on the part of the patient will result, both essential elements in medical communication. Examples are provided of ways in which typical patient/staff dialogs could be dramatically improved by implementation of the method. Suggestions for teaching the method in medical English classes are also given.

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**Key Words:** medical English conversation, foreign patients, medical communication skills

## 1. Introduction

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Correct grammar and vocabulary usage are important for effectively communicating in English with foreign patients. However, perfect sentences alone will not guarantee success. As with Japanese patients, it is also very important to maximize the level of patient cooperation in the communication process. This can only be achieved by keeping patients as calm and as comfortable as possible, and gaining their trust. This brief paper introduces a simple verbal technique for dealing with this difficult challenge in English, with examples of how it might be used on the job, as well as how it might be taught in medical English classes.

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## 2. Basic Concept and Key Language Patterns

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At certain points in conversations, phrases are added which clearly and strongly send messages of politeness/friendliness/reassurance to patients and/or family members. Some of the most common of these phrases for each category are:

### 2.1 Politeness

"I'm sorry to have to ask you this, but..."  
"It's a bit hard to talk about this, (I know,) but..."  
"Sorry if this makes you uncomfortable, but..."  
"I know this must be embarrassing for you, but..."  
"Pardon my directness here, but..."  
"I just need to know something:..."

### 2.2 Friendliness

#### 2.2.1 Explaining Procedures and/or their Results

"So, here's the way (or:the low-down on how) we do this:..."  
"Now, why we do that is,..."  
"You see, it's like this:..."  
"You know how...? Well, that's kinda like what this is!"  
"Have you ever...? This is the same basic idea."  
"Now here's what I'm just gonna do:..."  
"Just wanna check a little thing here, that's..."  
"Now, I gotta tell you that..."



### 2.2.2 Making Requests

- “It’d be a great help if you’d just ...”
- “How’s about just ...-ing for me now?”
- “Be a sport (or:dear) and just ... for me, would you please?”
- “You wouldn’t mind just ...-ing for me, would you?”
- “Help me out here and just ..., would you please? Great!”
- “Now, I’m gonna have to ask you to just ..., OK?”

### 2.2.3 “All-purpose” interjections/descriptive terms

- “(a) little”
- “just”
- “kinda (like) X”
- “this (ol’) X here”

## 2.3 Reassurance

- “It’s not so ..., really!”
- “It’s nothing to ..., believe me!”
- “Now don’t let it ...you, it’s no big deal!”
- “It’ll be over ...”
- “Then you’re all done! Nothing to it!”
- “Now that wasn’t so bad, was it? Nothing more than a ...!”

## 3. Examples of Use

### 3.1 “Politeness” Phrases

Expression of politeness is particularly important when the subject of discussion is “delicate”—meaning in practice anything related to excretion, sexual organs or activities, and body odors. It is even more important if members of the opposite sex are involved in the discussion (a classic example being a male gynecologist talking to a patient from a country which is very conservative in terms of attitudes towards male/female interaction, or an open discussion of reproductive organs).

Here is an example of the kind of discussion in which the above phrases could greatly improve communication by softening the impact of embarrassing questions. It is excerpted from the textbook *医師のための診療英会話/English for Doctors* (メジカルビュー社, 2002, p. 153):

[ *patient’s responses in original omitted* ]

Do you have regular bowel movements?

When you say you have diarrhea, do you mean the stool is very loose, or that you have to go to the toilet more frequently?

When you have to go, do you have to go quickly?

Could you describe your stool?

Do you have any problems flushing it down at all?

Has there been any blood or mucus in the stool?

Is it mixed in with the stool or is it just there on the paper when you wipe yourself?

Bowel movements and similarly “extreme” topics can probably never be easy for a patient to talk about. However, adding some of the phrases in 2.1 could make the questions seem at least a little less harsh. *The result may be a greater willingness on the patient’s part to interact with the doctor and provide more detailed, accurate information.*

It’s a bit hard to talk about this, I know, but do you have regular bowel movements?

Pardon my directness here, but when you say you have diarrhea, do you mean ...?

Sorry if this makes you uncomfortable, but when you have to go, do you ...?

It’s a bit hard to talk about this, but could you describe your stool?

Sorry to have to ask you this, but do you have any problems flushing ...?

Sorry if this makes you uncomfortable, but has there been any blood or mucus ...?

Pardon my directness here, but is it mixed in with the stool or is it just there ...?

### 3.2 “Friendliness” Words/ Phrases

The purpose of using the words and phrases in 2.2 is basically the same as that of using 2.1, even if the subject matter is not particularly “delicate”: *to make the staff member’s task (whether an examination, test, or surgery) easier to perform by making the patient and/or family members as comfortable as possible.* Some of these words and phrases (such as “this ol’”) do not actually have any particular meaning by themselves, but for native speakers of English the friendly nuance is clear. In a medical situation, they can communicate to native speakers the message “We are your friends, we care about you, we will do all that we can to help you, so we want you to trust us.”

Here are some instructions in a typical physical-examination procedure, as found in *医師のための英会話フレーズ500* (メジカルビュー社, 2007, pp. 74–84):

Now let’s have a look at your eyes. Look up for me, please.

Let me check the reflexes in your arms and legs. Relax.

Please take off your shirt so I can listen to your heart and lungs.

Breathe deeply and relax. I need to take your pulse rate at rest.

Let's listen to your lungs. Breathe in and out deeply through your mouth.

The overall tone here is very businesslike: It only says "I have a lot of things to check, let's get them done!" Given the situation—the patient's body is being touched in various places—it is likely that the patient is at least a bit uncomfortable, and would probably appreciate a friendly sign, however small. Rewording the instructions as follows could provide that sign:

It'd be great if you'd just look up for me. I'm just gonna have a look at your eyes.

You wouldn't mind just letting me check the reflexes in your arms and legs, would you? How about just relaxing for me now, would you?

Be a sport [dear] and just take off your shirt. Just wanna listen to a little thing here, that's your heart and lungs.

Help me out here and just breathe deeply and relax for me, would you please? Great! Just wanna check another little thing here, that's your pulse rate at rest.

How's about just breathing in and out deeply through your mouth for me now, would you? Just wanna check a little thing here, that's your lungs.

### 3.3 "Reassurance" Phrases

The phrases in 2.3 are necessarily used in situations which would be the most stressful and fearful for a patient and/or his family, such as major surgery or a painful test procedure. If the health-care staff member does not use such phrases, there is a real possibility of a serious breakdown in communication and cooperation due to the high levels of stress and fear confusing the patient/family member's mind.

An example of such a situation which could benefit from the addition of expressions of reassurance is this general-anesthesia explanation, taken from the above-cited textbook *医師のための診療英会話/ English for Doctors* (p. 197):

We're going to give you an injection. You'll feel yourself going to sleep. I'll give you some oxygen to breathe through a mask. We are giving

you the anesthetic now. Breathe evenly through your nose. You may feel a little dizzy. Don't be worried. Have a nice sleep.

While the anesthesiologist in this example does make some effort to calm the patient, a much more reassuring version is certainly possible, such as:

So, here's the low-down on how we do this. We're just going to give you a little injection. It's nothing to be scared of, it's not so painful, really; nothing more than a pinprick! You'll feel yourself going to sleep. Now don't let it scare you, it's no big deal! I'll just give you some of this oxygen here to breathe through a mask. Have you ever tried scuba diving? This is the same basic idea! We are just giving you this ol' anesthetic now. Be a sport [dear] and just breathe evenly through your ol' nose there for me, would you please? Now, I gotta tell you that you may feel a little dizzy. Don't be worried, it's no big deal! Have a nice sleep, it'll be over in a flash!

### 3.4 Combination Example

As the anesthesia example suggests, many situations require a combination of phrases from two or more of the above categories. The following excerpt from a gynecological examination (as it appears in *外来診療のための英会話* (メジカルビュー社, 1999, pp. 50–52) is a good example of such a situation:

[*patient's part omitted*]

(2nd time the doctor speaks)

[J]just take off your clothes from the waist down.

You can put them in this wire basket here. I'll step behind this curtain while you change.

(3rd time)

Let me adjust this table now so I can get a better look. [...] Here, please put each foot into one of these stirrups. Good.

(5th time)

This may feel a bit cold. Sorry. Just relax these muscles that my fingers are touching. Good.

(7th time)

[...] I do see the yellowish discharge you were talking about. Now I'll take a sample of it to send to the lab. You may feel some slight pressure as I do that.

The 2nd time the doctor speaks, adding expressions of friendliness (and perhaps politeness) would seem most

appropriate:

I know this must be embarrassing for you, but it'd be a great help if you'd just take off your clothes from the waist down. You can just put them in this ol' wire basket here. I'll just kinda (like) step behind this ol' curtain while you change.

The 3rd time the doctor speaks, it would probably be helpful to not only maintain a friendly and polite tone, but also to add some reassurance:

What I'm just gonna do now is adjust this ol' table here so I can get a better look. Be a dear and just put each foot into one of these ol' stirrups for me, would you please? Sorry if this makes you uncomfortable, but it'll be over in a flash.

By the 5th time, the examination is in process; at such a point, the patient probably needs (or would at least greatly appreciate) continual and firm reassurance more than anything else:

Now, I gotta tell you that this may feel a bit cold. Now don't let it scare you, it's no big deal! It'll be over quicker than you can spell "encyclopedia". Help me out here and just relax these muscles that my fingers are touching, would you please? Great!

The 7th time could be improved in all 3 basic areas, given the subject matter:

It's a bit hard to talk about this, but I gotta tell you that I do see the yellowish discharge you were talking about. What I'm just gonna do now is take a sample to send off to the ol' lab. It's nothing to be freaked out by, we don't know that it's that bad yet, believe me!

#### 4. Teaching Approaches

To make effective use of the words and phrases suggested in this paper, the learner would obviously need not only memorize them, but also become thoroughly familiar with when to use them—which words/phrases would be appropriate for which situations. One efficient way for instructors to cover both of these targets would be to simply give a student a line from a medical dialogue and have him/her quickly produce a more polite/friendly/reassuring version:

[instructor]

"Breathe evenly through your nose."

[student]

"Be a sport and just breathe evenly through your ol' nose there for me, would you please?"

A key part of the challenge for the students here is that they will sometimes have to think about whether a dialogue line *definitely* needs a "polite" attachment because it concerns something that may be embarrassing to patients. The students might initially imagine, for example, that *all* obstetrics/gynecology-related discussions would require polite revision for every line, but in some cases this is in fact debatable, as these questions commonly asked in a discussion about prolapse illustrate:

"Is this lump there all the time?"

"Is the lump there after you urinate, or after you have a bowel movement, or both?"

"Are you able to push the lump back up inside?"

The 2nd line would probably be easy for the student to judge, since it refers to excretion. However, the other two lines are not so clear in terms of "delicateness": It could be said that they do not require any special revision because they do not refer directly to such things as sexual organs or activity, bodily wastes, or body odors. (The teacher might remind the students that the most obvious, "safe" approach—*always* using the polite words and phrases—could be counter-productive, since their positive impact would probably be weakened due to overuse.) In any case, the instructor should make the students explain their reasons for or against revision, which would have the double benefit of strengthening their understanding of the words and phrases they are practicing, and giving them some additional conversation practice.

Besides training students to quickly and accurately use polite/friendly/reassuring phrases and words, this teaching approach would also provide students with listening-comprehension practice covering a fairly wide range of topics (a wide range being best for thoroughly testing the students' ability, especially with regard to the "delicate/embarrassing" determination dilemma mentioned above).

A variation of this teaching approach particularly useful in larger classes would be to put students in pairs or small groups (4 or 5) and have them practice in the way outlined above without the instructor (who could move

around from group to group monitoring the practice and giving advice).

## 5. Conclusion

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The natural goal for Japanese health-care professionals when interacting with foreign patients and/or family members is smooth, accurate, and efficient communication. When English is the medium of communication, solid command of grammar and a wide-ranging vocabulary (both medical and non-medical) are of course essential. However, truly efficient and effective communication can only be ensured by taking English use to the next level: *by using the language not just as a tool for giving or*

*obtaining information, but also as a means of creating the best possible psychological environment for medical communication.* This paper has proposed a simple technique for doing so, one which focuses on making staff members' speech more polite, friendly, and reassuring as the key to winning the patient's solid trust and cooperation.

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医学・生物学研究者のための Powerful Vocabulary 3

明快な論理で綴ろう 英語論文用語集

林 皓三郎 (著), Laura C. Hooper (英文共著)

A5判, 280頁, 定価3,150円(5%税込), 2008年4月刊行, メジカルビュー社

Powerful Vocabularyシリーズ3巻目となる本書では, 英語論文を執筆するときに避けて通れない「論理表現語(リンクワード)」に焦点を絞って解説する。

「論理表現語」とはand, but, soなどの接続語の使い方, 2つの文章をつなぐ関係代名詞, さらにはカンマやピリオドを使うときのルールなど, “英語のロジック”で文章を書こうとするときに必要なボキャブラリーのことであるが, 科学論文は客観的な事実を積み上げて書かれるため, そのほとんど1文ごとに必要とされる。

日本人は(英語を話せなくても)文法とボキャブラリーだけは得意であると言われるが, 論旨をスムーズにつなげる「論理表現語」に関してはむしろ弱点になっている。いかに優れた新知見を論文に盛り込んでも, 正しいロジックで文章をつながなければ読者に正しい理解を得てもらうことはできないのは明白である。実践的な例文を豊富に収載しているので, “英語のロジック”の事典としても機能する1冊である。



VOAで学ぶ 医学英語リスニングマスター Vol.1 [CD付]

小林充尚(著)

B5判, 152頁, 定価3,570円(5%税込), 2007年9月刊行, メジカルビュー社

海外での学会発表や外国人患者の増大などで, 医師や医療従事者が英語を聞き取らなければならないケースが増えている。医学英語のリスニング能力を身に付けるためには, 「やさしく」て「よい」(適切な表現を含んだ)ネイティブの医療に関する会話を何度もくり返し聞くことがいちばんの近道である。

本書では, 適切な用語やよく使われる表現を含んでいる「VOA (Voice Of America) ニュース」から医学関連ニュース16本を厳選し, 全訳はもちろん, リスニングのポイントや一般医学用語と専門用語の対比など言い回しについての解説を随所に取り入れた, 医学英語のリスニングを強化するための書籍+CDである。

(CDには, VOAが作成した音源を, 許可を得てそのまま収録しています。)



外科研修医 熱き混沌 The Making Of A Surgeon In The 21st Century

Craig A. Miller, M.D. (著), 田中芳文(訳)

B6判, 480頁, 定価2,520円(5%税込), 2008年4月刊行, 医試薬出版株式会社

一人の外科医が誕生するまでに必要な経験とは何か? インターンからチーフレジデントを経て, 21世紀の新進外科医に成長するまでの, 臨床での葛藤を克明に描写し, 全米の読者に大きな反響を与えた注目書の邦訳版!

この1冊が医学生・研修医には, 真の臨床現場が理解できる鳥瞰図として, また, 現役と将来の医療スタッフを目指す方々や, 家族や身近に患者さんをかかえる方々には, ノンフィクションが伝える迫力で, 医療現場の一端が再認識できる好適書。



【教育講演(要旨)】

## iPod用とiTunes用のpodcastの作り方

演者

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望月葉子

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iPodはアップルから発売されている携帯プレーヤーで、音楽やビデオを楽しむだけでなく、英語などの学習にも用いられる。英会話やTOEIC TESTに関する教材は数多く発売されており、アマゾンなどから購入できる。iPodを用いると、英語などを耳から学習でき、電車の中でモバイル学習をしたり、昼休みにスキマ学習をすると、時間を有効に使える。

podcastを使うと無料で英語圏のニュース番組などをダウンロードでき、iPodで英語漬けの日々を送ることもできる。ネイティブスピーカーによる発音や会話を、無料でダウンロードできるインターネットのサイトも数多くある。英語タウンポッドキャスト、MediEigo、MedicineNetなどには、podcast libraryがある。

podcastは英語だけでなく、最新ジャーナルの情報収集や動画コンテンツの配信にも活用できる。*New England Journal of Medicine*、*Nature*、*Science*などの雑誌は、podcastで聴くことができる。American Heart Association、Society of Critical Care Medicine、Regenerative Medicine Today、Cleveland Clinic、Mayo Clinicなどは、podcastを配信している。

学生や一般人が無料で大学の講義を、いつでもどこでも何度でも見られるようにしたのが、iTunes Uである。iTunes Storeからpodcastをダウンロードできるようになっており、米国のトップ500の大学の半数以上がiTunes Uに参加している。Stanford on iTunes U、テネシー大学UT Internal Medicineなどは、医学に関するpodcastも配信して

いる。日本では久留米大学がpod academyを開校している。

iPod touchは480×320、iPod nanoとiPod classicは320×240の解像度であるが、iPodはテレビにつないで見ることができ、その場合は640×480の解像度を使える。

パソコンでpodcastを見ることもでき、その場合はiTunesというソフトを用いるのが普通である。iTunesではiPodで見られるpodcastはすべて見られ、iPodでは見られないようなハイビジョン映像も見ることができる。それ故、ハイビジョン映像を見たい場合は、パソコンのiTunesで見るか、パソコンからアップルTVを介してハイビジョンテレビで見ることになる。

podcastには音声だけのものと、ビデオpodcastがある。音声だけのpodcastは、GarageBandというソフトを用いると簡単に作れる。ビデオpodcastはiMovieまたはFinal Cut Proというソフトを用いると簡単に作れる。出来上がったpodcastはiTunes Storeに申請し、診査に通ると世界中からダウンロードできるようにしてもらえらる。iTunes Storeのpodcastはすべて無料でダウンロードできるので、教材として有用である。iTunesを持っていない人はアップルのホームページから無料でダウンロードできる。

大石実のpodcastは <http://homepage.mac.com/minoruoishi/> でiTunes用ビデオおよびiTunes用ビデオ2をクリックし、登録をクリックすると無料でダウンロードされる。「iPod用とiTunes用のpodcastの作り方」をインターネットで検索すると、今回の教育講演をビデオで見ることができる。

### 演者紹介：大石 実 氏 (おおいし・みのる)

1974年、慶應義塾大学医学部卒業。大学在学中にウィッテンバーグ大学留学、英検1級合格、日米学生会議参加。大学院を含め6年間慶應義塾大学病院で研修した後、米国で4年間臨床研修。

米国医師免許、米国神経内科専門医、米国臨床神経生理専門医(脳波専門医)、ECFMG Certificate、医学博士、日本内科学会認定医、日本内科学会専門医、日本神経学会専門医、日本てんかん学会認定医(臨床専門医)、日本医師会認定産業医、臨床修練指導医、介護支援専門員などの資格を取得。

現在、日本大学医学部神経内科准教授、日本医学英語教育学会理事。第10回日本医学英語教育学会総会(2007年)会長。





【会長講演(要旨)】

## 人名の母国語式発音

演者

大石 実

日本大学練馬光が丘病院神経内科

人名が付いた医学用語は数多くあるが、その表記は辞書によりまちまちである。人名はその人の母国語での発音に基づいて表記すべきであり、米国人の発音が常に正しい訳ではない。

Kirkは米国人なので、その発音は米国で出版されている *Stedman's Medical Dictionary* で調べればよいと思われる。*Stedman's Medical Dictionary* 28th edition で調べてみると Kirk の所には [kɪrk] と出ており、Kirk amputation を参照するようになってきている。amputation の所で Kirk amputation を見ると [kɛrk] という発音記号が出ている。同じ辞書に別の発音記号が出ているので、どちらが正しいかわからない。*Stedman's Medical Dictionary* では2カ所以上に同じ人名が出てきても、その発音記号の突き合わせとしていないと思われる。

人名のカタカナ表記をしてある日本語の辞書で、Mikulicz の発音をみると、“ミクリッツ”と出ている辞書が圧倒的に多い。『ステッドマン医学大辞典』では“ミクリッチ”と出ており、どちらが正しいかを検討した。Mikulicz はポーランド人であり、ポーランド語では cz は“チ”と発音するので、“ミクリッチ”が正しい。辞書を何冊か引き、多くの辞書に出ている方が正しいだろうと考えるのは間違っている。

そこで、*Stedman's Medical Dictionary* 28th edition に出てくる人名を母国語別に分け、その言語の標準語を話す人に e-mail を送り、人名の発音を録音してもらった。1つの言語について3人から録音した音声ファイルを添付して送り返してもらい、私がそれを聞き比べて人名のカタカナ表記をした。

3人のドイツ人の発音を並べたのを“German name pronunciation”というタイトルでインターネットに公開してあるので、検索すると出てくる。ポーランド人の発音は“Polish name pronunciation”というタイトルにしてあるので、“ミクリッツ”と“ミクリッチ”のどちらが正しいか聞き比べていただきたい。

*Stedman's Medical Dictionary* 28th edition に出てくる人名の発音記号と、『ステッドマン医学大辞典』に出てくるカタカナ表記を比較した。Brønsted は *Stedman's Medical Dictionary* 28th edition では [brɒn'sted] という発音記号が出ているが、『ステッドマン医学大辞典』では“ブレンステズ”というカタカナ表記が出ている。Brønsted はデンマーク人であり、デンマーク語では“ブレンステズ”と発音する。*Stedman's Medical Dictionary* 28th edition ではデンマーク人の名前に英語読みの発音記号を付けているので、母国語式発音ではないことがわかる。Brønsted の母国語式発音を聞きたい人は、“Danish name pronunciation”をインターネットで検索すると聞くことができる。

人名の発音は、その人の母国語での発音に近くなるようにすべきであるか、英語式に発音すべきであるかを考えてみる。日本人が米国に行き自分の名前をアルファベットで書いた場合、日本語式に発音できる米国人はほとんどいない。日本人は自分の名前が日本語での発音に近くなるようにされた方がよいのか、英語式に発音された方がよいのかを自問すべきである。ほとんどの日本人は自分の名前が日本語での発音に近くなるようにされた方がよいと思うであろう。それ故、人名の発音はその人の母国語での発音に近くなるようにすべきであり、英語式に発音すべきではないと考える。英語が世界共通語であるから、人名も英語式でよいと考える日本人は、自分の名前が英語式でどう発音されるか考えるべきである。

『ステッドマン医学大辞典』では、人名の表記はその人の母国語での発音に基づいて、カタカナ表記してある。他の医学辞典は、母国語式発音に基づいたカタカナ表記をしているのはほとんどなく、英語式が多い。これは日本人が米国人の発音はすべて正しいと勘違いしているためであり、直すべきである。

“人名の母国語式発音”とインターネットで検索すると、今回の会長講演をビデオで見ることができる。

【特別講演】

## Alienation in Contemporary Japanese Youths

演者

渡辺久子

Hisako Watanabe

慶應義塾大学医学部小児科専任講師

Assistant Professor, Department of Pediatrics

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As a child psychiatrist coping with diverse problems of children and adolescents in Japan for over 30 years, I am alerted to insidious alienation progressing in our modernized society as manifested in young patients' conflicts. For example, we rarely saw a girl suffering from anorexia nervosa 30 years ago, while now we constantly have several emaciated girls in our pediatric ward dying in relentless pursuit of thinness and appreciation from others. Only after painstaking intensive treatment can we save their lives, while we gradually come to realize their tense lonely lives having had to perform as perfect children. Anorexic girls represent family dysfunction in today's affluent Japanese society. Very often the mother is unhappy and depressed suffering from alienation from her spouse. No wonder her daughter suffers from a paralyzing sense of low self-esteem believing in such proverb as "Silence is golden," "See no evil, speak no evil, hear no evil" and "A nail that sticks out will be hammered in." In facilitating these girls for an open honest communication, the old folk tales of *Kaguyahime* (Shining Princess) and *Tsuruno Ongaeshi* (Crane's Repayment) are useful. They provide us with prototypes of Japanese women's mentality and alert us to the risk of false self and self-destruction in well-intended dedication and aspiration.

As a child psychiatrist coping with diverse problems of children and adolescents in Japan for over 30 years, I am alerted to an insidious alienation progressing in our modernized society. It is manifested in young patients' conflicts such as depression, suicidal attempts, psychosomatic disorders of all kinds, chronic fatigue syndrome, eating disorders, conduct disorders, delinquency, alcohol and drug addiction and sexual promiscuity.

From my daily practice as a child psychiatrist in the Department of Pediatrics in Keio University Hospital, I understand most of these problems in children and adolescents to be reflections of family dysfunction which is

nationwide today. By using the term family dysfunction I am referring to both manifest and hidden family dysfunction. Because of the privacy of each family, we never know from the outside, what in fact is happening inside the family relationship, especially in families with unresolved conflicts.

For example, we rarely saw a girl suffering from anorexia nervosa thirty years ago. Now we constantly have several emaciated girls in our pediatric ward dying in relentless pursuit of thinness and appreciation from others. The struggle is hard to save their lives and intensive treatment is vital. Most of them have lived tense



演者紹介：渡辺久子氏（わたなべ・ひさこ）

慶應義塾大学医学部卒業。同大学小児科教室助手，精神科助手，老人リハビリテーション友愛病院，小児療育相談センター，横浜市立市民病院精神科医，同神経科医長，ロンドン・タビストッククリニック臨床研究員を経て現在に至る。専門は小児精神科医学、精神分析学、乳幼児精神医学。

現在，慶應病院小児科で思春期やせ症、被虐待児、人工授精で生まれた子ども、自閉症、PTSD（心的外傷後ストレス障害）など、工業化社会の複雑な葛藤に生きる子どもたちを治療的に支援している。

lonely lives having had to perform as perfect children. Anorexic girls represent family dysfunction in today's affluent Japanese society. Very often the mother is unhappy and depressed suffering from alienation from her spouse.

In Japan today, the rapid modernization after World War II has radically changed the lives of people on the surface. But at the root of daily life, traditional mentality still prevails. Pervasive are such notions as "Silence is golden," or "Drain the past down the water" and "See no evil, speak no evil, hear no evil" which come from old proverbs.

People follow these ideas more or less unconsciously as ways of adapting to the reality of life. They fear ostracism and stigma believing that "A nail that sticks out will be hammered in." The speed of social changes in postwar daily life was too fast for most Japanese people to look back at the wartime trauma. This made it difficult for people to lay down their grief and move forward. Without reflection they still live the nightmare of unresolved wartime loss and trauma. They linger all the more because they have not grieved. Those who cannot remember the past are condemned to repeat it.<sup>7)</sup> Past conflicts continue to permeate invisibly in daily life intruding into intimate relationships through nonverbal interactions, like the aftermath radiation of the Hiroshima bomb. The infant will become an active receptacle of such permeation. Unresolved conflicts will be transmitted down the generations.<sup>3,12)</sup> Repressed aggression and unresolved conflicts arise at the onset of adolescence. The child as well as the whole family will be affected by them.

Following is an example of a 16 year-old anorexic girl whom I treated fifteen years ago. At that time she was hospitalized in a critical state from emaciation and malnutrition. When I first met her she was pale and thin, but was a perfectly polite, well-composed elegant girl with a full smile.

In contrast, her mother was brooding, dark, depressed and devastated by her daughter's disease. On the following days, her mother refused to come and visit the daughter. "Why?" I asked and she muttered "I am furious with my daughter. I want to say to her 'How dare you betray me? I won't forgive you!'" Then she turned to me and said. "So. I am to blame aren't I?" I immediately replied "Oh no, No! We don't blame anybody here. We only try to understand you and your daughter. Please don't feel guilty. We cannot work together if you keep blaming yourself." After this the mother started to tell me

the narrative of her life over weeks and weeks, while her daughter steadily recovered.

Following is a summary of the mother's story. She was born in China in 1940. She was five years old when the World War II ended. Her life turned upside down overnight. Her mother and her baby brother and herself became war refugees fleeing for life. One day on board a ship to Japan, her baby brother died due to lack of milk. Her mother had not eaten for days and could not produce enough milk to keep him alive. The mother kept hugging the dead body but had to finally let it go. The five-year-old girl witnessed the dead baby sinking into the sea and her mother collapsing in grief. She felt helpless and guilty and this memory stayed in her mind for her entire life. After safely arriving back in Japan, the scene of the loss was never shared between her mother and herself. It became a taboo and was oppressed into oblivion. The daily survival struggle amidst the famine of postwar Japan left no room for them to reflect. The mother grew up to be a diligent woman, but inside she felt guilty as a survivor.

She got married at the age of 30 and gave birth to a boy. But her happiness was short lived. At the age of 4, the boy started to stumble and was soon diagnosed as having a brain tumor. Shocked the mother frantically tried everything to save the boy. Her in-laws blamed her with reasons which were ungrounded. She became silently enraged and felt unsupported. Her son died at the age of 5 and his thin body evoked in her memory that of her dead brother thrown into the sea from the ship when she was five. She had no one to confide in. Her husband did not protect her from his family blaming her. He was a quiet and meek man. She silently resolved to show people that she was not a failure and fight back.

The following year she gave birth to a girl and named her Eri. Eri was brought up in perfect meticulous care. 'This time I will raise my baby into a healthy brilliant child.' thought the mother. However, she was too tense and depressed to enjoy her life with Eri. Eri sensitively perceived her mother's tension and became a compliant obedient girl. She performed excellently in kindergarten and following schools up until hospitalization to the pride of her mother. Then at the age of 16, she became anorexic. Her thin dying body evoked in the mother the memory of her dead brother and her infant son and herself and her mother in grief. Enough is enough, the mother felt enraged at this unfair destiny and she refused to persevere further. She became depressed and had to be hospitalized in a mental hospital for a year. She was taken care

by a sensitive therapist who helped her sort out her conflicts and come to terms with her past. In the mean time, Eri felt freed from her mother's conflicts.

The ghost was the grandmother's unresolved wartime loss of her baby son which was passed down through the generations. This mother's loss was compounded by the death of her own baby son. Step-by-step the mother remembered and sorted out her family trauma to which she was exposed to as a child. When she told me how she was shocked and enraged by Eri's thin body, she was perhaps retrieving her own body memories of wartime hunger intruding into her intimate interaction with her mother as a small child

After Eri's recovery she was able to appreciate her mother who persevered to survive her predicaments. She became sociable and tomboyish and started to enjoy her life as a young girl. She grew up to be a pediatric nurse and is now caring for very sick children.

To me the double loss of a brother and son was a powerful revelation. But it explained to me why the mother showed such a consternation at Eri's hospitalization. She felt betrayed and humiliated by unforeseen response of her family. Though she was not a war orphan, she was deprived of her childhood security and joy and was a victim of the war. To live with a depressed mother throughout her own childhood is an experience which is less than optimal. Eri's anorexia nervosa served to expose her mother's hidden rage and provided a timely opportunity for her to redeem her plight. This kind of disclosure of the wartime trauma is a rare revelation in Japan.

The mother-daughter relationship became an arena for a re-enactment of the mother's conflict over her past trauma. Unconsciously Eri was repeating for the mother her unspoken unresolved fear for a hungry skinny child fleeing for life. How Eri's thin skinny body resembled the mother's baby brother, her own elder brother, her grandmother and her mother is striking. The fear of dying skinny figures had been haunting her mother like a ghost. 'Ghosts in the nursery' were the ghosts of her childhood and early motherhood.

Clinical practice and research in child and adolescent mental health reveal that a human child is an active participant in interpersonal relationships from birth. The child evokes in the parents their unresolved conflicts in the past. S. Fraiberg, a pioneer of infant mental health coined the phenomenon "ghosts in the nursery."<sup>4)</sup> The child takes on a double role of an activator and receptor of unresolved family conflicts, often leading to revelation of a family trauma which the whole family has long for-

gotten.

From a very young age, our children are extremely perceptive to emotional states of the mother and father.<sup>6,8,9)</sup> The baby without words keenly engages in nonverbal dialogue with his mother through gaze, voice and gestures. The mother in turn intuitively responds in infant-oriented rhythmical, melodious voice and facial expressions named motherese.<sup>9)</sup> When the mother is distressed or depressed, her baby perceives it and resonates in her mood. The mother unconsciously conveys to her child what she expects of it, whom it represents and what frightens or pleases her. The child is exquisitely receptive to her projections and actively resonates to them.<sup>2)</sup> Through subtle and repetitive clues of gaze, emotional display, physical exchanges and intonation of voice, unresolved family trauma come to be enacted leading to intergenerational transmission of psychopathology.

Adolescence is a second version of infancy, a time of rapid brain development activated by secretion of endocrinological substances. M. Mahler who established the theory of Separation and Individuation Process in personality formation called adolescent its second version.

Japanese mothers and wives have complied with the cultural submission for centuries. This deep-rooted masochism combined with a ratrace for postwar academic and economic competition could make a mother into a remote figure for the child.<sup>12)</sup>

In the aftermath of Japan's defeat in World War II, Japanese families were the target of retaliation by the oppressed Chinese people.<sup>1)</sup> As a baby Eri could have been caught up in the dead mother complex as depicted by Andre Green.<sup>5)</sup> During her early infancy and childhood Eri's mother must have suffered difficulties in taking care of her baby, constantly intruded by conflicts of unresolved losses. Such a family story could never have come into the open in Japan. Eri's s anorexia nervosa became a window into the mother's trauma. Through revelation of the mother's childhood memories and her true feelings of resentment she could reflect and redeem the family struggle. Though much remains to be revealed about her plight of wartime trauma, it is relieving to know that at long last she was coming to terms with her past.

In Japan where people tend to hide their feelings for fear of stigmatization, child psychiatry practice provides a unique window into unresolved family trauma and an opportunity for repair and redemption.<sup>10-13)</sup> Truly there

is no such thing as an adolescent, an adolescent is part of someone the family and the society with its unique culture and history.

In facilitating the girl for an open honest communication, the old folk tales of Shining Princess (*Kaguyahime*) and Crane's Repayment (*Tsuruno Ongaeshi*) are useful. They provide us with prototypes of Japanese women's mentality, and alert us to the risk of false self and self-destruction in well-intended dedication and aspiration.

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## Continuing Professional Education

### The thorny issue of and and or, (or is it and or or?)

Reuben M. Gerling

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The word **and** means that both (sometimes more than two) things were included.

The study included patients with MI.

The study included patients with IHD.

“Both patients with IHD and patients with MI were included in the study.”

Notice the word *both*. When using and for two items, the correct sentence will be ‘*both A and B*.’

When using or, you are telling the reader that you have chosen one of two or more things, but not any combination of these things. Thus the sentence above can be rewritten as:

The study included some patients with MI.

The study included some patients with IHD.

The study did not include patients who had MI and IHD.

“Either patients with IHD or patients with MI were included in this trial.”

Here we must remember to use the word *either* at the beginning of the sentence.

In the following sentence, some patients were given one dose (2.4 g) once a day, and others two doses (1.2 g) twice a day.

“Patients entering this 12-month maintenance study were randomized to unblinded therapy with either MMX mesalazine 2.4 g/day (given once daily) or MMX mesalazine 2.4 g/day (1.2 g given twice daily).”

In the following sentence, the newborn babies were excluded if they had one of the conditions described.

“Neonates with any apparent illness or use of medication were excluded.”

Changing the word or to the word and will mean that only those babies who had both an illness and also used medication were excluded. Babies who had an illness but were not being medicated were included in the study.

In the following sentence some of the patients were treated with a drug eluting stent, and the others with a bare metal stent, but none of the patients had both treatments.

“Restenosis in patients treated with either bare metal or drug eluting stent implantation is predominantly mediated by smooth muscle cell proliferation.”



In the following sentence there are four conditions for inclusion in the study:

“We carried out a retrospective review of patients who had undergone peritonectomy and intra-operative, intraperitoneal chemotherapy infusion by a single surgeon between April 2000 and October 2004.”

Patients who had only peritonectomy were not included, so the word and indicates that they also had to have intra-operative, intraperitoneal chemotherapy infusion. The other two conditions are that the procedure was performed by the same surgeon and the dates during which it was performed.

In this way, it is important to distinguish whether we wish to be inclusive: both a and b; or exclusive: either a or b and use the appropriate word.

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The purpose of *Continuing Professional Education* is to provide enjoyment for the medical healthcare professionals as well as the English teaching professionals who make up the JASMEE membership. Prepared by the editors, with special reference to certain tough spots in English as a foreign language in Japan.

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2. 医療と通訳 : コミュニケーションの視点から (鳥飼玖美子・立教大学)

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