

Journal of Medical English Education

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Journal of Medical English Education

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第14回 日本医学英語教育学会 学術集会 開催案内

日本医学英語教育学会は1988年に第1回医学英語教育研究会が開催され、その後、医学英語に関する研究を推進し、医学英語教育の向上を図る目的で学会として発展して参りました。現在では400名以上に及ぶ会員を有しております。

医学英語教育は卒前・卒後・生涯教育として重要であり、医療の国際化、医師国家試験の英語問題導入や医学英語検定試験など、専門職教育の限られた時間でどのように教育を行うかが課題です。学術集会では例年、医療系の英語教育に係わる教員・研究者が参加し研究・事例を報告します。平成23年度学術集会は下記により開催します。日本医学教育学会の委員会に起源をもつ本会に是非ご参加いただき、医学英語教育について情報を交換していただければと思います。

記

学会名：第14回医学英語教育学会学術集会

日時：平成23年7月9日(土)～10日(日)

会長：吉岡俊正（東京女子医科大学医学部医学教育学）

会場：東京女子医科大学（〒162-8666 東京都新宿区河田町8-1）

演題募集：平成23年2月1日 正午～4月20日 正午

（医学英語教育の目標・教育方法・評価、学生評価、語学教育と専門教育の統合、実践力教育、医学・看護学・医療系教育における医学英語教育、英語教員による医学英語教育、医学・看護学・医療系教育者による医学英語教育、医学英語教育におけるシミュレーション教育・ICT活用、教員教育能力開発、医学英語論文校閲、医学論文編集、医学論文作成における倫理、医学英語検定試験、その他の医学英語教育に関連する演題）

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* 学会ホームページ： <http://www.medicalview.co.jp/JASMEE/gakujutu.shtml>

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First Announcement

The 14th Academic Meeting of the Japan Society for Medical English Education

The Japan Society for Medical English Education (JASMEE) held its first meeting as a 'study group' in 1988. Since then, the society has continued to grow in promoting the development of medical English education supported by over 400 members.

Medical English education has become a significant part of basic, postgraduate and continuing education. With the globalization of medicine and recent changes, such as the introduction of the Examination of Proficiency in English for Medical Purposes (EPEMP), JASMEE has become active not only within the society itself but has also extended its involvement and responsibilities in ways which contribute to society.

The 14th JASMEE academic meeting will include plenary lectures, oral presentations, poster presentations, symposia and workshops. We welcome submissions on various topics related to medical English education such as: educational methods, assessment, student evaluation, integration of language education and specialized education, medical English for nursing and other healthcare related fields, medical English editing, teaching of medical writing, EPEMP etc.

Date: July 9 (Saturday) to July 10 (Sunday), 2011

Venue: Tokyo Women's Medical University
8-1, Kawada-cho, Shinjuku-ku, Tokyo 162-8666

President: Toshimasa Yoshioka
(Department of Medical Education, Tokyo Women's Medical University (TWMU), School of Medicine)

Abstract submission: abstracts should be submitted online, in either English or Japanese.

Online abstract submission begins: February 1, 2011 (noon)

Deadline for abstract submission: April 20, 2011 (noon)

Registration: Please access the JASMEE homepage for details.

URL: <http://www.medicalview.co.jp/JASMEE/gakujutu.shtml>

The 14th JASMEE Academic Meeting Organizing Committee:

President: Toshimasa Yoshioka (Dept. of Medical Education, TWMU, School of Medicine)

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Editor's Perspectives

The present issue features articles by two distinguished clinicians who are also veteran advocates of the EMP cause.

Dr. Hinohara of St. Luke's in Tokyo is not exactly the youngest physician in Japan yet, as JASMEE members were able to witness in the last conference, he is still as vigorous and assertive as many, if not more than many, younger practitioners. Born in 1911, Dr. Hinohara graduated from Kyoto and started his work at St. Luke in 1941, not the easiest of times.

As a physician, tutor and director of one of Japan's finest hospitals he knows more about the insides of the Japanese system than most and he edited his inspiring talk for the benefit of our readers.

Prof. John Benfield started his medical career in the 1950s and has been instrumental in the promotion of international cooperation and good will among medical scientists. In addition to his work as a

leading thoracic surgeon, he also did much to help young medical practitioners publish their work. Professor Benfield has had a long association with Japan that is still going strong and that has enabled him to provide an informed outsider's view of the Japanese EMP scene. Of particular interest to JASMEE members is his belief that cooperation between the language specialist and the physician is crucial to the success of effective EMP courses.

Together, these two outstanding physicians and scholars provide our readers with a coherent view of the challenges and opportunities of EMP in Japan. We thank them and wish them a great many more years of productive life.

Journal of Medical English Education
English Editor

Reuben M. Gerling

A Half Century Perspective of English in Japanese Medicine

John R. Benfield, MD, FACS

Professor of Surgery Emeritus
David Geffen School of Medicine at UCLA

J Med Eng Educ (2011) 10(1): 7–13

Introduction

by Reuben M. Gerling

Professor Benfield graduated from Columbia University in 1952 and the University of Chicago School of Medicine in 1955. In 1967 he joined the faculty at the University of California in Los Angeles (UCLA) where he is now Professor of Surgery Emeritus. He has held numerous leadership positions that reflect his interest in education.



Professor Benfield is a widely published author, reviewer and editor of major journals. He became interested in helping medical scientists with their English in 1988 when his offer to deliver invited lectures in German, his native tongue, was declined in favor of English, his daily language. His sense of relief because he did not need to use German, sensitized him to the burden borne by English Second Language authors who must write and speak in a language in which they are not fluent. Hence, as the Honored Guest of the European Association of Cardiothoracic Surgery he spoke about ***The Language of Science*** (*Eur J Cardiothorac Surg* 2000;18:642-648). Professor Benfield thinks that the privilege of being fluent and proficient in EMP confers a responsibility to help others with their use of English (*Eur Science Editing* 2003;29(2): 37).

This article reflects Professor Benfield's strong advocacy of cooperation between medical language specialists and physicians to create an effective environment for authors whose language is not English to acquire and strengthen their skills in English for Medical Purposes (EMP). Examples of this are his publications in the past decade with Applied Linguistics professionals Kathryn Howard (formerly of UCLA and now with the University of Pennsylvania) and Christine B. Feak of the University of Michigan's English Language Institute.

Professor Benfield's long association with Japan and the use of English by Japanese scientists is reflected in the following article. He is well positioned to reflect on this topic and to provide an insight into future needs for high quality EMP in Japan.

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“The difference between the almost right word and the right word is really a large matter
—it's the difference between the lightning bug and the lightning.”

Samuel Clemens (Mark Twain), Letter to George Bainton, October 15, 1888¹

1. Background

English as an International Language (EIL) is the current language of science. The term EIL is now preferred by many language professionals, at least in part to show respect for more than 90% of the world in which English is not the daily tongue.

High quality English for Medical Purposes (EMP) in Japan is important because many publications in the best peer reviewed scientific journals come from Japanese authors. For example, Table 1 shows that Japanese cardiothoracic surgeons have consistently been prolific among EIL authors in the *Annals of Thoracic Surgery*.² The relative success of Japanese authors as compared to German and Italian authors who ranked next in the number of publications is shown in Table 2.

The English Language Burden (ELB) of Japanese scientists became clear to me in 1957 when I was privileged to speak to the Japanese Association for Thoracic Surgery (JATS) because its 10th president, the late Professor Miyoshi Urabe of Kanazawa University, gave me the opportunity to present my first research work to JATS before it was published in the U.S.³ At the time, few Japanese thoracic surgeons had a working knowledge of English. However, we somehow overcame the language barrier to communicate well enough so that some of my best friendships with Japanese academicians evolved from that visit. Seventeen years later I was honored to be invited to lecture at the JATS meeting in Tokyo, and thereafter to be honored at three additional major medical meetings in Japan.

The ELB in Japan was clear to the late Professor Yoshihiro Hayata of Tokyo Medical University (TMU) in 1970 when he retained J. Patrick Barron, then a Scottish graduate student of ancient Japanese, to help him with medical writing. Barron hesitated to accept the position because he knew nothing of thoracic surgery, but Hayata assured him that they would work together.⁴ There is no better example of a language professional and a medical professional supplementing each other's knowledge than the team of Hayata and Barron that began 40 years ago. Barron became a Professor at TMU and the director of its International Communications Center (ICC) that was founded in 1991—the first such center in Asia. In 2009 the ICC was elevated to the status of a TMU department, thus making it possible to create EMP oriented courses to enhance the number and quality of professionals able to overcome the ELB in Japan. In my view, Barron is the

Table 1. Manuscripts in *Annals of Thoracic Surgery* 2005–2009 (2)

Japan was the most prolific contributor among authors from more than 27 EIL countries that provided about 70% of manuscripts and about 55% of publications.

	2005	2006	2007	2008	2009
Submitted from Japan	382	403	353	395	436
Submitted from EIL nations	1801	1777	1697	1762	1980
Published from Japan	151	128	96	94	115
Published from EIL nations	616	561	512	521	562

leading specialist in EMP in Japan, and perhaps in all of Asia.

My invitation to JATS in Tokyo came from its 27th president, the late Professor Hideo Katsuki who was also President of Chiba University and a respected media personality in Japan. In 1971 Katsuki had sent his associate professor, Sohei Horie, to introduce the new flexible Japanese bronchoscope to the U.S. Horie was instructed to leave 3 new instruments as gifts to the best thoracic surgery centers, and one of the bronchoscopes was left with me.⁵ Katsuki then sent his assistant professor, Koichiro Shimada, to the U.S. to work in my laboratory.

From 1972–1975 Shimada was either first author, or co-author of 10 peer reviewed English language papers. His 10th paper was presented to the American Association for Thoracic Surgery (AATS) in New York.⁶ The proposed manuscript, the text for the presentation, as well as the slides the Chiba group had planned to use, suffered badly from the ELB. Neither the slides, the presentation, nor the manuscript planned by the Katsuki-Shimada team would have done justice to the contents. I knew what my Japanese colleagues wanted to say because they had presented their work to me in Chiba a few months previously, and so we worked intensively and hard together to revise the manuscript and the presentation into English that said what they had wanted to say. The new approach of Induction Therapy (originally *Intermittent Long-Term Chemotherapy*), that had begun in Japan 20 years before, was well received in New York. The paper was accepted for publication in the oldest and most prestigious U.S. journal in our specialty without significant changes, and the Chiba University approach was gradually tested on a small scale in various center worldwide. Eventually, about 20 years after the New York presentation, a cooperative trial of Induction Therapy for lung cancer in the U.S. definitively confirmed its impor-

Table 2. Publication rate* in Annals of Thoracic Surgery (2)

Authors from Japan, Germany and Italy, in that order, provided the most publications from EIL authors.

	2005	2006	2007	2008	2009
Japan	39.5	31.8	27.2	23.8	26.4
Germany	58.1	52.7	42.4	44.7	52.8
Italy	39.6	38.7	39.8	34.7	33.5

*Publication rate (%) = manuscripts submitted/publications x 100

tance.⁷ Shimada became the Professor of Cardiothoracic Surgery at Dokkyo University and remained my life-long close friend.

2. What is the ELB?

2.1. The ELB is the struggle to express ideas and subtleties.

It is the cause of either inability or weakness to take a position in controversial matters. The ELB results in the inordinate effort EIL authors expend to achieve efficiency of expression and clarity. The ELB is particularly burdensome in the discussion sections of articles wherein authors need to defend new and sometimes controversial viewpoints and try to justify their conclusions. There the choice of words and phrases can be crucial. Because of the ELB it is a special challenge for EIL authors to say in English what they can easily say in their own language. The ELB is a particular challenge in preparing abstracts for articles or for conferences because abstracts usually require authors to summarize their message, with 250 words. Barron told me that one of his younger Japanese colleagues had taken 2 days and 2 nights to write an abstract in English.⁴

2.2. The ELB is a lack of familiarity with the English conventions of academic discourse.

Such conventions vary from one language and one culture to another. Brevity, clarity and efficiency are the hallmarks of good academic discussions in English. In German, my native language, value is given to lengthy and detailed academic scientific discussions that most writers in English would consider excessive. Evaluating the relative merits of academic discourse in various languages and cultures is beyond the scope of this article. Suffice it to say that English is the current language of

science and that facility with the English and American approach to academic discourse is now required of all EIL authors. In almost all of Japan's leading universities a track record of successful publication in international journals with a high impact factor is a requirement for professorial appointments.

2.3. The ELB is a struggle to move beyond English as taught in Japan.

The Japanese secondary school system emphasizes the importance of grammar, arguably to the point of impeding communication. Thirty years of service as an editor and reviewer taught me that imperfections or errors in grammar are rarely, if ever, responsible for the rejection of a manuscript. Manuscripts are rejected because they lack new information, new ideas, clarity and credibility. Good copy editors correct grammar and thereafter authors are given the opportunity to review their manuscripts to ensure that their published papers say what was intended. Thus, Japanese authors need to concentrate more on their message and less on grammar.

3. Challenges and opportunities for improvement in Japan

3.1. Atrophy of disuse

Shimada had a sound working knowledge of English after 3 years in the U.S. Following his return to Japan in 1975, his English suffered from lack of use. He knew and deplored that. It was therefore that he asked me to speak at his professorial retirement ceremony at Dokkyo University about the special challenge of the ELB in Japan. I accepted the topic with reluctance, and only because I knew its importance for Shimada, as I had neither formal education in the subject nor schooled expertise in linguistics. The information I gathered from Barron and from others in Japan was crucial for synthesizing my thoughts about this topic.

3.2. Opportunity to combat atrophy of disuse

The late Tsuguo Naruke of the National Cancer Hospital in Tokyo and I were on the Shinkansen from Sendai to Tokyo in 1999 when he impromptu invited me to his hospital that afternoon. No one at the National Cancer Hospital knew that I was coming. However, when we joined an ongoing patient care conference the discussion seamlessly changed from Japanese to English. I expressed my

Table 3. Evaluation of Psychiatry Academia Expert Seminar (16)

44 attendees, 40 evaluations:	
Very helpful	29
Helpful	11
Examples of attendee comments:	
High school and university curricula should incorporate a course like this	
The lecture gave me practical knowledge which I can apply immediately	
Hands-on knowledge which is not written in a text book	
The speaker spoke a little too fast	

surprise about the good quality and the ease of the use of English and Naruke, then the head of the National Cancer Center, said that he had required that once each month each of the center's regular conferences be conducted fully in English.⁸

The idea of using English regularly at conferences had been Professor Hayata's brainchild in 1972 at TMU. His proposal encountered serious, nearly fanatic opposition based on concerns that language inadequacy might impede discussions enough to be potentially harmful to patients.⁴ Despite opposition, Hayata's proposal was implemented at TMU and subsequently elsewhere in Japan. After nearly 40 years of using English regularly at patient care conferences in a few Japanese medical centers, the staff at those centers is generally quite comfortable and spontaneous in the use of English. Surely, here is the opportunity for widespread, regular use of English in Japan. Were it to be widely implemented, this approach would no doubt combat the atrophy of disuse that Shimada suffered.

3.3. English education in Japan

I do not presume broad knowledge of Japanese education, but it is my understanding that the complexity of kanji needs a fixed curriculum and that Japanese students get virtually no secondary school education in writing logical paragraphs or in making spontaneous oral presentations. Additionally, in medical education there is a lack of instruction in reading and writing professional texts in English.⁴ My observations are that adherence to rules, respect for authority, attention to detail and con-



Figure 1. Christine B. Feak, MA, University of Michigan's English Language Institute, and John R. Benfield, MD conducting a workshop for EIL cardiothoracic surgeon authors. The combination of a language professional and a peer is more effective than either alone.

cern about English grammar are characteristic of Japanese professionals. All of the young Japanese men who worked with me were initially unwilling to risk imperfection in English. This made them hesitant to try to communicate. Characteristically it took roughly 3 months in my laboratory for my young colleagues to start to overcome the inhibitions that English education in Japan had engendered.

3.4. Opportunity to improve English education in Japan

When I was honored to give a lecture at the JATS in Kanazawa in 1997, the assistant professor of surgery who served as our guide communicated unusually well in English. Therefore, when I was preparing to speak at Shimada's retirement ceremony in 2001, I called him to ask how he had become so proficient. He said that he had been a poor student of English in school. When he wanted to improve he began to seize every opportunity to use English. He said he had relied heavily upon radio and cinema, imitating the English he heard "like a parrot." Contrary to the requirements of his English education in school, he minimized emphasis upon grammar. Instead, he focused upon phraseology and upon making his message understandable. Independently, he learned that it is acceptable to take the risk of making a mistake for the purpose of conveying a message.⁹

The late Professor Yoh Watanabe of Kanazawa University spoke to me about improving English education in Japan on a broad scale when he was a member of the Science Council of Japan (the Council). After Watanabe

Table 4. English for Medical Purposes Workshops for EIL authors

These principles were successfully employed in 6 annual national meeting of the largest specialty society in cardiothoracic surgery. Each annual meeting included 3 workshops — 2 in conjunction with breakfast and 1 with lunch.

Limited attendance to allow instructor-participant interaction
Instruction from language professional and subject expert

Tasks:

- Using subject matter of the professional specialty
- Teams of 2 people, preferably not of same nationality
- Address areas of greatest challenge for EIL authors.
- At least 3, workshops for each group
- Duration of each workshop at least 1 hour
- At least one homework assignment
- Encourage interaction among participants and instructors

heard my address to the European Association of Cardiothoracic Surgery entitled *The Language of Science*,¹⁰ he told me that the Council had made it a priority to improve the education system in Japan; high on its list of the necessary steps to take was to develop programs and methods to help Japanese scientists to cope with the ELB.^{11,12} Less than 2 months before writing this article, on August 25, 2010, the Council's President Ichiro Kanazawa delivered its recommendations to Prime Minister Naoto Kan. This encourages me to hope that the Council will be able to influence the agencies that make budget allocations to improve English education in Japan.

3.5. Postgraduate programs in Japan

Starting in 1957, I have participated in numerous postgraduate medical education programs in Japan. In 2007 and again in 2010, Elsevier Science Publishers invited me to speak to relatively small groups of selected, promising young academicians about how they might improve their English. Each time we also invited Christine B. Feak of the University of Michigan's English Language Institute to join me in our presentation because she is an applied linguist and an experienced, highly acclaimed teacher of EIL postgraduate students.

Why did I want Feak to join me? As a language professional, Feak brings schooled expertise about writing. She has skills and knowledge that I do not have despite my years of serving as a reviewer, editor and mentor for EIL clinical scientists. I am a physician, a peer of the audiences we address. I have subject expertise that Feak, a



Figure 2. Young academicians who wanted to improve their ability to cope with the ELB by attending Elsevier Science Publishers Psychiatry Academia Expert Seminar, September 14, 2010 in Sendai.

Benfield (front row, 5th from left) and Feak (front row, 7th from left) spoke about Writing Abstracts and Responding to Editors in Psychiatry, September 14, 2010. There was simultaneous English-Japanese translation.

language professional, lacks. Our joint experience,¹³ and the experience of others^{14,15} show that the skills of language professionals and peers supplement and complement one another. The course attendee's evaluations of our recent presentation in Sendai entitled *Writing Abstracts and Responding to Editors in Psychiatry* (Table 3) support our own view that Feak and I together (Fig 1) achieve better teaching than either of us alone.¹⁶

Like almost all postgraduate programs in which I have participated in Japan, we met with the interpreters before the presentation in Sendai to go over each slide and the text of our joint, integrated presentation. There was simultaneous translation from English to Japanese. The chairperson introduced us in Japanese. Questions from the audience were posed in Japanese, and our answers were translated. Discussion and questions were brief and stilted, in part because of traditional Japanese shyness toward professors, but largely because of the ELB. The use of simultaneous translation strongly emphasized that the use of English in Japanese postgraduate programs needs to be improved. I suggest that a major goal of EMP education in Japan should be to elevate competence in English to the point of making simultaneous translation obsolete.

3.6. Opportunity for postgraduate programs in English for Medical Purposes in Japan

One prototype is the format of 6 successful programs that Feak and I conducted in consecutive years during the Society of Thoracic Surgeons' annual 3 day meeting. Each year we conducted 3 interactive workshops. To

permit interaction between us and the audience and among the members of the audience, we limited attendance to 35 EIL authors. The same 35 participants from various nations attended 2 breakfast sessions before the major meetings of the day and 1 session during a lunch break. Each session focused on specific topics such as introduction sections or abstracts or correspondence with the editor. Members of the audience were active participants, employing exercises (tasks). The participants would carry out the tasks in teams of 2 participants, each from a different country, communicating in English. Completion of each task was followed by a group discussion of the exercises. Each year, at the conclusion of the 2nd session the participants were given an exercise as a homework assignment. The 3rd session opened with a group discussion of that assignment. The shyness of the participants towards each other and us, the course leaders, decreased rapidly in the course of the sessions. Each year, the goal of free interchange of questions and ideas between the audience and us and among the members of the audience was achieved. The audience evaluations of the sessions confirmed that Feak, the language professional, and Benfield, the peer subject expert, offered different types of help and instruction. The principles employed in these workshops are summarized in Table 4. The written anonymous evaluations of these workshops were strongly supportive each year, and some of the participants enrolled for the workshops during 2 or more successive years.

Objective data to compare the efficacy of a series of interactive workshops, without simultaneous translation, against single hour presentations with translation are lacking. I am, however, convinced that a series of workshops with a curriculum is far more effective than lectures. Thus, I am hopeful that Japanese professional societies will seize the opportunity to develop and to present interactive workshops as part of their annual meetings and as free-standing courses seeking to alleviate the ELB.

4. Conclusion

The use of English in Japan has improved greatly since my experience with it began in 1957. Japanese academicians are respected world-wide and their contributions are appreciated. We, who use English on a daily basis, are privileged because ours is the language of science. We accept with enthusiasm the responsibility to assist our EIL colleagues in their struggle with the ELB, meanwhile recognizing the practicality that the new programs and the changes needed for ongoing progress will need to come from Japan.

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[Postscript]

Professor John Benfield

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Professor and Chair

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Professor Benfield has had a remarkable and stellar career in not only surgery, but also medical publishing, surgical mentoring, medical experimental investigations and in the field which most of our readers are involved with: English for Medical Purposes.

Although few people who have talked with Dr Benfield would realize it, his first language was German, as he was born in Vienna, going to the US shortly before the outbreak of the Second World War. As such, he is much more aware than many other North American scientists of what he has called "The Language Burden" of those whose first language is not English, but for professional reasons are required to publish in high-ranked scientific journals.

Dr Benfield has made a passionate case for the collaboration of medical professionals who have a deep experience of medical publications, and those who are in a related field but whose

abilities in English might have some limitations. He has also mentored several of the leaders in the field of thoracic surgery in Japan and has been invited many times to give presentations on the art of medical writing in Japan.

For my part, I have known his name for over 30 years, because my mentor in the field of medical communications, Professor Yoshihiro Hayata, was also a thoracic surgeon and was also interested in the experimental induction of lung cancer in dogs, which have a large enough airway to observe the carcinogenic process and the effect of possible therapeutic regimens. I would also like to take this opportunity to thank him for advising me to accept the invitation to organize the 5-year monthly series on medical writing in the journal *Chest*, as this allowed me to electronically meet, and learn from, some of the best specialists in many aspects of publishing in medicine.

Examining How Native English Speakers in Japan View Japanese Physicians' Bedside Manner

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Good bedside manner is crucial for physicians and patients to have a good relationship. Unfortunately, according to numerous reports on Internet blogs, the bedside manner of Japanese physicians is generally considered to be lacking. In this study, the author examines these mostly negative reports as well as their validity. Although those authoring these reports may be prone to exaggeration, at least one claim—consultations with doctors in Japan are extremely short—has some amount of validity. Although this is likely more of a time issue, rather than an uncaring attitude on the part of the physician, the abruptness of these meetings can foster patient resentment. In addition to the unsatisfactory amount of doctor-patient consultation time, language difficulties may also contribute to tensions between foreign patients and Japanese doctors. Without a huge increase in the number of doctors in Japan, it is unlikely that much can be done to increase the amount of time available for consultations. As such, it is important that physicians have the necessary skills, both language and social, to make these meetings with foreign patients as stress-free as possible. In the latter half of this paper, the author reports on a course offered at Sapporo Medical University that addresses this issue. A major objective of the course is to assist students in conducting medical histories in a relaxed and sympathetic atmosphere for patients, and the ways in which the course does so will be outlined in this paper.

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Keywords: Bedside manner, language difficulties, foreign patients

1. Introduction

Although it would seem to be fairly apparent, a proper bedside manner is something that most patients hope for—if not expect—from their physicians. As Berry et al. report, “Physicians evoke patients’ trust and convey respect by listening carefully to their patients, developing whole-person knowledge about them, explaining issues clearly and forthrightly, treating patients as partners in their own care, showing compassion and being thorough.”¹ Ideally, patients can speak at length with their

physicians, describing in detail their concerns and ailments, and in turn, the doctors provide comfort, both emotional and physical.

Japanese doctors, however, are commonly portrayed as lacking this bedside manner and are often described as cold and distant. Particularly critical of these physicians’ supposed unsympathetic attitudes toward patients are Japan’s foreign residents. Surveying a seemingly endless number of accounts of hospital visits in Japan as described on various Internet blogs, it becomes readily evident that Japanese physicians are routinely described as incompetent and unfeeling for the needs of their patients. Certainly, these accounts should be read with at least a bit of skepticism; bloggers are often prone to exaggeration, and their descriptions of disastrous encounters with Japanese doctors may differ somewhat from what actually occurred. However, the overall impression one reads about Japanese doctors and their manner of handling patients is usually less than positive.

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Why are Japanese physicians so criticized, and, perhaps more importantly, can anything be done to improve the situation? In this brief study, from information gathered through a search of numerous blogs (the search engine query was "Japanese doctors bedside manner"), the author presents a few of the common complaints foreign residents have concerning doctors in Japan, as well as examine their validity. Additionally, the procedures of one course offered at Sapporo Medical University, in which a major focus concerns bedside manner and how it can be improved, are discussed.

2. Negative Reports Concerning Japanese Doctors' Attitudes

As mentioned in the introduction, if one is to believe the vast number of Internet reports that delve on the topic, seeing a doctor in Japan can be an almost nightmarish experience. Granted, blogs do not necessarily portray the reality of the situation with pinpoint accuracy. All too often, they appear to be avenues in which frustrations are vented; bloggers may be more likely to emphasize (and exaggerate) bad experiences rather than dwell on those that were positive in nature. Moreover, in contrast to what is written in the blogs, there are certainly numerous academic-based studies that laud the professionalism of Japanese physicians. These papers, however, do not always have the same reach as the blogs. The majority of blogs that were read for this study had been visited, or "hit," by well over 30,000 readers. Two of the sites claimed to have more than one million subscribers or friends.^{2,3} Moreover, given that the opinions of authors on these sites are generally considered representative of those of "regular" people, readers may well feel a certain kinship with them and take their ramblings as the views of "one of us." Therefore, despite the potential exaggeration, or even misinformation, that may be found on these sites, the blogs are influential, and the opinions written on them need to be considered seriously.

If one does acknowledge that the contents of these blogs have some basis of validity, it becomes clear that Japanese physicians do not appear to have a sterling reputation online. As one blogger writes, "Given the general poor quality of doctors in Japan, I'm really surprised that people live so long over here."² According to this blogger, doctors receive commissions on the amount of medicine they prescribe for patients and thus prescribe entirely too much. However, they do not actually bother to explain to patients why the medicine is necessary.

Worse, they are arrogant and contemptuous toward patients who dare question them about this. Physicians who *do* provide explanations are likely to be those who have studied outside of Japan, according to the blogger.

Another blogger, titling an entry "Bad Bad Medicine: Doctors in Japan," describes a frustrating visit to the doctor's office due to an attack of hay fever.³ The blogger complains that the doctor had little interest in his explanations for what may have caused the attack and instead merely asked a few mostly basic and irrelevant questions. To his irritation, the entire consultation lasted only two or three minutes, hardly sufficient in his view to make a proper diagnosis. The blogger further adds that his other visits to Japanese doctors have been awful as well. At the end of the entry, readers are invited to contribute anecdotes about their own experiences with Japanese doctors, and the majority of those who do so express opinions similar to those of the blogger. Among the complaints, there is the claim that Japanese doctors are not obliged to be honest and that a degree from a pedigree university such as Tokyo University allows even the most incompetent doctor to continue practicing without fear of losing his or her license.^{4,5}

On a blog in which a pregnant woman recounts her unpleasant experiences with doctors, a reader offers sympathy for the woman's plight, opining, "In my experience, Japanese doctors seem to have a lot lacking in the bedside manner department."⁶ Another reader agrees with this assessment, claiming, "Doctors here definitely lack in the bedside manner department!"⁷ Bedside manner is mentioned on yet another site as something in which "Japanese doctors are shockingly lacking."⁸ This, according to the author, is due to "the result of the way doctors are elevated in status in Japan. They think they don't have to treat their patients with compassion, kindness, etc. because they, essentially, 'outrank' you in status. It's a license to scold and condescend."⁸

Even a report that is intended to present Japanese health care in a neutral light makes mention of the less than sympathetic attitudes of physicians.⁹ The reason for this, the site informs readers, is because "medical ethics and bedside manners are not taught in Japan."⁹

The overlying view of the Internet community concerning Japanese doctors can be summarized by one blogger, who, when recounting "all the horror stories I hear about Japanese doctors," concludes, "If you are in need of a doctor in Japan, it's generally best to find one that studied outside of Japan."¹⁰

3. Validity of Negative Reports

These reports are just a few of the many anecdotes that can be found on the Internet, among which several recurring themes are evident: Physicians are incompetent, do not spend nearly as much time with their patients as they should, show little to no compassion toward their patients, and resent being questioned.

Concerning the matter of doctors' ineptness, there is of course ample evidence to discount this conclusion, and it is a topic beyond the breadth of this paper. Additionally, the claim that ethics and morality are topics not covered in medical school is questionable at best. Regarding the matter of brief consultations, however, there is some validity to this complaint. Patient-physician meetings do tend to be short, although the reason for this is not likely because doctors simply do not care about their patients' well-being, as numerous bloggers would have us believe. Rather, it is a matter of time, or lack thereof. According to data from the Organization for Economic Cooperation and Development (OECD), in 2008, Japan had only 2.2 practicing physicians for every 1,000 people, a figure significantly below the OECD average of 3.2.¹¹ Moreover, Japanese patients on average visit hospitals far more often than do patients in countries such as the United States, according to a study from Ohtaki et al.¹² The study reports that Japanese patients will usually visit their physicians at the first sign of illness. Additionally, those with chronic medical problems see doctors every two to four weeks. In contrast, patients in the United States thought to have self-limited illnesses are usually encouraged to treat their problems themselves and see a doctor only if their conditions show no sign of improvement. Those with chronic problems schedule visits every one to six months. Consequently, Japanese doctors see significantly more patients on an annual basis than do doctors from countries such as the United States. In fact, the average Japanese doctor may see close to 8,400 patients annually, while his or her counterpart in the United States may examine 2,200.¹³ In short, comparatively, Japanese physicians simply do not have ample time to spend with patients. What is perceived as uncaring abruptness, then, may instead be a physician attempting to allot time prudently in order to be able to attend to all the patients waiting for assistance.

Interestingly, according to the Ohtaki et al. study, the average duration of patient-doctor meetings is 668.7 seconds in the United States and 505 seconds in Japan.¹² Whether the approximately extra two and a half minutes

should be considered significant is open to interpretation. On the other hand, the report also finds that 12% of time spent during these meetings revolves around "social talk" in the United States, while the figure is only 5% in Japan, suggesting that the importance of "bonding" does play a role in the United States (although it would be interesting to see the figures if Japanese doctors had more time available to spend with patients).

Difficulty in communication due to the language barrier may also be a source of friction between Japanese doctors and foreign patients, leading to complaints of incompetence and rude treatment. In many cases, foreign patients may possess only rudimentary Japanese language skills, particularly concerning specialized medical terms. In turn, Japanese physicians often struggle with communicating in English, and misunderstanding and resentment can occur as a result. Even clinics that make a proactive attempt to communicate in English may experience difficulties. One (dental) clinic, for example, has posted an English greeting on its website in an attempt to introduce potential foreign clients to its practices and regulations.¹⁴ Unfortunately, although well intentioned, the manner in which it is written does little to create a welcoming atmosphere. At one point, the greeting informs site visitors that "understanding conversation among a patient, a doctor, a hygienist, and staff is very important."¹⁴ As such, "if you are NOT good at Japanese, you'd better be with an interpreter."¹⁴ The differences between "had better" and the usually softer "should" have long caused difficulties for many Japanese learners of English; in this case, what is likely meant to be a suggestion could easily be interpreted as an order. In another section, when informing potential patients that all meetings require an appointment, there is the suggestion that foreigners tend to be self-centered: "Handling your schedule is your responsibility, not us. Everybody takes care of their schedule. We never accept selfish reason for taking an appointment."¹⁴ Finally, foreign patients are singled out as being impatient. The clinic advocates long-term treatment for patients, but "some of foreign patients insist on just fixing problem; however, it's not a good solution for the patient with short-term treatment."¹⁴ Ironically, what is meant to provide helpful information to foreign patients, and clear up potential misunderstandings, may inadvertently be viewed as almost insulting.

4. Spoken Medical English Course at Sapporo Medical University

4.1 Overview of class procedure

Given the limited time physicians can spend with patients, it behooves them to make these encounters as welcoming and free of stress as possible. To address this issue, one of the objectives in the Medical English speaking course at Sapporo Medical University is to guide students through the process of taking medical histories in English. The course is an elective offered to fourth-year students during the fall semester. It is taught jointly by Dr. Peter Olley and the author and meets a total of eight times, each session being sixty minutes. Classes are usually small; ten students, or approximately ten percent of all fourth-year students, enrolled the previous year. In addition to familiarize students with the importance of obtaining good medical histories, another focus of the class is to prepare them for the rigors of medical rounds. For the purpose of this paper, the author concentrates on the medical history aspect of the course.

During the first meeting, after general introductions have been completed, the necessity of establishing a good rapport with patients is emphasized. Toward that end, a guideline outlining essential procedures one should follow when taking a proper medical history is distributed. The goals of a history are presented as: 1) Gaining the patient's (or patient's family's) confidence; 2) Assessing the patient's personality and character; 3) Arriving at a tentative diagnosis; 4) Guiding the physical examination; and 5) Planning further investigation. Much of what is emphasized in the class focuses on the first two steps.

Throughout the course, students are made aware of the importance of being sympathetic toward their patients, and how it is vital that said patients are put at ease during histories. In addition to learning many of the standard goals of a history—such as gathering information about a patient's past history, family history, social history, current treatment and/or medication—students are provided with suggestions on how they can help patients relax. They are encouraged to think about the importance of good visual communication, and even the very way they position themselves before a patient (off to his or her side, with no barriers such as a desk between them). They are reminded that many patients welcome the opportunity to offer their own input concerning whatever ails them. As such, they are informed that questions such as “Do you have your own opinion of what may be

wrong?” are potentially useful to ask toward the end of a history.

Starting with the second meeting, and continuing throughout the remainder of the course, students are split into pairs and engage in role-playing activities; one student plays the role of doctor, while the other assumes that of a patient. Samplings of the ailments from which the “patients” suffer include difficulty in breathing, chest pain, dyspnea, syncope, jaundice, and fever. Role-plays are based on actual case-studies, many of which have appeared in medical publications. At the end of each class, students who the following week are slated to act as patients receive detailed information about their role, including the patient's current ailments, past notable medical history, medication currently being taken (if any), and family situation, and are expected to be prepared to describe their problems to the doctors the following week. One example of such a case—based on a study in *The New England Journal of Medicine*¹⁵—is that of a man suffering from a fever. The students who are to play this role learn that the man currently suffers from fever, pain and swelling in his right hand and left elbow, and weight loss among other ailments, has had chronic arthritis for over twenty years, is taking methotrexate, prednisone, glipizide, and naproxen, and is married with two grown daughters.

As a general rule, there is little active involvement from either instructor during the role-play. Rather, the doctor-patient encounters are observed silently and the instructors intervene only when necessary (one example being that a student playing the role of patient disbursts erroneous information to the doctor). Upon completion of the role-play, students receive feedback on the performances and are given suggestions for improvement.

4.2 Struggles and improvement

Perhaps not surprisingly, during the early sessions, both patients and doctors struggle somewhat in their roles. Patients, for example, have the tendency to recount the entirety of the information that was provided to them the previous week when asked what is troubling them. They need to be reminded that much of the information they are volunteering from the onset would, in an actual scenario, be more likely drawn out through the physician's questioning. For instance, a patient suffering from chest pain is not likely to mention within the first few moments of meeting the doctor that her husband had died in a farming accident.

Additionally, the patients tend to use specialized med-

ical vocabulary that it is perhaps unlikely actual patients would employ. For example, it may be the unusual patient who says, "I coughed up some frothy blood-stained sputum," rather than "I coughed up some blood." However, as the course progresses and students become more used to their roles, they tend to become much more adept as to what kind of information is pertinent and also simplify their language considerably.

In the role of doctors, initially students have a tendency to take very detailed notes as patients inform them of their problems. Visual communication suffers as a result, and there are often periods of extended silence as doctors write down every detail of what the patients have told them. Since the doctors' attention is divided between the patients and the notes in front of them, the atmosphere that permeates is not entirely conducive toward helping the patients relax. However, as they become more accustomed to listening to patients, students are able to employ more of a shorthand note-taking style, and also become more skilled at discerning relevant information. Consequently, the focus gradually shifts from their notes to the patients.

The doctors' general approach also progresses in a positive manner. It is a commonly held belief that "Westerners" are far more direct than the Japanese. However, this often does not hold true for students during the early sessions, particularly those assuming the roles of doctors. In contrast, students are often extremely direct in their queries, bordering on aggressive, or even rude. One common example occurs upon a patient concluding describing his or her ailments. Often, when the doctor determines the patient has finished, he or she then asks, "Is that all?" This can perhaps be considered a "lost in translation" response, but if spoken to an actual foreign patient, it is one that probably could be somewhat unsettling, almost as if the patient's suffering is trivial. As the course progresses, however, students learn to replace such expressions with far more diplomatic questions such as "Is there anything else you'd like to tell me?" Additionally, concerning delicate topics such as alcohol or drug intake, it is impressed upon students that it is preferable to ascertain whether the patients actually *do* drink alcohol or take medication before asking about the quantity or specificities of such. As such, they soon learn to ask questions such as "Do you drink alcohol?" before querying, "How much alcohol do you drink?" Similarly, "Are you taking any medication?" precedes or replaces "What drugs do you use?" These may be minor points, perhaps, but the author has met a number of foreign resi-

dents in Japan who complain bitterly about what they feel is the Japanese assumption that foreigners are heavy drinkers who also have a proclivity for dabbling with controlled substances. As such, it may be beneficial if potentially sensitive topics such as alcohol or drug intake be approached in a manner that does not cause foreign patients to believe doctors may already hold negative presuppositions concerning their lifestyles.

Doctors are also prompted to voice expressions of sympathy for the patients' troubles. In the example mentioned in the first paragraph of this section concerning the woman who lost her husband to a tragic accident, doctors are informed that "I see" is not a suitable response when hearing this type of information; a statement such as "I'm sorry for your loss" is far more appropriate.

Simplicity of language is something that is also encouraged to the students, but they also need to be mindful that there are limits to how casually they should speak. Petruschak and Kobayashi suggest the use of slang or colloquial expressions as a means to achieve a bond with foreign patients.¹⁶ This could certainly be ideal, but it is not something emphasized in the course. Such expressions can be useful in helping patients relax, but possibly only if the speaker has the language skills necessary to make them sound natural. Students who are not entirely comfortable with English but attempt to use slang or be overly colloquial run the risk of sounding shallow. Moreover, there are times when more formal language is preferable to casual expressions. For example, if a doctor is inquiring about nausea, it is questionable as to how impressed a foreign patient would be if asked, "Did you feel like puking?" rather than "Did you experience nausea?" or even "Did you feel like throwing up/vomiting?"

5. Conclusion

There are, of course, limits to the extent in which this class can prepare students for actual encounters with foreign patients. That the course only meets eight times limits the amount of practice the students receive. There have been recent reports in the university that within the next two years all sixty-minute classes will be increased thirty minutes. If this occurs, it may be possible to use that extra time to include a second role-play each week, providing the students with additional practice.

Getting the students to be able to make quick evaluations of what information is of the most importance also

remains a challenge. Although the majority of the students playing the roles of doctor show improvement with each week, there is still a tendency for them to ask too many questions of their patients. Often these are general well-being questions and have been prepared in advance, and the doctors are determined to ask every one of them. A drawback to this is that rather than ask follow-up questions to the information provided to them by patients, doctors choose instead to jump to the next prepared question. Trying to determine which questions are pertinent is a matter with which students struggle. Considering the severely limited amount of time they will be able to spend with actual patients, it is important that students recognize quickly which questions are of the greatest relevance. To address this issue, during the early sessions, rather than observing the role-play interaction silently, it may be beneficial if the instructors play a more active role, interceding whenever they feel that exchanges between doctors and patients are producing irrelevant information.

Despite these limitations, it is encouraging to see the progress made by students throughout the course. For many patients, a visit to the hospital can be an extremely stressful undertaking. This is particularly true for those residing in a foreign country. If students are able to use what they have learned to make the undertaking less daunting for future foreign patients and can play even a small role in improving the general reputation concerning Japanese physicians' bedside manner, then the course will have served its purpose.

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English Textbook Preference among Japanese Medical Students Reconsidered: Textbook Content, Testing and Student Performance as Factors

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Students' needs must be considered by instructors when selecting textbooks for a course. It has been demonstrated previously that Japanese medical students desire English instruction that is tailored for their needs, and also that they tend to evaluate English textbooks with interesting medical content more highly than textbooks with no such content. As a follow-up to an earlier study of freshman medical students conducted in 2008–2009 at Akita University that dealt with this issue, two different classes (spring 2009 and spring 2010) of freshman medical students at the same university were polled on the three textbooks they were using in their required English course in order to verify whether or not (1) they in fact preferred the one medical-oriented book they were using, (2) testing them over that textbook influenced their choice of favorite book as compared to data obtained during the 2008–2009 academic year, when students had not been tested over the textbook, and (3) students with higher scores in the English course preferred the medical-oriented textbook. In this new trial, the answers to questions (1) and (2) were positive and mildly positive, respectively, with the answer to question (1) being in-line with previous data. In addition, the answer to question (3) was not statistically demonstrated to be positive, even though a slight correlation seemed evident in the data. In addition, there was an unexpected difference in textbook preference regarding sex, with women showing a greater affection for the medical-oriented textbook. The paper concludes that even core English courses at Japanese universities should be tailored for medical students' specific needs.

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Keywords: medical English, textbook preference, testing, English for specific purposes

1. Introduction

The importance of taking student needs into consideration when planning an English for academic purposes (EAP) or English for specific purposes (ESP) course is widely recognized.^{1–4} Although the concept is relatively simple, there are many different opinions about how this ought to be done concerning medical and nursing students, with regards to their individual needs,^{3,5} and also to exactly what they should be taught.^{6–8} Textbook content and appropriateness lie at the core of most of these

arguments.^{7,9–12} Medical and nursing students, indeed, have their own specific needs, and these students are likely to feel dejected when they are forced to use textbooks that are completely unrelated to their chosen fields in core English (EAP) courses.

This study, building on an earlier study of Japanese medical students,¹³ focuses on English for medical students in Japan, and primarily on the problem of student feelings about their textbooks. In addition, it addresses the new question of whether or not Japanese medical students are more likely to prefer a medical-oriented English textbook if they are tested over it. It also revisits the problem of the relationship between student performance and textbook preference, which was explored in the earlier study. Then, final course scores were linked to motivation, with the hope of finding a positive correlation between motivational level and affection for the medical-oriented textbook, but this was not statistically

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shown, although a mildly positive correlation did appear evident in the data. However, due to the relative weakness of the argument that individual motivation can be measured by final scores,^{14,15} that particular argument was not pursued further in this study. However, evidence of a positive correlation between final scores and favoring the medical-oriented textbook was sought, hence hypothesis (3) (below). This was done partly because of the existence of evidence that student performance relates to motivation at least to a degree,¹⁶ but mainly because of the trend I noticed in data from the autumn of the 2008–2009 year and because of my own general observations that students who are more serious about their medical studies tend to exhibit higher scores in the English class and also to seek out more individual help with medical-oriented English. Additional motivation for the present study came from the fact that Japanese medical students in Japan have been shown to generally want Medical English in their required English classes,^{3,17} and also from evidence that they tend to enjoy studying a variety of topics in English.^{18,19}

There are currently almost 80 medical schools in Japan, with a total of nearly 47,000 students.²⁰ Considering the size of this pool of students needing specific medical English education, the right kind of courses must be offered, meaning that the right kind of materials need to be utilized. This study relies on previously-obtained data and also on new data from two classes of medical freshmen at a Japanese university to test the hypotheses that (1) they will generally prefer a medical-oriented English textbook to non-medical English textbooks, that (2) testing them over that textbook will influence their choice of favorite book as compared to data obtained during the 2008–2009 academic year, when students were not tested over the textbook at all, and (3) students with higher scores in the English course will prefer the medical-oriented textbook.

2. Research Methods, the Course, and Instructional Materials

This study is based on data obtained from two different classes of Japanese first-year medical students at Akita University—in the spring of 2009 and again in the spring of 2010. There were 36 students (18 men and 18 women) in the former class, and 39 (20 men and 19 women) in the latter class. The data were compared with similar data obtained in the autumn of the 2008–2009 academic year at the same university.¹³

2.1. Research Methods

At the end of the spring 2009 academic term (April–July), I asked each student in the English class I was teaching to rate the three textbooks we had used during that term from most to least favorite. I asked them to do this by writing their answers on the back of a quiz on a day when all students were present (N=36). One year later, I asked the members of my class (N=39) to do the same, but this time by writing their responses on their final exam answer sheets. However, some students did not answer clearly, so I asked them again to respond to the question by writing on their quiz papers, two days before the final class meeting. In this way, answers were obtained from all students in the class. In both cases, I requested that the students tell why they preferred a particular textbook, and asked them to be honest in reporting their opinions, making it clear that certain kinds of answers were not being sought, and that their answers would not influence their grades. I also explained that the data might be published as an academic study, that their individual identities would not be revealed, and that answering was voluntary.

2.2. The Course

Medical students at Akita University spend their freshman year primarily at the main campus—home to the colleges of Education and Human Studies, and of Engineering and Resource Science—where they must pass a variety of basic courses. Among these, they must take two terms (one year) of freshman English: English for Academic Purposes (EAP) I (spring term) and II (fall term). Since 2005 the university has been implementing a standard EAP course for all freshmen—a course planned by the English teaching faculty of the College of Education and Human Studies. The goals of the course as stated on the syllabus are “to help students develop basic language use ability in academic contexts” but specifically students are supposed to understand long passages, learn various expressions for academic use, summarize texts, use English in groups, learn about a variety of fields, and write a short essay. Previously, the medical students were simply divided into two classes, Med A and Med B, with roughly 50 students in each class, and a few students from each class were sent to an advanced class, based on the results of a placement test administered to all freshmen. The advanced class was comprised of the highest-scoring students from all three colleges of the university. However, an increase in the number of students admitted to the medical program

each year prompted the university to begin splitting them into three classes of about 40 students instead. This is the current situation, and it is also done in accordance with placement test scores—two “advanced” classes being comprised of the highest-scoring students and one of lower-scoring students. However, the curriculum for the medical students’ English classes (EAP I and EAP II) is still the same as that for all other freshmen in the university, as the standard course was not changed, with the same textbooks and mid-term and final exams, and the same schedule. The only difference is that the mid-term and final exams for the medical students are slightly more challenging (and these are made by different teachers each term, and not by me). Teachers must use the standard materials, but they are free to bring extra materials into the classroom and to assign homework or give quizzes of their own choosing. While the medical students all remain in the same class for the entire year, they have different teachers in the spring and in the fall. I now teach one of the advanced medical classes in the spring and the other in the fall, for three hours per week for 15 weeks, or 30 meetings each term.

2.3. Textbooks

As before, three textbooks are currently being used for the medical students’ EAP courses: (1) *Weaving it Together: Connecting Reading and Writing*, Second Edition, Book 3 (hereafter, WIT),²¹ (2) *Science for Inquiring Minds* (hereafter, SIM),²² and (3) *Thinking with William Osler* (hereafter, TWO).²³ WIT is a reading/writing textbook, with 16 chapters, each with a long essay on a certain topic, vocabulary and general comprehension questions, and a writing section. Medical students can cover the chapters very quickly. SIM is different. Each of the 14 chapters contains the script of a short video offering a scientific explanation for some phenomenon or situation, necessary vocabulary, and some simple comprehension questions at the end. The videos are challenging but the scripts make it possible for any student to comprehend them. Many students like the videos because they can learn many natural expressions and because they feel like they are learning “real” English. But since the book provides only scripts with minimal explanation, the teacher must interpret the text and expressions.

TWO, which has 15 chapters, was written especially for Japanese medical students. Each chapter revolves around a conversation relating to the medical care profession. There is also a vocabulary section, and comprehension questions, as well as a variety of exercises covering the words, themes, or situation featured in the chapter. After reviewing a sample copy sent by the publisher I chose to use TWO for the medical students in conjunction with the other two books, which were picked by the members of the English teaching faculty of the College of Education. Finally, all EAP classes do some basic “Group Work” conversational activities which were written by a member of the English-teaching faculty.

2.4. Implementation of the Course

As was explained in 2.2 and 2.3 above, each year the students in the EAP courses must cover the same chapters of the same textbooks, do the same group work activities, and take mid-term and final exams, which are essentially the same, on the same days. As was explained in 2.1, this study rests on data collected in the fall term of the 2008–2009 academic year (EAP II), reported on previously, and on new data obtained in the spring term of 2009 (EAP I) and in the same term of 2010 (EAP I). Therefore, while the chapters and other materials used for the latter two terms were nearly identical, those used in the fall term of the 2008–2009 year were somewhat different, as is shown in Table 1.

When teaching the course, I normally hurry through WIT and SIM, in order to maximize the amount of time that can be spent on TWO, but I often dwell on the writing parts of WIT so as to ensure that the students learn how to write an essay properly. Even so, one chapter of

Table 1. The schedule followed for the two EAP classes (spring 2009 and spring 2010) included in the present study, with the fall 2008 class for comparison.

Fall 2008 (EAP II)	Spring 2009 (EAP I)	Spring 2010 (EAP I)
WIT Ch. 8	WIT Ch. 1 & 2	WIT Ch. 1 & 2
SIM Ch. 5	SIM Ch. 3	SIM Ch. 1
Group Work 3 & 4	Group Work 1	Group Work 1
TWO Ch. 7 & 10	TWO Ch. 1 & 2	TWO Ch. 1 & 2
(mid-term exam)	(mid-term exam)	(mid-term exam)
WIT Ch. 13	WIT Ch. 3 & 6	WIT Ch. 3 & 5
SIM Ch. 10	SIM Ch. 4	SIM Ch. 4
Group Work 5 & 6	Group Work 2	Group Work 2
TWO Ch. 9 & 12	TWO Ch. 3, 4 & 5	TWO Ch. 3, 4 & 5
(final exam)	(final exam)	(final exam)

WIT can easily be covered in three class periods. A SIM chapter can generally be completed in two class periods. Group work assignments can easily be done within a single class period. Information from TWO does not appear on the mid-term or final exams. When the students in the autumn term of the 2008–2009 academic year were sampled, they were not being tested over TWO—they were merely going through the chapters and practicing the vocabulary and then acting out the conversations in the chapters in pairs.¹³ The main difference between that term and the two later terms with which this study is concerned is that I started giving regular quizzes (of my own making) to the students from the spring of 2009, the scores of which factored into their final grades for the course (explained in 2.5 below). The quizzes generally consisted of two parts, the first requiring them to write the English equivalent of a number of words taken from each chapter's list, and the second requiring them to either fill in blanks in a conversation or list of sentences with appropriate words from the main conversation of the chapter or from one of the exercises we did in class, or perhaps to write a short essay or long commentary relating to the chapter topic. Also, in addition to using TWO with the medical students, every term I distribute to each a photocopied packet of anatomical drawings with labels in English and Japanese. Whenever I have extra time at the end of class I review the terms on the drawings with them, having them repeat the English terms after me, and explain briefly their etymology or usage, and also give the students more common alternative terms as well.

2.5. Grading System and Assignments

The grading system for all terms concerned here was as follows: mid-term exam = 25%, final exam = 25%, attendance and participation = 20%, homework, etc. = 30%. I generally checked attendance about two-thirds of the time. This may seem insufficient, considering the weight of attendance in the final course grade, but checking to this degree offers a rather accurate measure of actual attendance, and checking attendance is not always feasible. In addition, the 20% figure was decided by the English teaching faculty and not by me. The final category here (homework, etc.) is where each teacher has some flexibility in course implementation and grading. I covered chapters 7, 9, 10, and 12 of TWO, in the fall 2008 term (EAP II) and covered chapters 1 through 5 of that book during both the spring term of 2009 and of 2010 (Table 1). In the autumn term of 2008–2009, I gave one

small homework assignment on a chapter of TWO, and a quiz over each of the two chapters of WIT that we covered. These three assignments were averaged together to make for 10% of their final grade, or one-third of the “homework, etc.” category. The other 20% was split evenly between their two essay assignments. All students had to write two essays of about 300 words each. The first was in answer to the question, “Why did you decide to enter medical school and why did you choose this university?” They were free to answer both parts of this question or only one part as they pleased. For the second essay, in accordance with one of the chapters of WIT, they had to write a persuasive essay on a topic of their choice. In both the 2009 and 2010 spring terms the students were required to write one paragraph on why they chose to go to medical school and one persuasive essay, with the topic open. The paragraph counted for 5% of their final grade and the essay for 10%. The five quizzes over the TWO chapters were averaged together to make the final 15% of each student's grade. Many students did well on the TWO quizzes, but some had consistently low scores, reflecting a general unwillingness to study that material outside of class on their part.

3. Results

As explained in 2.1 above, students were asked in the spring of 2009 (EAP I) and 2010 (EAP I) to rate their textbooks and to give their main reasons for choosing one as a favorite. The data were then tabulated and compared with similar data from the autumn term of the 2008–2009 year (EAP II) from the earlier study.¹³ As explained in 1 above, no attempt was made to connect the students' final scores in the course to individual motivation, as had been done in the earlier study, but I did look for any signs of a positive correlation between said scores and textbook preference. All p-values were calculated using GraphPad Software 2x2 contingency tables, at the 95% confidence level.²⁴ Therefore, p-values below 0.05 were considered to be statistically significant.

First, data from the two more recent polls (spring 2009 and spring 2010, both EAP I) were tabulated and compared with data from the autumn of the 2008–2009 year (EAP II) in order to test the questions of (1) of whether or not the medical students generally preferred the medical-oriented textbook (TWO), and (2) whether or not testing them over each chapter of TWO in spring of 2009 and spring of 2010 had influenced feelings toward the book. As with the previous study, there was a clear ten-

Table 2. Data from the classes polled in the 2009 and 2010 academic years with data from the fall term of the 2008–2009 year for comparison.

	Fall 2008 (EAP II)	Spring 2009 (EAP I)	Spring 2010 (EAP I)
Favorite textbook = WIT	5	5	6
Favorite textbook = SIM	21	11	9
Favorite textbook = TWO	25	20	24

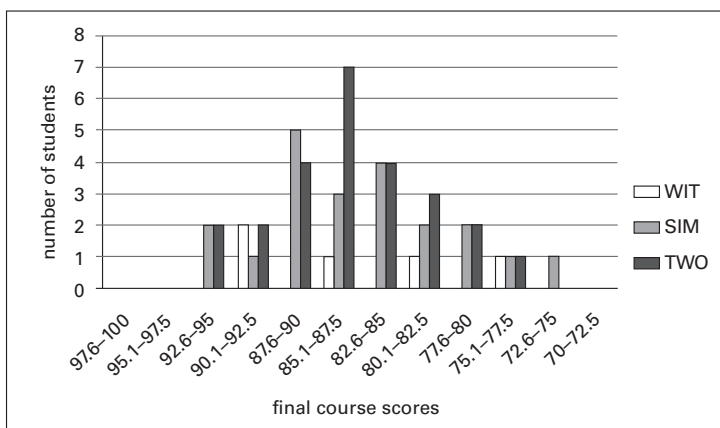


Figure 1. Data from the autumn term of the 2008–2009 academic year (EAP II).

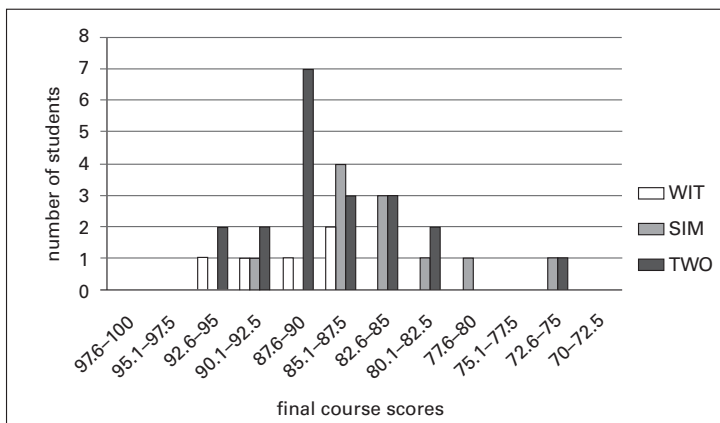


Figure 2. Data from the spring term of the 2009–2010 academic year (EAP I).

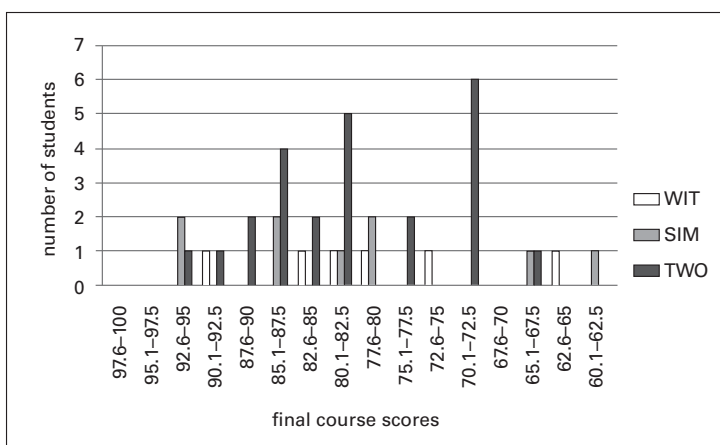


Figure 3. Data from the spring term of the 2010–2011 academic year (EAP I).

dency for the students to favor TWO over their other books (Table 2).

Overall, therefore, TWO emerged as the more popular textbook across the three classes, providing support for a positive answer to question (1). Furthermore, TWO's popularity among the students in the spring 2009 and spring 2010 classes appeared to rise significantly above its popularity level for the autumn of 2008–2009, indicating a possible effect of testing the students on the chapters, as that was the only main difference between the two more recent polls and the earlier one, which provides support for a positive answer to question (2): whether or not testing the students over TWO caused a greater proportion of students to favor that book. However, when the data for each of the more recent polls (spring 2009 and spring 2010) were individually compared with the autumn 2008–2009 data, no statistical significance was shown to exist between them (the two-tailed p-value was 0.66 for the spring 2009 data and 0.29 for the spring 2010 data), which makes it hard to argue that testing significantly boosted TWO's popularity.

Next, since the data from the autumn term of the 2008–2009 academic year (EAP II) appeared to show a slight positive correlation with overall student performance as measured by their final numerical scores in the course (linked to the concept of motivation in the previous study), the data from the spring 2009 term and the spring 2010 term (both EAP I) were tabulated in order to compare textbook preference with individual student performance. Student scores were divided into categories, ranging from 60 to 100. The same was done for the earlier data for comparison. It is necessary to note here, though, that the spring 2010 class had a greater score range than either of the earlier two classes, with some students falling in the 60s, whereas no student had done so in either of the earlier two classes. Therefore, the graphs for the autumn 2008–2009 year (EAP II) and for spring 2009 (EAP I) do not extend beyond 70. The generally lower scores in the spring 2010 class were probably due mainly to the fact that the final exam that term was far more difficult than the

students had anticipated, resulting in grades that were about 20 points below the usual final exam scores for the medical students. Interestingly, data for the 2009 spring class (EAP I) appeared to be much closer to that which was generated from the autumn 2008–2009 class (EAP II), reported on previously, than the data from the spring 2010 class was to either of the two other classes, as is shown Figures 1, 2, and 3.

Figures 1 (EAP II in autumn of 2008–2009) and 2 (EAP I in the spring of 2009) appear to indicate a slight preference for TWO among the higher-scoring students in the classes, with the latter showing a stronger correlation than the former, while Figure 3 (EAP I in the spring of 2010) does not seem to indicate any such association. In fact, the overall low scores for that class seem to have thrown the entire data set into disarray. It is possible that many of the students had become frustrated with the EAP course by the time I asked them to rate their textbooks the second time on their quiz forms, following the final exam, because that exam, as explained above, had turned out to be rather hard. Since the mid-term and final exams are made by different members of the English teaching faculty each time, there is often a problem with consistency—an unfortunate result of implementing standardized exams for different classes taught by different teachers. Figures 1 and 2 seem to show that higher-performing students tend to prefer the medical-oriented textbook (hypothesis 3), but averaging the scores for the students who chose TWO as their favorite book and those who did not choose TWO and then comparing them revealed no relationship between

Test One – Top One-Third of Each Class

(Top 1/3)	TWO is my favorite	TWO is not my favorite
Autumn 2008-2009 (EAP II)	8	10
Spring 2009 (EAP I)	11	4

two-tailed p-value = 0.16

(Top 1/3)	TWO is my favorite	TWO is not my favorite
Autumn 2008-2009 (EAP II)	8	10
Spring 2010 (EAP I)	8	5

two-tailed p-value = 0.47

(Top 1/3)	TWO is my favorite	TWO is not my favorite
Spring 2009 (EAP I)	11	4
Spring 2010 (EAP I)	8	5

two-tailed p-value = 0.69

Test Two – Middle One-Third of Each Class

(Middle 1/3)	TWO is my favorite	TWO is not my favorite
Autumn 2008-2009 (EAP II)	11	8
Spring 2009 (EAP I)	6	9

two-tailed p-value = 0.49

(Middle 1/3)	TWO is my favorite	TWO is not my favorite
Autumn 2008-2009 (EAP II)	11	8
Spring 2010 (EAP I)	9	6

two-tailed p-value = 1.00

(Middle 1/3)	TWO is my favorite	TWO is not my favorite
Spring 2009 (EAP I)	6	9
Spring 2010 (EAP I)	9	6

two-tailed p-value = 0.47

Test Three – Bottom One-Third of Each Class

(Bottom 1/3)	TWO is my favorite	TWO is not my favorite
Autumn 2008-2009 (EAP II)	6	8
Spring 2009 (EAP I)	3	3

two-tailed p-value = 1.00

(Bottom 1/3)	TWO is my favorite	TWO is not my favorite
Autumn 2008-2009 (EAP II)	6	8
Spring 2010 (EAP I)	7	4

two-tailed p-value = 0.43

(Bottom 1/3)	TWO is my favorite	TWO is not my favorite
Spring 2009 (EAP I)	3	3
Spring 2010 (EAP I)	7	4

two-tailed p-value = 0.64

Figure 4. Results of breaking the three classes down into sub-categories according to student course scores, correlated with textbook preference, and comparing them.

“TWO is my favorite” and “TWO is not my favorite.” (For the spring 2009 class, the value for “TWO is my favorite” was 86.93 and that for “TWO is not my favorite” was 85.53, while for the spring 2010 class the values were 80.39 and 79.72, respectively. These were in line with values for the autumn term class of the 2008–2009 year.¹³) Furthermore, when these data sets were broken down into smaller categories (the top one-third, the middle one-third, and the bottom one-third of each class) and tested against each other with 2x2 contingency tables, no relationship of statistical significance was observed, as is demonstrated by Figure 4.

Indeed, the high p-values for all nine individual comparisons shown in Figure 4 make it impossible to argue for a strong positive correlation between student perfor-

Autumn 2008-2009 (EAP II)	TWO is my favorite	TWO is not my favorite	Spring 2009 (EAP I)	TWO is my favorite	TWO is not my favorite	Spring 2010 (EAP I)	TWO is my favorite	TWO is not my favorite
Men (N=37)	19	18	Men (N=18)	6	12	Men (N=20)	10	10
Women (N=14)	6	8	Women (N=18)	14	4	Women (N=19)	14	5

two-tailed p-value = 0.76 two-tailed p-value = 0.02 two-tailed p-value = 0.19

Figure 5. Student responses for all three classes as sorted by sex.

mance and preference for TWO, meaning that hypothesis (3) remained unproven. However, the relatively low p-value for the trial at upper left, comparing the highest one-third of the autumn 2008–2009 class (EAP II) and the corresponding section of the spring 2009 class (EAP I) does indicate a possible positive correlation, which is hinted at by a visual comparison of Figures 1 and 2, although the small sample size is a major limitation.

Third, although sex was not a central concern in the present study, the data was once again analyzed in order to determine whether or not there was any relationship between student sex and textbook preference (Figure 5).

As Figure 5 demonstrates, men far outnumbered women in the autumn term of the 2008–2009 year (EAP II), when the students were not tested over TWO, but as the very high p-value attests, sex was not a factor in preferring TWO over the other two textbooks. On the other hand, it is interesting to note that the p-values dropped dramatically when the students were tested over TWO and when the number of men and number of women were equal or nearly so. In fact, at 0.02, the p-value for the spring 2009 (EAP I) class was the only one generated in the entire data set for this study that clearly indicated statistical significance, meaning that at least for that class women were far more likely than their male counterparts to prefer TWO to the other textbooks when they were being tested over the material. It should also be noted that the p-value for the spring 2010 class (EAP I) was also fairly low (at 0.19), indicating a similar pattern. In addition, when the data for the women of the autumn term class of the 2008–2009 year (EAP II) was compared with that for the women of the spring 2009 class (EAP I) in a 2x2 contingency table, a p-value of 0.07 was generated, indicating a situation just shy of being termed statistically significant. This means that not only were the women of the spring 2009 class (EAP I) more likely than the men of the same class to favor TWO over the other two books under the condition of being tested over the

material, but that they also were somewhat more likely to favor TWO over their female counterparts from the previous academic year, who were not tested. Testing, therefore, does appear to have an effect on preference for a medical-

oriented textbook among these particular medical students, at least for the women if not for the men. This lends more support for hypotheses (1) and (2).

Finally, student responses from the spring 2009 (EAP I) and spring 2010 (EAP I) classes as to the question of exactly why each liked a particular textbook over the others were enlightening, but space limitations prevent a detailed analysis of that data here. In general, however, reasons given for preferring TWO were mostly based on its contents—the vocabulary and conversation topics. A number of students wrote that they felt that TWO held more value for their futures than the other books, or that the conversations were “interesting,” or both. A typical reason given for preferring WIT was that it taught the students how to write an essay in simple terms. And concerning SIM, some students liked the fact that they could learn natural expressions from it, and some felt that they had benefited from the listening practice offered by the combination of the book with the videos. A more detailed analysis of this qualitative data will be conducted in the near future.

4. Discussion and Conclusions

This research began with three questions: (1) Do the medical students prefer TWO (a medical-oriented textbook) to the other two textbooks? (2) Will being tested over the medical-oriented textbook affect their feelings toward it as compared to previous data, when students were not tested? (3) Will students with higher scores in English class prefer the medical-oriented textbook? Students in two different classes (spring 2009 and spring 2010) rated their textbooks and also gave reasons for their answers. I hypothesized (1) that overall, they would prefer TWO to the other textbooks, (2) that having been tested over TWO would result in a greater proportion of students in each class reporting that they prefer that book, and (3) that students with higher scores in the

course would prefer TWO. My hypotheses were based on prior findings about value of student needs in course planning,^{1,4} on the fact that Japanese medical students have been shown to want Medical English to be a part of their English courses,^{3,17} on evidence that they tend to enjoy studying various topics *in* English^{18,19} and also on data generated by a previous study¹³ and on personal observations as well.

TWO was in fact the most-liked textbook. This trend was seen clearly in the two newer trials as well as in a re-tabulation of the earlier data, which lends strong support to the conclusion that medical students are likely to favor medical-oriented textbooks in their required English courses over non-medical textbooks, thus answering question (1). The data also indicates a positive answer to question (2). The gap between “my favorite textbook is TWO” and “my favorite textbook is not TWO” for both the spring 2009 (EAP I) and the spring 2010 (EAP I) classes (Table 2) is clearly larger, and more in TWO’s favor, than that for the autumn class of the 2008–2009 year (EAP II). The main difference between the earlier class and the latter two classes was that the students of the earlier class were not tested over TWO. Although statistical tests failed to generate clear proof of a positive correlation between testing over TWO and higher overall appraisal of that book, when viewed visually the data indicates such a trend, if only a mild one. A larger data set might show a stronger trend in the same direction. Moreover, though, when sorting the data by sex such a relationship appears obvious, with the women of the spring 2009 class (who were tested over TWO) clearly preferring TWO over their male classmates and also over the women of the previous year (who were not tested). Therefore, this study has generated notable support for the contention that testing medical students over a medical-oriented textbook can help raise their appraisal of that book, and answering question (2) in the positive, although with slightly less confidence than when answering question (1). Last, the hypothesis that higher-scoring students would prefer TWO overall, which informs question (3), was not proven here, despite a careful analysis of each class, broken into thirds, to make a total of nine extra contingency table trials. However, Figures 2 and 3 seem to indicate the existence of such a pattern, reflected in the relatively low p-value generated by comparing the top one-third of the students from the autumn 2008–2009 (EAP II) and the spring 2009 (EAP I) classes (Figure 4). This phenomenon deserves greater attention in the future.

In conclusion, medical students at Akita University have again been demonstrated to favor a medical-oriented textbook over non-medical textbooks in their required core freshman English course, further supporting the argument for the implementation of ESP for them over EAP. In addition, when tested over that material they tend to favor it even more. Perhaps they will also remember what they have learned better. As with the previous study upon which this one builds, however, this study was unable to generate any statistical proof that higher-performing students will be more likely to prefer a medical-oriented textbook, although such a trend does appear evident, at least at the higher score levels, and in at least some classes (one class, in this study). That only three classes in one university were sampled is a strong limitation of the data, as is the curious mismatch of data from the spring 2009 and spring 2010 classes, which were nearly identical in composition and in the materials covered (they were even held in the same classroom). Another limitation is the fact that the data used for comparison here came from an autumn term class (the 2008–2009 academic year), which means that those students had already used TWO and the other textbooks for a full term plus more than one-half of another before being polled on the books. Yet this factor was probably not very significant because they had had a different teacher the previous spring, and my way of using the textbooks differs significantly from that of the other teachers. A larger data set, such as one containing information from every class of every term over several years, will be needed to overcome such data problems. Plans are underway for such a survey at Akita University.

In sum, this study has shown that Japanese medical students are likely to want their core English courses to be tailored for their needs—both immediate and future. Since medical-oriented ESP will probably be more interesting for them than completely non-medical, standardized EAP, using at least one textbook like TWO for medical students should be advantageous for both the teacher and the students.

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About Cover Letters for Manuscripts Submitted to Biomedical Journals

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I have often heard experts on manuscript-writing pronounce that manuscript submissions to biomedical journals must be accompanied by a well-written cover letter. In a quest to find evidence for this pronouncement, I asked eighteen European and American editors “How much importance is attached to the cover letter and what are you looking for that might not be in the abstract?” I also checked journals’ instructions to authors for mention of a cover letter and reviewed the literature on cover letters, which did not take long because there isn’t much. An editorial in *Medical Education* noted that, while it had previously been hard to imagine sending a parcel to an editorial office without a cover letter, in the first three weeks of 2005, when the journal moved to electronic submissions, 68% of papers were submitted without comments to the editor. As a result the editors thought the cover letter was becoming an endangered species.¹

Most cover letters go unread by the *NEJM*, according to information I received from the journal’s media manager. Their instructions to authors state that authors do not need to send a separate cover letter with their online submission because they offer a text box in which the authors can type information for the editor—but this can also be left blank.²

By contrast, *The Lancet* stipulates that authors should use the cover letter to explain why the paper should be published in “a leading international general medical journal, rather than elsewhere (e.g. a speciality journal).”³ They also state that it is helpful to indicate what could be shortened in the paper because the whole paper can be reviewed and published on their website and a shortened version published in the printed journal.

The topic of cover letters was raised at one of the Committee of Publication Ethics’ annual seminars that I attended in London. Most editors said that they looked at cover letters, but disparate views were expressed as to their importance. Among editors representing a certain big journal at the meeting, those who read cover letters were in a minority, although one editor at the same jour-

nal stated that he always read the letters.

The views that I received from my questioning of editors ran the entire gambit from “I ignore cover letters because the manuscript should speak for itself” and “editors do not rely on cover letters to explain the message” to “cover letters are a golden marketing opportunity” and “cover letters are a key part of the editor’s appraisal of a paper and I consider any author who fails to make use of them an idiot.”

As in the absence of specific requirements like those made by *The Lancet* the author (or medical writer) will usually not know if an editor is of the ‘ignore’ or ‘always read’ ilk, it seems wise to take the time to write a cover letter—even though it might never be read. The comfort for the author then is that writing a cover letter can help to refocus the author’s mind on how the paper has been written. If the letter explains the message in a better way than the paper, the paper should be revised. In this sense, as one editor said, it is a last check before submission. And again, to quote an editor “A good cover letter will never make up for a poorly written abstract or poorly performed study, but it will help [those editors who read it] to decide whether it is worth getting the paper reviewed, who would be the best reviewers and if there is anything salvageable about the paper if the reviews are bad.”

What should I write in the cover letter?

In this article the term ‘cover letter’ is used for a letter accompanying the initial submission of a manuscript. Letters that accompany a revised manuscript, where it is important to detail the revisions that have been made, are not discussed, as these have a clearer *raison d’être*.

The advent of online manuscript submission has obviated the need for letters that merely state that a manuscript is enclosed and make some non-specific general pleasantries. The modern cover letter provides whatever information the instructions to authors specify should be included in a cover letter and is a medium of persuasion.

Many journals reject a manuscript without passing it through an external review process. The trend of rejection without external review arose from increasing numbers of submissions and demands from authors for ever more rapid decisions, and it has risen in recent years with the great increase in research activity in some countries, such as China, where the use of English as a medium of scientific communication is not yet well established. Rapid rejection on the basis of internal review means that editors often only read the manuscript abstract or the abstract and the cover letter. External reviewers are not usually given access to the cover letter in the electronic manuscript system, although the editor may send information to the reviewers from the letter.

One editor, who relies on the abstract only to give an initial sense of whether the paper is within the journal's scope and of good quality, explained that as the abstract should contain key information about the study "there would not be much to be gained from the author's point of view to include a cover letter." However, among the editors who considered letters to be important, albeit not essential, one wrote that she did read them because (disappointingly) authors explain the topicality and importance of their work better in the letters than in the abstract. But I also received comments that well-written manuscripts are often accompanied by badly structured and ill-prepared letters, indicating that the authors had help with the manuscript but not with the letter.

Information the journal might require in a cover letter

Even journals with online submission systems sometimes ask in their instructions to authors for information to be included in cover letters. The following is a list of the type of items which might be requested:

1. Confirmation that the data in the manuscript is original and the manuscript is not under consideration elsewhere.
2. Confirmation that none of the manuscript's contents have been previously published. Some journals request that copies of related papers be submitted as supplementary data so that the editor can check for possible duplicate, salami or prior publication. Prior publication does not include conference abstracts/posters. You would be wise, however, to mention such previous publication.
3. Confirmation that all authors have read and approved the manuscript and its submission to the journal.
4. Confirmation that all authors have agreed to be authors and accept responsibility for the study or that the corresponding author takes full responsibility for the contents of the paper.
5. A few journals (e.g. *The Lancet*) request that copies of previous reviews of the submitted manuscript be included as supplementary data, in which case you should explain in the cover letter what you have done to deal with the reviewers' comments.
6. Financial disclosure including funding, employment by a sponsor, consultancies, share ownership, equity interests or patent-licensing arrangements. If no potential conflict exists, this should also be stated.
7. Whether any of the material could be published as data supplements rather than in the print version of the article.
8. Full contact details of the authors' postal/e-mail addresses, telephone and fax numbers (in addition to inclusion of this information on the title page of the manuscript).
9. Agreement to pay for colour figures or for online fees if the submission contains supplementary files.

Information that might be included to increase the manuscript's chances of external review

Where the online submission system is silent on cover letters but asks the authors to include information directly in the submission system, a letter can be used to expand on the information provided. Otherwise the task of the cover letter is to persuade the editor that the manuscript is of sufficient interest to warrant sending it out for external review. The following is a summary of the type of things editors said they wanted to read about in the cover letter as well as suggestions gathered from the 'cover letter' literature.

1. Why you conducted the study and contextual details of the research project.
2. A description in everyday terms of what the paper is about and its major implications. Do not reiterate the abstract and avoid too many technical details.
3. What is unique about the study, and how it differs from other studies. The significance of the study results should be neither under nor overplayed. As John Swales emphasises, dropping hints that you consider your paper to be eminently publishable at best is only likely to raise some quizzical editorial eyebrows.⁴ The cover letter must be consistent with the manuscript. One editor said she was irritated when the cover letter enthused about promising results which were not to be found in the manuscript submitted.

4. A statement that the study is the first of its kind. This is particularly important if the journal does not allow claims of priority in the manuscript, as the significance and novelty of the work can always be explained in the cover letter.
5. Why the journals' readers would be interested in the work. If an article relevant to your study has recently been published in the same journal, refer to the article to show that you read and are familiar with the journal.
6. What the paper will add to the literature. Emphasise any unanticipated or surprising results.
7. Information about controversies in the field and how the paper is positioned within a debate.
8. If you have not published in the area before, give the basis of your expertise and years of experience in the field. One editor impressed me by saying that when authors told her "this is my first paper and I'd welcome any feedback and assistance you can give" she was happy to keep working on it. The difference that this can make, she explained, is that the editor is more likely to ask the author to revise the manuscript than to reject it on round one.
9. If no opportunity for suggesting reviewers is provided in the online submission a cover letter is a valuable opportunity. One editor commented that the convenience of receiving names of reviewers and their e-mail addresses can make the difference between sending out for external reviewer and making a decision to reject. Collaborators or co-authors of previous papers should not be suggested. Editors sometimes check PubMed or other databases before sending papers out to review. The names of people who should not be chosen as reviewers can also be mentioned. Joshua Finkelstein from *Nature* considers this information useful, acknowledging that competition and bias exist.⁵ The reason for excluding a potential reviewer should be given; one editor stated that without an explanation she did not feel obliged to consider such requests.
10. Joshua Finkelstein recommends that if you've talked with an editor about the work (at a meeting, for example), you should mention this in the cover letter. The manuscript might be assigned to another person in the editorial team who will then ensure that their colleague sees the paper before any editorial decision is made.⁵
11. A statement that the manuscript is based on a conference presentation (if it was!)—even when this has been mentioned in the manuscript.
12. A description of any other submission or previous publication that might be considered redundant or may duplicate part of the manuscript.
13. Information that you have already published on the topic or have a similar paper published elsewhere.
14. If necessary: a persuasive explanation of why the manuscript does not comply with the instructions to authors, for instance, if the word count exceeds the word limit stipulated in the instructions, or the format is unconventional.

Sample letter covering the points an editor wanted to read in a cover letter*

Dear Dr Besteditor

We are pleased to submit our manuscript for consideration for publication in the Journal of Excellent Research.

In Wonderland, more than 60% of the population lives in urban areas and most of them have never or only once seen a tree. Urban men are in particular affected by this. To date, no scientific attention has been given to the determinants of tree-spotting among this afflicted population. This article describes a theory-based analysis of the primary psychological determinants of tree-spotting behaviour among these men. Results of this study are important for the development of focused intervention programmes targeting rural men in particular.

We believe that our article is of interest to the Journal of Excellent Research as it falls within the scope of the journal on publishing psychological studies of vulnerable populations. In addition its open access would ensure a wide distribution of our results.

The manuscript reports original research and is not under review with another journal. The authors have no conflicts of interest and have all read and approved the manuscript.

We are looking forward to your response.

Yours sincerely

Hopeful Author PhD

* The names in the letter have been changed.

15. If the journal requires people whose names appear in the Acknowledgements to give permission to be named, the cover letter should include confirmation that permission has been granted and the permission letters/e-mails can be uploaded as supplementary data.
16. Finally, Steven Gump in his article on cover letters suggests that closing the letter with a congenial note places trust in the editor and reminds him that you are eager to receive his decision.⁶ John Swales advises refraining from exerting pressure with terms like “as soon as possible.” He also considers there is nothing to be gained by such endearments as offering to revise.⁴

Length and format of the cover letter

Ideally, the cover letter should not exceed one page—as one editor commented, there’s nothing worse than a rambling letter. If you are wondering how you can include all the above information, see the example in the Box. It covers points 1–6 and 16. The rest of the suggestions were not applicable for this manuscript. The final paragraph of the letter provides details that the instructions to authors required to be in the cover letter.

The cover letter gives a first impression of the authors and establishes their credibility. Attaching a letter on headed paper from your academic institution, company or organisation as a pdf/scan in an electronic submission tells the editor where you come from. If, for example, the academic department lists its professors on its headed paper, the editor might recognise the names. You should also use your job title and academic degrees.

Your credibility will suffer a nasty blow if you don’t get the name of the editor and journal right! More than one editor told me that it was amazing how many letters arrive addressed to the former editor of the journal, or editor of another journal that has just rejected it—to quote an editor “interesting information for the editor but not always in the interest of the authors.” Writing the former editor’s name shows you know little about the journal and maybe also the literature. An incorrect journal name raises suspicions of duplicate submission or doubts about whether you had intended to submit to that journal.

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日本の英語教育の課題と方策

演者

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私は医学英語についてはまったくの素人です。ではなぜ今ここにこの話になりますかという話になりますが、菱田先生(学術集会会長)には日本コミュニケーション学会で大変お世話になり、それ以来何もお返ししておりませんで、今回このようなお話をいただきましたので、勉強のつもりで来させていただきました。よろしくお願いします。

きょうは医学英語についてお話をするのではなく、「日本の英語教育の課題と方策」というような、かなりマクロ的なトピックについてお話させていただきます。私のバックグラウンドはコミュニケーション教育学でして、これは言ってみれば隙間産業です。英語教育でもなく日本語教育でもなく、コミュニケーションという観点から教育の改革等にいままでかかわっていました。英語教育に顔を出したり、外国語としての日本語教育にかかわったり、あるいは小学校の教育など、さまざまなフィールドで仕事をさせていただいています。

こういった関係で、日本の教育全体について考える機会がほかの先生たちよりも若干多いのかなと思います。よって、本日はマクロ的な視座からお話をさせていただければと思います。

じつは、医学部では医学英語を教えたことはありません。東海大学に8年ほど勤めていたのですが、そのときに医学部でクリニカル・コミュニケーションという日本語による授業を開発するときにかかりました。中沢先生という先生が中心となって開発することになり、そのチームに入りまして2年ほど医学部の学生さんに「クリニカル・コミュニ

ケーション」という授業を持たせていただきました。主に模擬患者と医者との面談等を中心に、振り返りを重視したコミュニケーションの授業を展開させていただきました。

それと、東京女子医科大学で、ピンチヒッターとして「表現技術」という授業を1セメスター教えさせていただきました。学生のインタラクションを中心とした日本語による表現技術の向上を目指したものでした。

英語教育を取り巻く社会環境の変化

きょうはまず「英語教育を取り巻く社会環境の変化」ということ、次に「中学、高校における英語教育の変化」を見ていきたいと思っています。

東海大学に8年間勤めていたときに、全国に付属高校が14校、中学校が6校あるのですが、その英語教育の改革というものに取り組んでいました。それ以外にも、文科省のさまざまなプロジェクトに参加して、中学、高校の現場をかなり見てきました。2012年度以降大きく変わることになる中学、高校の英語教育の施策に関しても、少しかかわっていますので、その辺についてお話をさせていただければと思います。

また、現在、立教大学の経営学部において、新しい英語教育プログラムの主査をさせていただいていますので、それも踏まえて、「大学の英語教育の課題」について皆さんと考えていきたいと思っています。

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青山学院大学経営学部卒業、マサチューセッツ大学大学院修士課程修了、九州大学大学院博士課程単位修得。神田外語大学助教授、東海大学教授などを経て現職。専門はコミュニケーション教育学。また、これまでに、中教審外国語部会専門委員、文科省 SELHi 企画評価会議協力者、文部科学省「英語教育改善のための調査研究企画評価会議」委員、日本学術振興会「質の高い大学教育等推進事業委員会」専門委員、経済産業省「グローバル人材育成委員会」委員などを歴任。

『大学生のための「読む・書く・プレゼン・ディベート」の方法』(玉川大学出版部・共著)、『異文化コミュニケーション・ハンドブック』(有斐閣、共著)、『英語ディベート 理論と実践』(玉川大学出版部、共著)、中学校検定済教科書 *One World* (教育出版、代表著者) など多数の著書がある。また、NHK テレビおよびラジオの英語番組「リトル・チャロ2」総監修者としても活躍。



さて、「英語教育を取り巻く社会環境の変化」にかかわり、21の国家戦略プロジェクトが政府から発表になりました。この先10年の目標ということで、2020年を目標にこういふことをするということが政府が宣言をして、10年後に同じ党が政権についているかはわかりませんが、国家戦略のプロジェクトが立ち上がったということになります。

その中で今回の皆さんのご研究、あるいはこの学会に係るであろうことを、3つ取り上げてみたいと思います。

国際医療交流

1つは国際医療交流。外国人患者の受け入れに資する医療機関の臨床制度の創設です。外国から患者さんをつれてくるということを大々的に行っていくという戦略に基づいて、それを受け入れる医療機関を認証するというのです。海外にプロモーションして、医療言語人材の育成というアイデアが出てきました。ドクター、あるいはナースの皆さんに英語、ほかの外国語を話していただくということだけではなく、医療言語という医療に関する外国語を操れる人材の育成を目指していくということ、2020年には日本の高度医療等がアジアでトップに評価されるようになるということ、ということです。

この戦略に関連して、当然、教育現場においてもさまざまな施策がこれから展開されていくのではないかなと思います。大学関係者でいうとGPといった形で来年度、想定されているものがあるのではないかなということ、ということです。

グローバル人材の育成，高度人材の受入れの拡大

次に今回取り上げたいのはグローバル人材の育成，高度人材の受け入れの拡大ということ、です。私もこの3月まで、経済産業省のグローバル人材育成委員会の委員をさせていただきました。その報告書が3月に出ています。経産省のホームページにいただくと、かなりの枚数になっていますけれども見ることができます。グローバル人材を育成しなければならないという産業界からの声を吸い上げ、そして日本の大学・大学院はどう対応しなければいけないのかということについて、かなり踏み込んだ提案がされています。

それと同時に質の高い外国人学生を30万人程度受け入れていくということになっています。いままで留学生という、日本語および日本文化を学びにきてもらうという発想が強かったわけですが、今回大きく違うのは日本語、あるいは日本文化ではなく、日本の大学で英語で専門科目を学ぶという方向性がより強まっているということです。これに関してもGPという形で具体化されているということが言えるかと思えます。

リーディング大学院構想

さらにリーディング大学院構想においては、国際競争力強化と人材育成ということが焦点になります。これは専門教育にかなり特化される形になると思いますが、特定分野で世界のトップに入る研究教育拠点を100以上構築するというものです。100以上という施策目標を挙げていまして、これが本当に可能なのかなどなのか、意見の分かれるところだと思います。日本の大学の地盤沈下が深刻な事態になりつつあるということでしょう。何とかしなければいけないという危機感がこういう構想に結びついているように思えます。

民間企業の変化

では、民間企業ではどうなのかということですが、人材を国内だけで育成するというだけではもう間に合わないということで、海外で外国人を幹部候補として大量採用していくような流れが生じてきています。それから、社員全員を海外要員候補にするという方針を打ち出した企業もあります。民間の方とお話をしている特にいまままで違うのは、昔は国内要員と海外要員と2つの人事の山があって、国内要員の人事の山のほうが高い。つまり偉くなるためには海外に出ないほうが得であるという流れがありました。この山がだんだんマージし始めているところ、幹部にするためには何年目かに一度、海外に出す。そこで国内よりもレベルの高い仕事を与えて、何年か働いてから日本に戻す。日本に戻してそこで海外よりもさらにレベルの高い仕事を与える。何年かしたらまた海外へ出す。日本、海外、日本、海外という流れで人材育成していったら、最終的には幹部になる。マネージャーになるためには海外に出なければいけないといったような人事のあり方というのを、実際に始めている企業が増えてきているということです。こういう方針があって、「社員全員が海外要員」なのだということ、ということ、ということです。

そして、外国人が1人でもいれば英語、あるいは社内のメール等はすべて英語で行うといったような会社がぼちぼち増えていまして、数日前も楽天の三木谷社長が英語でスピーチをして、数年後までには社内を英語化すると発言しました。そして、にわか「企業内英語公用語化」が話題になっているといった状況です。

これはどういうことかということ、まずは国内の市場とか海外の市場とかいうように分けている時代ではないということですね。世界を相手に仕事をしていかなければならず、本社での決定等が日本語だけで説明されていると、意思伝達に問題が生じるということ、海外において優秀な人材を獲得できないといったことがポイントとして挙げられると思われ、思われます。

問題視される日本の若者の国内志向

では日本の今後はどうでしょうか。今、非常に問題視されている点ですが、20歳代の出国率が1997年から続落傾向にあります。完全に毎年下がっています。新入社員に対する意識調査でも、海外で就労することについては、できればそうしたくないという率が年々高くなっています。その中でも特に日本の企業にとって重要な新興国での就労には、会社をやめてまで拒否したという率が高くなっています。日本の若者の内向き指向は非常に強くなっているというところが問題視されています。それだけ日本が豊かになって、日本で十分満足しているということなのでしょう。

こういう状況は大学の交換留学プログラムでも見られます。立教の場合も交換留学の枠が埋まらないという状態で、うちだけかなと思いましたが、この間NHKのテレビで京都大学も同じ状況だと報道されておりました。京都大学全体で三百数十人しか交換留学の枠がないらしいのですが、それが埋まらないという状況だそうです。京都大学の教授がこんなにいいプログラムで、こんなに得をする、お金を払わなくていいんだ、ということと言っても、手を挙げる学生が少ないという状況になっているとのこと。若者の意識がずい分変わってきたのでしょうか。

中学校における英語教育の変化

では、こういう状況を踏まえて、中学、高校における英語教育はどのように変わりつつあるのか、あるいは変わっていないのかということについてお話しさせていただきます。

まず、中学校の学習指導要領が2008年3月に告示されまして、2012年度に一気に1年から3年まで教科書が変わります。今年3月末までに各出版社が新しい教科書を文科省に提出しました。いま文科省がいわゆる教科書検定をしている最中です。多分、英語に関しては、今月の中旬から後半にかけて検定意見が各出版社に提示されると思います。中学の場合、教科書は6社か7社か、その程度しかありません。これらの教科書が2012年度から使われることとなります。

今回大きく変わった点は、英語の時間が週4時間になったということです。「戻った」という言い方がよいかと思いますが、それも3学年とも4時間になったということです。これによって英語の時間数がどの教科よりも多いということになりました。国語よりも英語の時間が長い。各学年とも週4時間、これが3年間というのは英語だけなのです。

ですから、中学校の英語の先生は言い訳できなくなってしまいます。いままでは時間が足りないと言えたわけです。4時間が3時間になって、やれることが限られている。行事があつていろいろな時間が割かれて、計算してみると週2.5時間ぐらいしか授業していない。そんな状況で英語をマス

『高等学校学習指導要領』
(2009年3月告示, 2013年4月実施)

【目標】外国語を通じて、言語や文化に対する理解を深め、積極的にコミュニケーションを図ろうとする態度の育成を図り、**情報や考えなどを的確に理解したり適切に伝えたりするコミュニケーション能力を養う**

(2016年1～2月の大学入試から)

図1

ターさせることなど無理な話だということで、ずい分、泣き言をおっしゃっていた先生もいらっしゃるわけですが、今度から週4時間ということですね。

週4時間になることによって、読むこと、書くことも重視しましょうとなりました。3時間になってしまったときには、読むこと、書くことは、できれば教えてほしいということだったのですが、今度からは読むこと、書くことも復活して、四技能を統合的に教えていきたいと思いますということになりました。多分、教科書も現在使われているものよりも、25%近くページ数の多いものになっていくのではないかと思います。そういうことで、中学の英語教育が変わる予定であるということです。

高校における英語教育の変化

では高校のほうはどうかというと、昨年の3月に新しい学習指導要領が告示されまして、2013年4月から年次ごと、まず1年生から変わっていくことになりました(図1)。中学とはちょっと違ひまして一斉にはなくて、1年次、次の年は1・2年次、その次は1・2・3年次というように随時変わっていきます。

この太字で示したところが中学校との文言の違いになります。情報や考えなどの的確に理解したり、適切に使えたりするコミュニケーション能力を養うということで、先ほどの中学とは違います。中学のほうはコミュニケーション能力の基礎を養うというようになっています。

ですから、2016年の春に行われるセンター入試や個別の入試等で出題される問題というのは、新しい学習指導要領に則った問題を作成することになります。目標については、いまの記述と大きく変わっていないわけですが、科目構成が大きく変わるということをご理解いただければと思います。

これが現在の学習指導要領に則った科目構成と、今度新しく展開される科目構成の比較対照したものです(図2)。現在の、旧学習指導要領に則った科目編成は、オールコミュニケーションIとII、英語I, II, リーディングとライ

英語の科目構成	
旧 (1999年度版)	新 (2009年度版)
オーラル・コミュニケーション I	コミュニケーション英語基礎
オーラル・コミュニケーション II	コミュニケーション英語 I
英語 I	コミュニケーション英語 II
英語 II	コミュニケーション英語 III
リーディング	英語表現 I
ライティング	英語表現 II
	英語会話

図2

ティングという6科目から構成されています。左側の太字の部分、オーラルコミュニケーションのI, または英語Iが必修、いずれかの科目を履修しないと、普通科以外の高校であっても高校を卒業できないというような科目構成になっています。

コミュニケーション英語の新設

それが今度は、「コミュニケーション英語」というのが基礎、I, II, IIIと4段階できまして、それと同時に「英語表現」のIとII、「英語会話」という科目構成になり、右欄で太字になっている「コミュニケーション英語I」というのが必修科目になっています。これを履修しないと高校卒業できません。

中教審での討論の一部を紹介すると、高校の英語教育というのは中学に比べて改善のスピードが非常に遅い、という点が挙げられます。その1つの原因としてオーラル・コミュニケーションという科目の存在があるのではないかという議論がありました。どういうことかという、「オーラル・コミュニケーション」の授業においては、いわゆる会話的なことをやったりプレゼンをやったりということはするけれども、そういう科目があるので、核となる科目である「英語I」と「英語II」では旧体然とした訳読でかまわないという発想があるということです。「オーラル・コミュニケーション」はいわゆるALT(Assistant Language Teacher)等に任せて、週1時間程度やって、悪い言い方をするとお茶を濁して、英語I, IIのほうで「しっかりと」英語を勉強させる-先生が日本語で説明をし、生徒に、英文を日本語に訳させる。50分かけて読む英文量は1ページにも満たない。半ページ程度を読んで終わり。そのような授業が今でも綿々と行われているという状況です。

コミュニケーションというのは何もスピーキングとリスニングに限られていることではないので、読むこと、そして書くことも含めたコミュニケーションという発想から、「コミュニケーション英語」という科目に統合してしまおうということで、核となる「英語I」「英語II」という科目の指導

法、あるいは内容を大きく変えるために、「コミュニケーション英語」という科目を設定することになったわけです。

また、中学の英語の基礎的な部分を理解しないで高校へ行ってしまっている生徒の割合が5割、6割という状況において、中学と高校の橋渡しをどうするのかということが非常に重要な問題です。中学校でいちばん使われている教科書の最後のレッスンと、高校でいちばん使われている教科書の最初のレッスンを比較すると、大変なギャップがあるわけです。英文の難しさ、英文の量。これはどうしたらいいのかという問題が当然あるわけです。そのために「コミュニケーション英語基礎」という科目を設けたのです。

これは、中学校の英語が定着していない生徒さんが多いと思われる学校においては、中学校レベルの英語を高校生にも興味を持ってもらえるような内容にして、定着を図るための教科であるということですね。それが終わってから高校レベルの「コミュニケーション英語I」をとっていきましようということなのです。

コミュニケーション英語I, II, IIIが四技能統合型になりますので、「英語表現」はどのようにしたらいいのかということになりますが、こちらのほうは基本的にライティングとか、スピーキングというアウトプットを重視して行く。旧カリキュラムのほうでは「ライティング」という科目がありました、「ライティング」という科目と「オーラル・コミュニケーション」を合体してアウトプットを重視した授業をしていきます。評価の面で「コミュニケーション英語」と「英語表現」に差をつける。つまり「コミュニケーション英語」の場合には四技能をまんべんなく評価対象にするのに対して、「英語表現」のほうはアウトプットの面を評価するという違いをはっきりさせているということが、文科省の方針になっているわけです。

さらに高校現場では、本当にできるのかと、いろいろ議論されている部分というのは、「英語に関する各科目については、その特質にかんがみ、生徒が英語に触れる機会を充実するとともに授業を実際のコミュニケーション場面とするため、授業は英語で行うことを基本とする。その際、生徒の理解の程度に応じた英語を用いるよう、十分配慮するものとする」という部分ですね。

つまり、いままでは、先生が中心で、先生が生徒をあてて答えさせているという、teachers-centeredの授業だったわけです。しかし、今後は、授業中に生徒同士がインタラクティブにする。別にそれは会話練習だけをするという意味ではなく、読んだり書いたりも含めて、生徒主体の活動を行うということです。そのようなコミュニケーション活動を提供するような授業をし、基本的にそのインタラクティブ等は英語で行うということです。

これを読んだ高校の先生の中には「いままでやっていた文法事項の説明を全部英語でするんですか。仮定法も英語で説明するのですか」と疑問に思った方が少なくないわけですが、そういうことではなくて、生徒が英語を使うというこ

とを重視した授業展開に変えていきたいと思いますということなのです。

文法はどうするのかということについてですが、文法についてもかなりディスカッションがありました。中教審以外の場でも文法指導をどうするのかということについての会議がかなり持たれました。基本的に文法は要らないということではなくて、文法はコミュニケーションを支えているという立場をとっているということです。これが意外と理解されていなくて、「コミュニケーション英語」という科目を見て、いわゆる薄っぺらな内容の英会話をするのかというような、的を射ていない批判とか、文法は教えないのかといったようなご批判もあるわけですが、そうではなくて、文法はコミュニケーションを支えているものなのだとしているわけです。ただし、文法指導というのは、用語や用法を解説しているだけではだめですよ、というわけです。

中学のレベルですと、いまだに「この文を受け身にきなさい」とか、be going to と will を単純に置き替えたりといったようなことが行われています。そういう意味のないこと、あるいは間違っただけを教えないといったことですね。機械的に文法を教えずに、必要な文法事項を使ったコミュニケーション活動をしていきたいと思いますということが、文科省の立場からも明らかになっていると思います。

根深い高校現場での二項対立

ただ、高校の現場には、いまだに根強い二項対立があります。受験派对コミュニケーション派。あるいは訳読・文法指導中心派と、コミュニケーション活動中心派。お互い、没交渉状態です。

大学ではほかの先生が見に来ることもけっこうありますし、授業公開されることも多くなっていると思います。中学は県の指導主事が来て、公開授業をしたり研究授業をしたりすることは珍しくないのですが、高校というのは校長にも授業を見せないという人たちがけっこういます。8年間、9年間、一緒に仕事をしている同僚でも、どんな授業をしているか、生徒からうわさを聞くだけです。そういうような文化ができ上がってしまっているものですから、お互い勝手にやっている。同じ教科書を使って、同じ学年を教えているのに、指導法についてもほとんど話したことがないというケースが珍しくありません。

では、どうやって試験を作るのかというと、輪番制。あるいは3人が教えていたら33%ずつ問題を作る。「レッスン6までは必ず終えておく」といった程度の話しかしないといったような状況です。この二項対立の発想をなくさないで高校の英語教育は変わっていかないと。

受験もコミュニケーションもないだろうと思います。本来ならばコミュニケーションというのは別にリスニングとかスピーキングに限られたことではないし、大学に来て専門書を英語できちんと読めて、論文を英語で書けるような

基礎力を高校で養っておいただかなければいけないわけですね。こういう指導は少なくとも長い目で見れば受験英語にも役に立つはずなのですが、なぜか受験重視の先生方というのは、いわゆる受験問題集ばかりをやる。教科書に関しては、ワンセンテンスごと日本語に訳していく。ほとんど英語は聞こえてこない授業です。いまだに日本の高校の7割、8割がこういう授業をしていると言っても過言ではないと思います。本当に何とかしなければいけないと思います。

こういう高校の英語教育が変わらない別の理由というのがいくつかあるかと思うのですが、その一つは受験の結果以外に目標達成の評価基準がないということです。たとえば外部評価委員に評価してもらおうとか、英語のさまざまな外部試験、TOEFLとかTOEICとか、そういうものを使って生徒さんの英語力の伸びを客観的に検証するというようなこともあまりない。そして、社会の動きがどうなっているかということにはほとんど関心がない。そういう学校文化ができ上がってしまっています。

主に高校で教えている英語の先生というのは、だいたい教育学部の英語教育専攻を出て、そのまま高校の先生になっています。大学の英語教員のように海外の学会で、英語でプレゼンするというような機会もなく、何十年も日本の高校の中だけで教えてきているわけです。実際に英語を使う体験がほとんどなく、英語で何かを学ぶというようなこともないし、英語を使って何かほかのことを学ぶということもほとんどない。そのような体験の不足という問題がどうしてもある。

どうして教師になったかということ、生徒が言うことを聞いてくれるから。卒業式に涙を流してくれる、その1日のために3年間我慢する。そういう中で生活をしているので、「私は先生である。先生と生徒との決定的な差は知識の差である。この構文について私は説明できるが、生徒は説明できない。だから私は教壇に立ってられる」といったような発想でいらっしゃるということで、受験英語という「神話」が必要なんだと思っています。

実際にはこの神話というのは崩れつつあります。指定校推薦とAO入試の合計が40%にまで増大していると言われていて、それからセンター入試問題には、皆さんご存じのようにガチガチの文法問題は出題されません。訳読の問題も一切出ない。リスニングの速度もアップしていて、CNNニュースと同じレベルです。

長文もたくさん出ていまして、1分間に180 words 読めないとセンター入試はクリアできないと言われていて、各大学の入試問題もずいぶん皆さん苦労されて、変化しています。長文の総語数というのが600～800 words が主体になってきていますし、意見を書かせる自由作文が増えていまして、「この日本語を英語に訳さない」という問題ではなくて、「こういう考えについてあなたはどう思うか、立場を決めてエッセイを書きなさい」といったタイプのものが増えてきて

います。ですから、受験のための英語ということが、教師の言い訳にしかっていないという場合も少なくないと思います。

ただ、一部の大学の個別入試の問題が変わっていません。特にきょうは医学部にお勤めの先生方ばかりなので、お願いしたいことがあります。立教大学の入試の英語問題が改善されても、残念ながら、高校の英語教育にはまったく影響を与えないのです。東大とか京大に加え、医学部が日本の高校生のトップ集団が目指すところになってきているわけです。ですから、医学部の入試問題というのはものすごく影響力があるわけです。「だって、京都大学の問題はまだまだこうですよ」、「大学医学部の問題はこうですよ」というように、旧態依然の授業をする言い訳に使われています。

もちろん訳すにしても、全文が英語で理解されて、ピンポイントでこの部分はどういう意味かというのを日本語で問うということは、必ずしも悪くはないと思うのです。なぜかという、全部を英語で理解していなければ、正しい日本語には変換できないと思うからです。しかし、それにしても問題の形式として訳読、あるいはガチガチの文法問題で、それぞれ学生さんの能力の差を区別するというようなことは、高校の英語教育の改善に携わっている者からすると、できればやめていただきたいです。

うちの息子も一時期、医学部目指していたときがあったので、さまざまな大学の医学部の入試問題を一緒に解いた思い出がありますが、「おや」と思う問題があったというのが私の正直な感想です。

大学での英語教育の課題

では、大学の英語教育というのはどうしていったらいいのかということについて考えていきたいと思います。これは皆さんのほうが私よりも熟知されていることだと思うのですが、大学における変化として重要なのは、国際競争力を重視しなければいけないということです。先ほども少し触れましたが、日本の大学の国際的評価ですね。先ほど名前が出ました東京大学にしろ、京都大学にしろ、地盤沈下が激しい。世界のトップ20に入っていない。それどころかアジアでもどんどん評価が下がってきているということで、文科省とか経産省も資金をまんべんなく全国の大学に振り分けるというよりも、日本のトップと言われる大学に集中的に特化するという傾向が強まっています。

グローバル30が始まりましたが、仕分けにあってグローバル30ではなくて、13になってしまったと揶揄されていますが、今年に入って日中韓というようなフレームワークでGPを出しています。今後、国際競争力をどう高めていくのかということは日本の大学にも重要な課題になっています。

たとえば東京大学の工学部においても、私の知人の日系人で、非常に有名な教授が、アメリカの某大学から引っ張

られて、いま東京大学にいます。彼は英語のほうがずっとできるのですが、留学生を受け入れるにあたって英語で専門を教えられる人を探していたんですね。名古屋大学等も全教員対象に英語で授業するためのワークショップを行っています。日本の大学を取り巻く環境もかなり変わってきたのかなという印象を受けています。

英語教育と専門教育の関連づけ

いままで大学の英語教育が成功しなかった理由はなぜかと考えると、私が思うに、まず英語教育の科目と専門教育の科目の関連性がないということです。これが決定的な問題としてあると思われます。つまり英語教育は、言ってみればおまけのような存在で、必修単位も数単位であって、一応それを取らなければ卒業はできないんだけど、大した時間数ではない。その内容は専門教育と何ら関係なかった。かつ、教えている教師同士、何らコラボレーションが行われていない。下手をすると上下の関係があって、英語教育を教えている人が下請けのような認識が大学教育の中にある。

それから英語教育の科目と、その他の基礎教育科目、一般教育科目の関連性がほとんどない。お互い担当者同士話したことがないといったようなことが現実としてあると思います。

英語教員はよく大学生に「将来、英語は必要なんだ。日本は国際化する。君らは英語ができないとだめだよ」というようなことをおっしゃるわけですが、学生にとっては卒業後どうのこうのと言われてもモチベーションの上昇にはつながらない。やはり大学の中に英語で何かをするというプログラムを作っていないかぎり、私はうまくいかないと思います。

やはり専門教育との関連性を考えて、専門教育の先生にも最初から入っていただいて、英語教育をどうするのか、英語教育と専門教育の関連性をどうつけるのかといったことを考えていくことが重要だと思います。最近では一般教育とか基礎教育の中にコミュニケーションに関する教育が日本語で行われるようになりました。文章を書くとか、人間関係をどのように構築するかとか…。そういう科目と英語教育をどのように関連づけていくのかということも重要な課題です。

英語でライティングができない学生というのは、日本語でもライティングができないというケースが多い。日本語でライティングを教えるのと英語でライティングを教えるのとは、かなり多くの共通点がある。それをどうすみ分けていくのか。あるいはプレゼンテーションにしても、基本的なプレゼンテーションの構成も、日本語と英語、かなり多くの共通点があって、それを整理した上でカリキュラムを効率的に運用していくことが必要だと思われます。

実際に英語だけの授業で卒業できる、専門科目を英語で

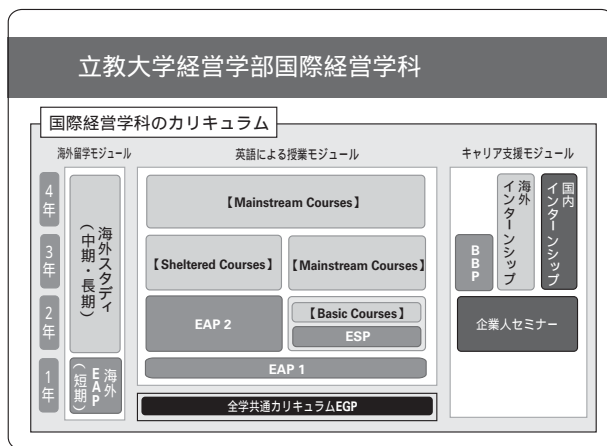


図3

受講できる大学、学部が増えつつあります。こうすれば受験生が増えるということではなくて、逆に減るケースもあります。立教大学の経営学部は、経営学科と国際経営学科があって、経営学科はほとんど一般教育の英語だけで卒業できるのですが、国際経営学科の場合は専門科目の7割が英語で展開されるとなると最初から受験生が敬遠するケースもあって、偏差值的には経営学科のほうがいまは上です。そういうリスクを冒してでも、なぜ専門を英語で教える大学が増えつつあるのかというと、結局、国際競争力の確保とそれに伴う国際認証を取るためには、専門科目を英語で教えていかないとならないということです。

まだ経営学部で国際認証を取っている大学というのは、ごくごく一部で、大学院レベルしかありません。学部では一橋でも取っていませんし、早稲田、慶應の商学部でも取っていない。そういう中で私どもはまだまだなんですけど、何とか取ろうとしていま動いています。専門科目の何%が英語で教えられているか。英語を使える教員は何%いるか。職員の中に英語で対応できる人は何%いるか。シラバスが全部英語になっているか。というようなことが、基本的な調査項目にあります。もちろん、教員の業績に関する評価が重要ですが、専門科目を英語で教えているかというのが国際競争上、非常に重要になってきています。

こういう認証を受けないと、海外の一流の大学と交換留学プログラムが結ばなくなってきているわけです。同じ認証機関に認証されている大学、あるいは学部間であれば、教育の質が同じレベルであると保証はされるということになるのですが、日本の場合は大学の認証というと、国内の認証しかなく、その認証は国際的にはほとんど価値がありません。ですから、やはり専門教育を英語で行うという方向に向かうと思います。

私どもの経営学部国際経営学科ではさまざまな専門科目が英語で教えられていて、各学期、50～60人の交換留学生が来ています。3年生、4年生が取る授業では、場合によっては半分以上が留学生で、英語だけで授業を展開しています。

医学部の特殊性

英語の必要性の相対的な低さ（単語レベルまで）
 専門性の高さ
 専門科目担当教員とのコラボのむずかしさ
 カリキュラムの余裕のなさ
 学生のプライドの高さ
 学生・教員の多忙さ
 国家試験の存在

図4

ただ、先ほどお話ししたように高校の英語教育があのように旧体然としている状況です。うちの学科で1年生と最初に会ったときに私がする質問があります。「高校時代、皆さんの先生は日本語を使って授業して、ほとんど授業中日本語しか聞こえてこなくて、やっていることはほとんど文法問題の練習か、英語を日本語に訳すということだった人は手を挙げて」と言います。8割くらい手が挙がります。

そういう学生を相手に私どもはどうしているかということ、1年、2年の間にビジネスを英語で読めて、ビジネスに関して英語でリサーチをしてプレゼンができ、ディスカッションできるというプログラムを作って、2年の後半から専門科目を英語で取り、その専門科目に対応する英語サポート科目を抱き合わせて履修し、徐々に英語でノートが取れ、英語でディスカッションができ、英語で試験問題に答えられる、ペーパーが書けるというところまで力を伸ばします。そして、3年生から徐々に英語のレベルを上げていくことをしています(図3)。

医学部での英語教育の特殊性

私も多少苦労しているわけですが、では皆さんの場合はどうなのかということで、私が垣間見た医学部の特殊性を書かせていただきました(図4)。自分が勤めたらどうなるんだろうということを多少考えさせていただきました。

経営学のレベルであれば、じつは私は学部では経営学を専攻したのですが、専攻していない英語教員でも、ある程度勉強すれば学部生が勉強しているレベルに追いつきます。ところが医学部の場合、専門性の高さというのがやはり大きなハードルになるのかなと思います。そういう意味で、医学部における英語教育は大変だなと思います。

私も一度、腎臓の移植をする患者さんの付き添い兼通訳でアメリカに行ったことがあります。そのときはやはりステッドマンの大辞典がお守りがわりでした。そんなものを現場で使っている余裕は当然ないのですが、わからない専門用語が出てきたらどうするんだという恐怖心はものすごく

医学部英語教育の改善に向けて

ニーズの創出（交換留学の促進，海外研修の開催，海外で活躍する卒業生の講演会開催，海外の医学部教員の招聘，一部の専門教育科目の英語化，外国人患者の受け入れに資する医療機関の認証制度など）

カリキュラムにおける「コミュニケーション教育」という発想（他の基礎教育科目との連携強化）と専門教育担当教員との連携強化

国際医療交流に向けた指導内容の修正，新科目設定，カリキュラム一部改訂など

国家試験における英語による問題の増加への働きかけ

図5

くありました。医学用語を英語で説明しなければいけないというのが、非常に大変だなと思いました。

カリキュラムも非常に過密になっていますね。経営学部，経済学部，あるいは法学部の授業ですと，だいたい90分の授業を1日で3コマ取ってれば多いほうで，あとは空き時間があるという感じです。しかし，医学部の学生さんの場合は朝から夕方まで授業がある。そのような状況で，英語の授業をどうやって増やしていくのかといったマクロ的な難しさもあるのかなと思います。

そういうハードなスケジュールで医学部生が勉強している中で，英語を勉強しなければというモチベーションは低くなる。英語の必要性も相対的に低い。大事だというのはわかるけれども，それ以前にやるのがたくさんありすぎるわけです。

そして専門科目の担当者とコラボレーションするといっても，向こうの先生も忙しい，こちらも忙しい，ほとんど接点がない。会うのは教授会くらい。

学生もやはりプライドが高い部分があると思います。東大か，京大か，医学部という認識で入ってきていますので，いまさらそんなことをやるの，といったような反応が，さまざまな基礎教育に関してもあります。

国家試験があるということで，とにかくそれに通らなければどうしようもない。国家試験における英語の問題の比率というのは微々たるものであるとなれば，英語教育を改善する，あるいは勉強をさせていくということはなかなか大変だと思います。

解決策はニーズの創出

「無理です」といった話で終わると大変なことになるわけで，私がそういう立場になってプログラムを開発するとなるとどうするか…。医学部の皆さんがやられていることを少し勉強させていただきまして，さまざまな試みをされている医学部もかなりあるということがわかりました。

いずれにしても，とにかくニーズを作り出すのがいちば

入試問題から見える英語教育の内容

アドミッション・ポリシーやカリキュラム・ポリシーとの整合性

中学・高校の英語教育との一貫性

(1) 翻訳問題は出題しない，
(2) 文法の用法を問う問題は出題しない

図6

んなのです。先ほど申し上げましたように文系でも英語教育と専門教育が離れていて関連性がないと，学生は一切興味を示しません。また，授業だけではだめなのです。留学生とのイベントとか，海外の著名な学者の英語による講演会とか，いろいろな揺さぶりをかけないと学生はやらない。興味を示さない(図5)。

ニーズの創出としては，交換留学の促進とか海外研修の開催。あるいは海外で活躍されている卒業生を呼んで講演会を行う。アメリカの医療現場ではこうこう，こうしているということを英語で話していただく。どういう英語力が必要なのかという話も交えてお話をいただく。あるいは海外の医学部の教授の招聘。その人たちによる講演。それから，一部の専門教育の科目を英語で行うような試みがやはり必要になってきます。

先ほど社会の動きで取り上げた外国人患者の受け入れ。これに関連するプログラムを立てるとか…。学生さんが英語をやりなさいと言われてやるのではなくて，授業の中，あるいは課外の活動の中に英語が存在する学習環境をいかに作っていくかということが，まず第一歩ではないかと思えます。

それからカリキュラムにおいてコミュニケーション教育という発想を持っていただいて，ほかの基礎教育の先生方とのコラボレーションをぜひ重視していただきたい。英語教育の人だけで闘うというような発想ではなくて，学生さんのコミュニケーションのための基礎的能力を上げる。それはもちろん読んだり書いたりすることも含めてです。人間関係をつくるということも。現在，さまざまな実習をされていると思うのですが，こういったものをすべてパッケージにして，その中で英語というものを行える。日本語でも英語でも行えるプログラムの構築を目指す，というようなことを考えていくことも1つの方法ではないか，と思えます。

先ほど申し上げたように国際医療交流に向けた指導内容の修正とか，新しい科目設定，カリキュラムの改訂。実際にこれから海外の患者さんを受け入れられるかどうかということに関して認証制度をつくるという方向で動いていくのであれば，それに対応してカリキュラムを一部変更していく。ですから，模擬患者を使つてのやり取りも，一部英

語にしていくといったような方向性というものが考えられるのではないかと思います。

そういった中で、専門教育の先生と英語教育の先生がコラボレーションするきっかけを作っていくことが重要だと思います。あくまで専門教育の人とコラボレーションしないと始まらないというのが私の考えです。経営学部の場合でも必ず専門の先生と話をしますし、われわれは専門科目の授業を見に行くし、向こうの人たちは英語教育の科目を見に来る。実際に専門を英語で教えるにあたって、学生はどのようなレベルかについて担当教員にアンケートを取るといったこともしています。このようなコラボレーションが必要です。

これはまったくの素人考えですが、国家試験で英語による問題を増やしていただくような働きかけができればよいのかなあ、と思います。

高校教育の改善にかかわってきている立場としては、入試問題を見ると、その大学の英語教育はどのようなものかという、印象を持ちます(図6)。

この入試問題で、この大学のアドミッション・ポリシー、カリキュラム・ポリシー、あるいは教育の内容とどうかわっているのだろうという疑問が出るケースがあります。とにかく受験生を単に選別をするというだけではなくて、アドミッション・ポリシーとの一貫性のある、あるいはど

ういう教育をしていく予定なのかということが入試問題を通して見えてくるような問題を作っていただきたい。中学、高校の英語教育が変わるためには医学部の入試問題が関連しているとぜひ考えていただきたい。

翻訳の問題がすべて悪いという意味ではないのですが、やはり英語を日本語に訳す、日本語を英語に訳すという問題形式が、高校の先生が授業を変えない言い訳に使っている実態を、英語教育の関係者としては重く受け止める必要があると思います。こういう点についても関心を持っていただいて、お忙しいでしょうけれども、入試の問題の改善にもぜひ取り組んでいただければと思います。

私の申し上げたかった点は、(1)英語教育を取り巻く国際環境はかなりの速さで変わりつつあるということと、(2)中学、高校の英語教育が少なくとも国家の政策レベルでは、ここ数年でずいぶん大きく変わる予定であるということ、そして(3)大学の英語教育では、専門を英語で教えるということ、あるいは実際に英語でビジネスができるかどうか。医学部であれば、外国人の患者さんをどうやって英語で診察するのかといった実践が問われている時代になってきた、ということです。

ご清聴ありがとうございました。

(2010年7月3日、聖路加看護大学にて収録)

日本語の医学用語と英語の医学用語の違い

演者

日野原重明

(聖路加国際病院理事長・同名誉院長, 聖路加看護大学名誉学長)

私はあと 3 ヶ月先, 10 月 4 日には満 99 歳, 白寿を迎えます。10 歳のときからピアノを習い, それ以来合唱の指揮をしたり作曲をしたりしていますが, 最近では「新老人の会」で俳句を指導してられる木下星城先生に習って俳句を詠んだりしています。

「白寿近し ステージに立つ我 息弾む」

そういう気持ちで今日は, 私の講演をしたいと思います。

Health の語源

最初に, 日本語では「健康」といいますが, 英語の“Health”という言葉の語源を探訪してみましょう。Healthという言葉は, ギリシャ語のHolosからきています(図 1)。1100 年以前にアングロサクソンの古い英語ではHälといっていました, これがHealtheとなり, 末尾に“e”がついていたのですが, それがなくなってHealthとなり, ここからHealingという言葉が生まれました。

また, ギリシャ語のHolosからは“Whole”(全体とか完全な)という言葉や, “Holy”(神聖な)という言葉も生まれました。つまり, Health(健康)にはこのように幅広いイメージが含まれています。

WHO は 1948 年に健康の定義を「完全に身体的, 精神的, および社会的によい状態であることを意味し, 単に病気がないとか, 虚弱でないということではない」と決めました。実はここにSpiritualという言葉を入れるべきだという意見

が出され討議されてはいるのですが, なかなか各国の賛同を得るのがむずかしく, いまだ決定には至っておりません。

さて, もう一つ看護の領域において大切にされる言葉, “care”(ケア)についてもみてみましょう。careという言葉は最初に使ったのは, ナースではなく, ハーバード大学内科教授のPeabodyでした。1927年に“The Care of the Patient”という論文を発表しています(図 2)。

この論文の中で, 彼は「臨床医に本質的に要請される大切な質の一つは, その医師が人間性に関心をもつということである。というのは, 患者のケアの秘儀は患者をケアする中にあるからである」と述べています。

では, 日本語では“care”という言葉はどのように用いられていたかをみてみましょう。1860年に刊行された増訂華英通話では, “Take care”を「キヤツケル」という日本語にしていますし, 英和対訳袖珍辞書では, 「心掛け」とか「気付」「心配」「心労」と訳されています(図 3)。

和漢語林の1868年の辞典では, 医者であり宣教師でもあったヘボン(ヘボン式のローマ字を発案した人でもあり, 本来はヘップバーンと発音するのが本当なのです)は, “care”という言葉に, Shimpai, Kokorodzakai, Anji などという日本語を充てています。そして, 医学や看護の領域ではcareと並んでよく用いられる“cure”という言葉には, Naoru, Iyeru, Zenkwaisuru という日本語を充てています。

ちょっと横道に逸れますが, 終戦直後アメリカが日本に食糧援助をしてくれましたが, それを私たちはCARE物資と言っていました。アメリカが, 戦争に負けた国, ドイツや

演者紹介: 日野原重明氏 (ひのはら・しげあき)

1911年, 山口県生まれ。京都大学医学部卒業, 同大学院修了。1941年に聖路加国際病院の内科医となり内科医長, 院長を歴任。現在, 聖路加国際病院理事長・同名誉院長, 聖路加看護大学名誉学長。1973年(財)ライフ・プランニング・センター創設。早くから予防医学の重要性を指摘, また卒後医師の2か年の研修制度を提唱, 看護大学に大学院を設置するなど, 医学・看護教育の刷新に尽力。患者参加の医療や終末医療の普及, 「成人病」に代わる「生活習慣病」という言葉を提言。2000年には老人の新しい生き方を提唱して「新老人の会」を立ち上げた。1998年東京都名誉都民, 1999年文化功労賞, 2005年文化勲章受章。2007年日本ユニセフ協会大使に就任。



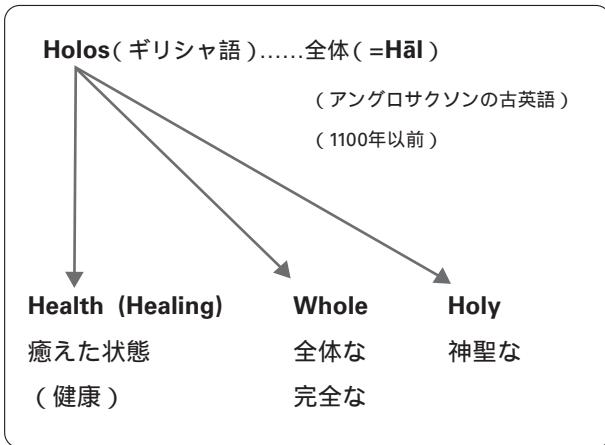


図1

辞書の種類	Careの訳	Cure	healer	therapeutic
増呈華英 通語(1860)*	Take care キヲツケル			
英和对訳 袖珍辞書 (1862)**	心掛け, 気付, 心配, 心労	治療, 薬剤, 心配, 説法者 の講座	治療 する人	平癒させる (therapeutics) 医術
和漢語林 集成(1867) ***	Shimpai, Kokorodz kai, anji	Naoru, iyeru, zen'wai szru		

* 福沢諭吉が中国人の著した『華英通語』
 ** 堀達之助等編で、この底本は、H. Picard: A New Pocket Dictionary of the English-English-Dutch and Dutch-English Languages
 *** ヘボン著の最古の和英辞典A Japanese and English Dictionary with an English and Japanese index

図3

The Care of the Patient
 (Francis Weld Peabody, M.D.)

One of the essential qualities of the clinician is interest in humanity; for the secret of the care of the patient is in caring for the patient.
 J.A.M.A. 88:877, 1927

臨床医に本質的に要請される大切な質の一つは、その医師が人間性に関心をもつということである。というのは、患者のケアの秘儀は患者をケアする中にあるからである。

図2

誤解されている英語の和訳

- ・ Physic 古い英語で医学または薬を意味する
例: Textbook of physic
(Text of Medicine: 内科書)
- ・ Physics 物理学, 理学
- ・ Physical examination
誤訳: 理学的検査
正解: 診察所見

図4

日本などに厚意でいろいろと食糧などを送ってくれたのですが、それを Cooperative for American Remittances to Everywhere といい、この頭文字をとって CARE 物資といったのです。ここで使われた CARE は、いわゆる医療や看護でいう care とは無関係の言葉であるということを入れたおいていただきたいと思えます。

実は、英語の care にいちばん適した日本語を用いたのは福沢諭吉と正岡子規ではないかと私は思っています。福沢諭吉は明治8年に著した『学問のすすめ』の中で「世話」と言っており、正岡子規は『病床六尺』の中で「介抱」という言葉を用いていますが、これが Peabody の述べた care の概念にいちばん近いのではないかとことです。

日本語の医学用語は英語の医学用語に比べてなぜ難しいか

日本では、病名や症状名は一般の人または患者に容易に理解できないような用語が使われています。つまり、患者にわかってしまうような用語は使ってはいけないという教育を受けてきたので、私たち医師はそのような医学用語を診療録にも書き、医師とナースの間でもそういう用語を使って会話をしました。これは、内側のことはなるべく患者

には知らせないということが眼目だったからです。医師やナースが話していること、あるいは回診のときに医師同士が話していることは、患者さんがそれを聞いても全く理解できないように患者は医療の枠外に置かれてしまっていて、医療は専門家だけのものと考えていたからです。

ところが、英米では医療職の間でも日常会話で交わされるようなわかりやすい言葉が用いられていますから、患者や家族は医療を自分たちのものとして受け止め、積極的に関わっていくようになってきているということです。

誤解されている英語の和訳

英語を日本語にする際に大きな誤解が生じる例もあります(図4)。たとえば Physic とするのは、古い英語では Medicine といい、医学または薬を意味するものです。ウィリアム・オスラーは1892年に Text of Medicine という教科書を書きましたが、18世紀までのアメリカや英国の医学の本は Textbook of Physic という表現でした。Physic garden というのは薬草園のことです。一方、Physics というのは物理学のことです。physical examination を日本では「理学的検査」と訳してきましたが、本来は「診察所見」と言うべきなのです。

これは *physic* と *physics* を訳し間違えたところからきているもので、末尾に“s”がつかない *physic* は「体の、身体の」という意味で、*physical examination* は診察所見、診察術のことを言うのです。今でも理学的所見と言う医師がありますが、それは間違いです。

日本では日本成人病学会という学会があり、何年も続いています。この言葉も外国に通用しません。「成人病」とは成人の病気、おとなの病気ということでしょうが、その意味は明確ではありません。英語でいえば、*life style related disease*、あるいは *habit disease* というべきなのですが、成人病を文字通り英語にすると *adult disease* となり、日本成人病学会というものでできてしまったのです。私は25年間も、これは正しくないと言いつづけて、1997年によく厚生労働省が成人病を生活習慣病と改めました。日本では法律を変えるのに20～30年かかります。よくない習慣の積み重ねによって起こる疾患なので、生活習慣病というのが正しいのです。

和製英語、造語

英語でない和製英語もあります。外国人に通じない日本語英語としてよく例に挙げられるのがナイトゲームです。英語では *night game* と言います。

診療録を英語では *chart* と言います。medical record とか health record とも言います。日本語ではドイツ語の *Karte* という言葉を長い間使って、いまでもカルテと言っている人がいますが、診療録、診療記録と言えばいいのですが、これからは *chart* という言葉がメインになってきて、電子チャート (*computerized chart*) という和製用語が使われています。

新しく造られた言葉でいちばん見事だと思われるのは“*serendipity*”という言葉です。これはおもしろい造語です。18世紀のイギリスの作家ホーレス・ウォルポールが使ったのが最初だといわれています。スリランカ、もとはセイロンと言っていましたが、アラビア語ではセレンディップと呼ばれていました。そこに伝わる民話で、スリランカの王様が3人の王子たちを国外に修行に出しているいろいろな事件に遭遇させ、それをかいくぐることによって人間として生きるために必要な知恵を発見させたということに由来します。

王様の命じた宝物を持って帰らなかった王子たちはそれを王様に謝るのですが、王様は3人の王子に「おまえたちは普通では得られない尊い人生体験をした」と彼らの労をねぎらったということです。

この伝説をウォルポールは、思わざる発見をすること、つまり“*serendipity*”と名づけ、日本語ではこれを「幸福な偶然」、あるいは「掘り出し上手」などと訳しています。

「幸福な偶然」によって、いくつもの大発見がなされています。ペニシリンの発見もそうです。フレミングが扁桃腺炎の治療法を研究するため、その原因菌である溶連菌をシ

ヤレに入れて培養していたところ、中に青カビがはえているのに気づきました。1928年の夏のことでした。「これは失敗した」と思って、捨てようと思ったのですが、カビのそばに溶連菌がまったくいないことに気づきました。それを見て、青カビには溶連菌の発育を止めるようなものがあるのではないかと考えました。その後共同研究者がペニシリンの濃縮を試みますが失敗に終わっています。それが1930年代の終わりに、オックスフォード大学のフローリーという学者がフレミングの発見を追跡してペニシリンを発見したのです。

ノーベル賞を受賞した科学者にはこのような実験の失敗が新しい発見につながったという例がいくつもあります。日本人でノーベル賞を受賞した田中光一さんも確か実験の失敗が新発見につながったと話していたように思います。

ただし、ストレプトマイシンの発表は偶然ではなかったのです。アメリカは死者を土葬します。結核で亡くなった患者を土葬して何年後に掘り返してみたところ、死体は腐ってばい菌がいっぱいいるだろうと思って調べてみたら、結核菌はなくなっていたということです。それで土の中の土壌菌が結核菌を殺すのではないかとということで、いろいろな場所から採取した土と組み合わせて実験したところ、ある場所の土が結核菌を殺す土壌菌を持っていることがわかりました。

この例は科学的な探究によって得られたのですが、思わざるところに発見があるというのはこれまでにいくつも報告されています。普通の人であれば、実験を失敗したりすると、「ああ、これはだめだ」とあきらめてしまうのですが、ノーベル賞を得るような人は、失敗から何か新しいヒントを得るアンテナをもっているのです。ちょっとした電波でも、それを鋭く感知するアンテナがあるからピピッと響くのです。普通の人にはアンテナがないからどんな電波がきてもわからないのに、そういう科学者は鋭敏なレセプターを持っているのです。そしていつでも鍵と鍵穴が合うような用意があるわけです。

さて、ウォルポールは *serendipity* という言葉を、思わぬところに新しいことを発見するという意味をもつものとして新しく造ったのですが、ニューヨークには *Serendipity* というカフェがあります。私はそこに行きましたが、とても変わった料理があって、そしてこの言葉を宣伝しているのです。私も、銀座あたりでこんな店をやったら、はやるかもしれないと思ったりしました。ニューヨークのこのお店は深夜まで非常に流行っているそうです。

私は学生に、辞書を買うときに、この単語が載っていない辞書は古いから買わないようにと言っています。『セレンディップの三人の王子たち』はじめ、これについて書かれた本が何冊も出ていますのでぜひ読んでいただきたいと思えます。

猩紅熱(scarlatina), 赤痢(dysentery)

Scarlatina とは猩紅熱のことです。scarlet というのは緋色ですね(図5)。『スカーレット・レター(緋文字)』というホーソンの小説がありますね。あのスカーレットは「赤い」ということで、皮膚に赤い発疹があるという意味です。おサルさんの赤い顔のようなという意味で、日本語では猩紅という難しい訳を充てました。

Dysentery は赤痢です。dysentery というのはギリシャ語ですが、dys-というのは「打ち消す」ことです。discount の dys は「悪い」ということです。enteria というのは腸からきた言葉で、「悪い腸」という意味ですね。ですから、dysentery というのは、下痢便に赤色の血液が混じる伝染病であるということになります。赤痢は出血もしますから、日本語では「赤い」という字をつけたのではないかと思います。

子供の赤痢は疫痢と言ったのですが、疫痢という病気の原因はとうとうわからないままです。アメリカ軍が日本に来たときに、日本の10歳児くらいの子供がこれにかかると4割は2週間のうちに死んだことに注目しました。死亡率が非常に高い病気です。疫痢は流行性の疫病の下痢を伴った疾患ですが、戦後子どもの栄養状態がよくなったからこの病気が自然になくなっていきました。

疫痢というのは外国の文明国にはなかったもので、そのまま疫痢を「ekiri」として使っていました。

戦前の子供は鼻汁を出していました。私が小学生のときには鼻汁は出るし、しもやけもできていました。みんな鼻汁を洋服の袖でふきますから、そこがテカテカになっていました。またしもやけで手や足が腫れて崩れてしまい、足袋をはいていても脱ぐときには出血しますから、銭湯に行っても足袋をはいたまま湯船に入って、だんだんお湯で溶けてきたら足袋を脱ぐ。思えば銭湯も汚いところでしたね(笑)。

だんだん栄養がよくなって蛋白質を摂るようになってきたら、鼻水もしもやけもなくなりました。生活が変わることによって病気が変わるということです。

アメリカ人の子供たちはもともと鼻汁も出ないし、しもやけにもならないのです。日本の子どもも老人も栄養がよくなってきたので、余りティッシュを使ったりしなくてもよくなりました。

津波もそのまま「tunami」といっています。津というのは船着き場のことですから、船着き場に大きな波がくるという意味ですが、これがどうしたわけかそのまま英語でも tsunami のまま使われています。

難しい日本語の医学用語

swollen lymphoma は、医学用語では癰腫(るいれき)といいますが、これは子供のリンパ腺が腫れることで、昔は結核性のものだと思って手術をしたものです。今はそういう

- | | |
|-------------------------------|-------------------|
| ・猩紅熱(しょうこうねつ) | scarlatina |
| scarlet(緋, 深紅色) | |
| ・赤痢(せきり) | dysentery |
| ギリシャ語の dysentery | |
| dys(悪い) + enteria (entera: 腸) | |
| 下痢便に赤色の血液が混じる伝染病 | |

図5

子供はいなくなったのですが、「累々」というのは重なり合うさまを表現したのですが、swollen lymphoma とは、つまり腫れた卵のようなものが累々と首いっばいにあるというところからつくられた言葉です。癰は病気という意味です。

Tenesmus は、裏急後重(りきゅうこうじゅう)といえます。下痢をして便が出てもすぐまた便意を催して頻回にトイレに行くのですが、便意があっても思うように出ないという状態を表します。どうしてこんな言葉を使ったのか、何のことがさっぱりわかりません。

日本語で「つわり」というのは、漢字で「悪阻」と書きますね。「悪い」と「阻」というのですが、これも何のことがわからないですね。英語では morning sickness といいます。朝、気持ち悪くなって、何となくムカムカするということから意味はよく通じます。

もう一つ、「失禁を来した」という言葉があります。失禁というのは「失う」と「禁じる」で、これも尿失禁とか便失禁といえはわかりませんが、ただ「失禁」というだけではわかりません。「失禁」というのは、どういう意味なのでしょう。日本語では「尿漏れ」といえばいいのです。urine というのは尿ですが、dysuria というのは尿が漏れることです。urine という英語はみんながわかる言葉です。

Diarrhea は下痢という意味ですが、もっと平易な医学用語にしても差し支えないのではないのでしょうか。そうすれば医師が書いたものを患者さんが読んでも理解できますし、あるいは「先生、ちょっとこここのところは違いますよ」ということも言えるのですが、医師の書いた診療録は、患者が読んでもなかなかわからないので、患者は医療の当事者であるはずなのに、何となく蚊帳の外に追いやられてしまっているというのが日本の実情のようです。

私も京都大学ではドイツ語でカルテを書いていたのですが、聖路加国際病院では診療録は全部英語でしたから、私も英語に切り替えようと思って診療録を英語で書くことを覚えました。

病気と社会

聖路加国際病院の塔のあるこの建物ができたのは昭和8年でしたが、創設者のトイスラー先生がまだ生きておられ

ましたが、その翌年に先生は心筋梗塞で亡くなりました。日本における最初の心筋梗塞の剖検例がトイスラー先生でした。当時は日本には心筋梗塞はあまりなかったのです。

私は京都大学の医学部を出て4年間循環器の内科にいたのですが、1例も新しい心筋梗塞の患者をみたことはありませんでした。心電図でSTが高くなるということは知っていましたが、こういう心電図がとれるような患者が来ればいいと心待ちにしていたのですが、とうとう4年間一度もその機会はありませんでした。

ところが東京の聖路加国際病院に勤め始めて4週間後に心筋梗塞の患者が来て、STが上がっているのを確認することができました。「これが見たかったのだ」と、患者が苦しんでいるのに、こちらはそれをみて興奮するというような状態でした。

京都は「着倒れ」です。しかし食事は本当に粗食で、お金持ちの人でもそうです。朝食はおみおつけとお新香とご飯だけです。心筋梗塞のような病気は起こらなかったのです。ところが、東京の商社の社長や専務などは、やはり西欧式の食事をとっていたので心筋梗塞になったのでしょう。生活によってこんなに病気が違うかということを実感しました。当時のアメリカ人の死亡統計では医師の死因は半分以上、6割くらいは心筋梗塞でした。日本では心筋梗塞の患者でいちばん多いのは外交官や商社マンで、一般の人たちには心筋梗塞はありませんでした。いかに食べ物、生活習慣が病気に影響するかが分かります。

しかし、日本も国民が豊かになるにつれて、心筋梗塞も増えています。日本食は、塩分さえ気をつければとてもヘルシーなのですから、欧米のよくない食習慣はそのまま受け入れたりせず、それと同時に、よい日本の習慣を外に紹介するというようにしなければならぬと思います。日本人の生活習慣と外国人の習慣がどの程度に健康に影響しているかを、私たちは医学を通して勉強していかなくてはならないし、それにはどうしても英語で論文を書かなくてはならないと思います。そういう意味において、これからの日本の医学や看護はもっと英語が使えるようになっていかなければなりません。

私は、中学校は神戸の関西学院というミッションスクールでした。中学の1年のときからデューク大学で私の父と同級だったオグバーン先生が日本語は全然使わずに英語で授業をしましたので、当時から比較的ヒアリングはできました。

ところが、私は1951年、39歳のとき1年間アメリカに留学しましたが、カンファレンスがよくわからないのです。ある場面でみんな「ワーツ」と爆笑しました。日本人の悪い癖で、私もわけもわからず一緒に笑ったのですが、そうしたら隣の友人が「君、わかったのか」と聞くのです。私は「わからない」と答えたのですが、そうしたら「どうして笑ったのか」とまた聞かれた。これで日本人のビヘービアというのはおかしいなということに気づかされました(笑)。

わかったふりをするというのは間違っていることだと。それから、私はわからなかったときには隣の人に尋ねたり、字を書いて「これは何か」と聞いたりするようにしました。「わからない」と素直に言うことができるようになってから、半年のうちに何とかヒアリングが上達したように思いました。日本から米国に留学する人は、講演や講義のときにはいちばん前に席を取るべきです。最前列に座っておれば、わからなければ質問もできるからです。講義を理解するためにはヒアリング力をもっと鍛えるようにしなければなりません。

ヒアリング力は、年を取ってくるとやはり落ちます。というのは、横のほうから耳に入る言葉は日本語でも英語でも聞き取りにくくなるからです。ですから、英語の講演を聞こうと思うのであれば、前方の正面の真ん中に座って聞くことです。後ろや横に座ったりしてはよく聞き取ることができません。

老人になると難聴になるといいますが、集中して聞こうとすれば聞こえるのですが、駅のアナウンスのようにいろいろな方向から声が聞こえてくると聞き取りにくくなります。ですから、よく聞き取れる場所に位置して、意識を集中して聞くようにすればいいのではないかと思います。

自分らしい文章を書く

最後に、私は『なぜ明快に書けないのか』という本を皆さんに推薦しましょう。聖路加看護大学で英語を担当された助川尚子先生と私との共訳です。

著者のKingという人はJAMA、アメリカ医師会雑誌の編集長を長年やって、その後Mayo Clinicに転勤したのですが、長い間、医学論文に手を入れてきた方です。アメリカ人や英国人の英語の使い方がどうして下手なのかということを指摘しています。

いろいろな有名な文章を見ると、若いときは非常に長い文章で、しかも形容詞が多いというのです。つまり格好をつけている。ところがだんだん年をとるにつれて文章は短くなって、形容詞も少なくなって、その人の言葉で書くようになるから、読んでみて非常にわかりがいい。若いときは装飾語をつけると文学的だと思うのです。

私は小学校6年のときに、夏目漱石の『我が輩は猫である』を読んで非常に感心したものですから、その文章をそのまま借りて作文を書いたところ、45人のクラスで43番目の点数をつけられました。それから借り物はだめだと思うようになりました(笑)。

ウィリアム・オスラーでも、若い頃の文章は気取っていて、ものすごく難しいですね。私は聖路加看護大学の仁木久恵先生と一緒にオスラーの講演集『Aequanimitas』を翻訳し、『平静の心』と題して医学書院から1983年に出版しました(講演17に対して注は800です)が、オスラーの文章には本当に難渋しました。古今東西の古典からの言葉をあまり

にもたくさん引用していて、どこまでが引用で、どこからがオスラー自身の言葉なのかを見極めるのがとてもたいへんでした。2001年にデューク大学から出版されるにあたってはそれぞれの出典(講演数20)をさらに詳しく調べて1600の注釈をつけました。書名は『Osler's "A Way of Life" & Other Addresses, with Commentary & Annotations』です。この仕事はアメリカのオスラー研究者からもとても高い評価をいただきました。

英語にも日本語にも共通するのは、医学論文や看護の論

文はなるべくクリアに書くということと、あまり気取った文章は書かないようにすべきだということです。

そして、患者さんにもわかる言葉を使うということです。医療の主役は患者さんなので、その当事者である患者さんの情報をなるべく多くしかも適切な表現で聞き出すためにも、私たち医療者は平易な言葉でわかりやすく患者さんとコミュニケーションをとるように努めていかなければならないと思います。

(2010年7月4日、聖路加看護大学にて収録)

Book Review

Because We Care

English for Healthcare Professionals

Authors: Maki Inoue and Tadashi Ihara

Published by Cengage Learning, 2010

ISBN 978-4-86312-129-4



As teachers, publishers, administrators and students realize the value of utilizing an ESP curriculum in higher education, we see an increase in English textbooks targeting healthcare workers. These textbooks in the health sciences have traditionally been utilitarian and tended to be rather formal and technical. EFL textbook authors on the other hand seem to have focused on being eye catching and hip. *Because We Care* (Maki Inoue and Tadashi Ihara, Cengage Learning, 2010, ¥2,310), is an ESP textbook targeting health care workers that thankfully does not take itself too seriously, and still offers what English teachers in the health sciences expect from a textbook.

In the introduction to the textbook, the authors state that their mission was to create a textbook targeting allied health science students due to the overabundance of textbooks geared toward medical and nursing students. The authors have combined their expertise in English and health care pedagogy, resulting in an effective and comprehensive text that integrates vocabulary, reading, listening and speaking in a way that should be engaging to healthcare students, English teachers and professionals in the field.

The text is divided into 12 units plus an introduction and an appendix. The topics covered are Hospital Floors and Healthcare Professionals, Body Parts, Musculoskeletal System, Circulatory System, Respiratory System, Digestive System, Nervous System, Urinary

System, Reproductive System, Endocrine System, Basic Life Support and Advanced Live Support, Rehabilitation and Diet and Nutrition. Two areas of this text stand out: the introduction to each unit and the appendices. Each unit introduces its theme with a comic strip from Osamu Tezuka's popular *manga* Black Jack, the rogue unlicensed physician. For example, the unit on body parts is introduced through Black Jack attempting limb reattachment on a victim of an explosion. Students may find the English translations of the *manga* difficult since they utilize quite a few medical terms, but the authors thoughtfully introduce each strip with a Japanese synopsis. By beginning each unit with a pop culture icon, the authors have deftly found a way to increase motivation and have the students become more engaged with the text, as most Japanese students are familiar with this character either through the drawings of Tezuka or the TV animated series. The appendixes in the back of the book alone are worth the price of the book. Included are all the major body systems with diagrams and an English/Japanese glossary. The illustrations are excellent, and the treatment of the vocabulary is quite thorough. There is also a section on medical abbreviations and acronyms. Although the abbreviation and acronym section is alphabetized, I wonder why only the section on hospital departments and facilities present the English words in alphabetical order, while subsequent sections in the appendix seem

to follow no discernable pattern. It seems to me that if a student encounters an unfamiliar word in one of the chapters, it would be easier to locate the word if it were presented in the appendix alphabetically.

Each unit is divided into six sections: the Black Jack warm up, three conversations, a listening exercise and a reading passage. All sections are thematically connected, and the conversation sections are organized according to the clinical process between a health care professional and a patient. For example, the three conversation sections relate to symptoms, assessment and treatment. The reading passages feel authentic and include medical case studies adapted from sources such as the National Center of Case Study Teaching in Science from the University of Buffalo. The authors attempted to integrate the skill areas in many of the sections. For example, they do not simply present the conversations as pair work; the tasks double as discrete point cloze exercises which also introduce relevant vocabulary. The student text includes a CD of the three conversation exercises, the listening exercises and the reading passages. The layout of the text is visually appealing. The font is large, nicely spaced, and there are illustrations which accompany the exercises on almost every page. The exercises, for example, use pictures only, and students simply number the pictures in sequence according to what they hear, thus utilizing their global listening skills. The listening audio script

also functions as the reading passage. Unfortunately, the authors decided to put the reading passage/listening audio script directly below the listening exercise. Many students will simply read the script during the listening exercise, thus making the listening practice mute. It would have been better if the authors had put the reading passage/listening audio script on a separate page from the listening exercise.

My impression is that Japanese teachers of English are the target market for this textbook; all of the instructions for the exercises are in Japanese, as are the reading comprehension exercises in which the students have to summarize each reading passage. This is not necessarily a drawback, but it may prove to be an obstacle to the many native English teachers in Japan with limited proficiency in written Japanese.

There is something in this textbook for almost every ESP teacher in the health sciences. Although the authors state that their focus is on the allied health sciences, this textbook could hold its own in a first or second year EMP college curriculum as well. Although this reviewer hopes that the second edition will alphabetize the glossary, and relocate the audio script I would not hesitate to team teach with Black Jack and Because We Care.

(Reviewed by Richard Caraker,
Associate Professor, Health Science University)

Writing Tips

In Consideration of Patients' Rights

Reuben M. Gerling

A clinician observes that a number of patients have come up with similar symptoms and developed similar conditions. He decides to follow these patients, trace their records backwards as it were and come up with common denominators. These, if elucidated, will provide future clinicians with an opportunity to detect similar problems earlier and to know whether a patient is at risk of developing the same symptoms and conditions.

For example, infants in most advanced countries receive early injections to prevent a number of infectious diseases (Diphtheria, Tetanus, Pertussis, Hepatitis B and Poliomyelitis are the most common). New and more complex vaccines are being developed and the choice for health authorities is difficult, especially since it is complicated by cost considerations.

Researches in Georgia, USA, studied the records of nearly 19,000 infants and discovered that recombinant drugs provide a better coverage than a series of individual injections (Gary, Happe, Lunacsek, et al., Use of Combination Vaccines Is Associated With Improved Coverage Rates. *The Pediatric Infectious Disease Journal*, Vol 26, issue 6 (June 2007). This is a retrospective study, i.e. it traced back the records of children who had received preventive injections two years previously.

A clinician reads this study and decides to trace the infants who are receiving their injections right now. The results are published two years from now. This is a prospective study. Both studies deal with patients' records.

Medical writers and editors need to be aware that in both these cases there are human subjects involved and an institutional review board approval is required (IRB). Also, complete forms of informed consent must be signed by those participating in the study, showing that they understand the aims and procedure involved and agree to participate. The example here is of infants, in which case the parents or guardian will have to sign the forms.

In recent years, the concern for the patients' rights and privacy has become predominant, making the need for the two forms (IRB & informed consent) an absolute must for any study that involves human subjects. Exemptions are usually made only in cases of common space (studies of general behavior in public places, studies of public records), but all other cases are included. The first example quoted here deals only with the examination of medical records, so there is no issue of personal contact or association. The main concern is invasion of privacy. With a prospective study, however, personal contact with the individual subject is likely and an

IRB and informed consent are crucial, although these will be required in the retrospective study as well.

Some of these studies are known at times as cohort studies as they tend to use two groups of people who have some common features. One of the groups will be exposed to the treatment and the other will not. The two will then be compared. Randomized control trials are always prospective and case studies are always retrospective. Cohort studies can be concurrent or historical. The former are prospective and the latter are retrospective.

Educators need to know that no work can be done without the patients understanding and consent. It is therefore important that students be taught from early on to how to explain things to patients and will be made aware of the need to receive formal permission for any type of exposure the patient may receive as a result of publication.

編集後記

新しい年を迎え新しい巻の1号をお届けします。本号には前回から始まった *Write Stuff* 誌からの転載論文や Book Review が掲載されています。研究論文としては日本の医学教育の特徴を検討した英文論文が2編掲載されています。これらは日本医学英語教育学会の裾野の広さを考えさせます。医学英語教育は多くの医療系の教育に拡がりながら開発途上にあります。その研究成果を示していただくことが本紙の発展につながりますので、会員の皆様の論文投稿をお願いいたします。本号にはまた、昨年の学術集会で多くの関心を集めた2つの講演が掲載されているので是非ご一読いただければと思います。

去年は学会にとって変革の始まりの年でしたが、本年は変革が形になる年です。会則の改訂に伴い、学会管理運営の手順が明確になり、学会としての意志決定が迅速且つ透明性を持って行われることになりました。同時に学会の構成者である会員の積極的参画により、会員と社会のニーズにも即した学会運営が行われることをめざしています。新制度による評議員の選出が既に進行中であり、今後理事の選出と総会の開催が予定されています。学会誌として学会のこのような変革に即して誌面を創っていきたいと思います。

新たな教育研究開発の成果をいち早く発表する機会が、本年7月に開催される第14回医学英語教育学会学術集会です。本号には開催概要が掲載されていますので参加の準備を進めていただければと思います。学術集会は毎日4,000人を超える外来と1,400の病床で医療と教育が行われている現場で開催されます。医療の臨場感を感じながらこれまでの成果や新たな取り組みについて活発に意見交換していただきたいと思います。学術集会は新たな学会執行体制を会員が決定する場でもあり、多くの会員の参加をお願いいたします。

日本医学英語教育学会誌
Japanese Editor

吉岡俊正

(東京女子医科大学医学部医学教育学)

How to submit papers to the *Journal of Medical English Education*

The Journal of Medical English Education welcomes well written, innovative papers on a wide range of subjects that relate to medical English and its teaching.

Prospective authors should consult first the Guidelines for Authors, which appears on every other issue and are available online at <<http://www.medicalview.co.jp/jasmee/index.shtml>> to ascertain that their work conforms to the format approved by the journal. The complete papers can be sent to the editorial offices at <jasmee@medicalview.co.jp>. A submission consent form, available at the end of each issue of the journal, should be completed and signed by the authors and sent by mail to the editorial offices at <The Journal of Medical English Education, Medical View, 2-30 Ichigaya-hommuracho, Shinjuku-ku, Tokyo 162-0845, Japan>. No submission will be published without the receipt of a completed and signed consent form.

1. Article categories and Journal aims

The *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, research, 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 either in English or Japanese.
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- 2.3. Use page layout 25-to-26 lines per A4 page, 12-point typeface of a common font such as Century.
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:

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- 3.2. Authors' names and affiliations: Write the full names

in the order agreed upon by the authors, without academic degrees. Use asterisks to designate authors from more than one institution; the asterisk goes after the author's name and after the comma (example: Jun SUZUKI, * Arnold PALMER** and Helen KELLER*). Include full names of the institutions and departments where the research was done, city and prefecture (state and country if outside Japan). If authors are from different institutions, put the appropriate number of asterisks before the institution name. Include the following information for all authors: e-mail address, telephone and fax number (example: *ABC Medical University, English Department, Nanai, Hokkaido; **XYZ Medical University, School of Nursing, Gunma).

- 3.3. Keywords: Include a maximum of six keywords or short phrases that would help in indexing the article.
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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. On the same page, state the background in one or two sentences (see 7.3 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 conclusions (or recommendations) in the present tense. Be concrete and avoid stating merely, "... was investigated" or "This paper describes"

5. English

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- 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.
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Japanese text may be written in 10.5-point or 11-point throughout the manuscript. Otherwise when writing an article in Japanese, follow the English guidelines in addition to providing English in the following 4 instances: (1) English title following the Japanese title, (2) author's name(s) in Roman characters following the name(s) written in Japanese, (3) institution(s) and department(s) in Roman characters just below the same author affiliation(s) in Japanese, (4) abstract in English only.

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