

Journal of

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## 第16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25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16回医学英語教育学会学術集会

日 時：平成25年7月20日（土）～21日（日）

会 長：伊藤昌徳（順天堂大学医学部附属浦安病院 脳神経外科）

会 場：東京ベイ舞浜ホテルクラブリゾート（〒279-0031 千葉県浦安市舞浜1-7）

演題募集：平成25年2月1日正午～4月20日 正午

[シンポジウム] 下記の2題に沿う演題を募集いたします。

- (1) 米国医師資格試験（USMLE）受験に向けての医学英語教育
- (2) 医学英語教育におけるICT（情報通信技術）の有効活用法

[口述演題] 下記の分野についての口述演題を募集いたします。

（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）

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

\* 詳細は学会ホームページをご参照ください。

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

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## Second Announcement

### The 16th Annual Conference 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 16th 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 20 (Saturday) to July 21 (Sunday), 2013

**Venue:** Tokyo Bay Maihama Hotel Club Resort

1-7 Maihama, Urayasu City, Chiba

**President:** Masanori Ito

(Department of Neurosurgery, Juntendo University Urayasu Hospital)

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

**Proposals are invited for 2 symposia under the following topics:**

- (1) Medical English education aimed at passing USMKE
- (2) Utilization of ICT (information-communication technology) in Medical English Education

**Online abstract submission begins:** February 1, 2013 (noon)

**Deadline for abstract submission:** April 20, 2013 (noon)

**Registration:** Please access the JASMEE homepage for details.

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

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# Journal of Medical English Education

The official journal of the Japan Society for Medical English Education

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## Editor's Perspectives

### Ongoing Concerns

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The language of medicine (English for Medical Purposes EMP) leads a sometimes uncomfortable coexistence with everyday English. As medical works are written in EMP, the writers need to use proper conventions or risk misunderstandings. This subject has not escaped our journal. In the previous issue Eric Jego argued that, following his corpus analysis, the patient should never be diagnosed, it is the disease that is diagnosed. This, he says, means that the holy writ of EMP is the AMA Manual. In the present issue Mark Irwin takes a somewhat more flexible view and adds a linguistic angle to the argument. He also stresses that, naturally enough there are differences between the various English speaking cultures, the American and British in particular.

The same point is also mentioned by Alistair Reeves in his 'Myths' series. The series was published over a period of 6 years in *The Write Stuff*, now called *Medical Writing*. Thanks to the agreement with that journal and Alistair's generosity, we are able to publish his eight articles in two installments, in this and in the October issue of our journal.

Surely the bottom line in this matter is whether one's discourse is comprehensible or not; whether the meaning that I receive is the original intended meaning. In most varieties of professional English (pilots

and the like) the language is so organized as to minimize the possibility of mistakes. EMP does obviously contain the same element but it also has a number of problems that make things more cumbersome. It is, of course, far richer and more complicated. It is also based on the dated convention of using Latin rather than the vernacular for scientific purposes, hence most medical words are Latin based. *Hemo* is used to describe things related to blood, hence hemorrhage means a discharge of blood. *Hemo* is, of course, New Latin and *rrhagia* is Greek, a combined form in which each part is from a different source. Vein, where some of the hemo flows, is New Latin. The Old Latin word for blood, *sanguis* (grandfather of the English *sanguine*) is also used in medicine.

Meanings in EMP are difficult to trace and there is little logic in this field used to describe things that, at least their advocates claim, are terribly logical. Therefore, we, in the field of EMP Education, need to convince those who wish to practice medical communication that the meaning should take precedence over conventions.

*Journal of Medical English Education*

Editor-in-Chief

**Reuben M. Gerling**

# Effects of Extensive Reading on Medical Students' English Proficiency, Reading Strategies and Learning Strategies

Harumi Oshita

Oita University Faculty of Medicine, Yufu, Oita

**Background:** Medical students should acquire reading skills and good reading habits in order to become independent learners.

**Objective:** This study investigated how effective extensive reading (ER) is for medical students and what factors in reading and learning strategies are affected by ER.

**Methods:** The participants were 99 first-year medical students. All were enrolled in a weekly ER program with 30-minute sustained silent reading from May, 2011 to January, 2012. In the program, the students chose books they were interested in, read as many of them as possible silently and wrote book reports in Japanese. Their general English proficiency and reading efficiency were measured with the Edinburgh Project on Extensive Reading Test A and Test Level C both at the beginning and the end of the ER program. In order to investigate the factors affected by ER, Carrell's questionnaire about reading strategies and Oxford's Strategy Inventory of Language Learning, both of which were translated into Japanese, were also conducted.

**Results:** The study found that ER not only improved the students' general English proficiency and reading efficiency but also led them to use more reading and learning strategies.

**Conclusion:** The findings in this study suggest that ER is an effective way of teaching medical students to become autonomous English readers and learners.

*J Med Eng Educ (2013) 12 (1): 7-11*

**Keywords** extensive reading, English proficiency, reading strategies, learning strategies

## 1. Introduction

Medical students need to acquire English medical terminology. In addition, they should develop the strategies for lifelong learning during college.<sup>1</sup> If they build good English reading habits during college, they will gain the ability to benefit from material written in English during their professional lives.

Most medical students are likely to have been instructed in the Grammar Translation Method (GTM) in their secondary education.<sup>2</sup> They tend to translate English into Japanese, focusing on the meaning of each word and on the grammar. Such a way of reading requires much time, effort and patience and it therefore impedes the students' understanding of the text, and, in the worst case, diminishes their interest and motivation for reading material in English.<sup>3,4</sup>

In order to acquire new and preferable reading habits by autonomous English learners while supplanting the continuous translation habit, extensive reading (ER) is becoming an alternative method of instruction.

ER is aimed at providing learners with an ample amount of English input through reading a lot of comprehensible material. It is an approach that fosters learning to read by reading.<sup>5</sup>

Research has proven that, through a large quantity of input, ER is more effective than intensive reading (IR), for which much time is allotted in GTM classes, in improving

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not only reading speed and comprehension but also writing, listening, and speaking skills.<sup>6, 7</sup> In addition, Takase (2007) points out that ER can enhance the motivation and attitude towards reading and learning English as well.<sup>8</sup>

In spite of these beneficial effects of ER, there are few empirical studies of ER with medical students.<sup>9</sup> Moreover, few studies explain which factors influence the improvement of students' reading skills through ER.<sup>10-12</sup> Therefore, this empirical study was conducted, focusing on the following four research questions (RQ):

1. Is ER effective in developing medical students' proficiency?
2. Does ER help medical students improve their reading efficiency?
3. How does ER influence the students' awareness of reading strategies?
4. Are language learning strategies affected by ER?

## 2. Method

### 2.1. Participants

A total of 99 first-year medical students (63 men and 36 women) participated in this study. They were divided alphabetically by family name into two groups, both of which had the same lessons.

### 2.2. Materials

About 200 leveled readers (LR) and graded readers (GR) such as Oxford Bookworms Library and Penguin Readers were used as material. LRs are books for children who use English as a native language, and GRs are books written for learners of English as a second or foreign language. In GRs, vocabulary and text structures are carefully arranged according to the levels of the books. These books were brought into the classroom by the teacher and the students chose the books in class.

### 2.3. Procedure

The research was conducted from May, 2011 to January, 2012. The ER sessions were held weekly. All students participated in 11 sessions in the spring semester, and a further 13 sessions in the winter semester. They were asked to read as many books as possible during 30-minute sustained silent reading (SSR) sessions in class. This is an essential key to successful ER, as it introduces all students to the habit of reading English.<sup>13</sup> Participants were asked to write reports which included: the book titles and the dates the books were read; information labeled on the back page of each book, such as the genres and the number of words, based on

Furukawa (2010)<sup>14</sup> and their impressions of the books in Japanese. Each class had 90 minutes: 30 minutes for SSR, 10 minutes to write book reports, and 50 minutes for lessons and quizzes on medical terms. In order to determine whether the practice of ER without any additional coaching will improve the students' reading strategies, no other help was provided in that area.

### 2.4. Analysis

To clarify the research questions, two types of reading tests and two identical questionnaires were conducted, one before and one after the experiment.

In order to assess the level of general proficiency, the Edinburgh Project on Extensive Reading (EPER) Test A was used. It is a cloze test that consists of 12 passages with 141 gaps.

EPER Test Level C was conducted for evaluating reading efficiency (RE). It consists of one passage with 1037 words and 10 questions. The participants were asked to write down the time they took to finish reading the passage and then answer the questions without rereading the passage. The RE was calculated according to the formula;  $RE = \text{Words Per Minute (WPM)} \times (\text{the number of correct answers} / \text{the number of questions})$ .

For the purpose of examining the factors affected by ER, Carell's questionnaire and Oxford's strategy inventory for language learning were used.<sup>15, 16</sup> Both questionnaires were translated into Japanese so that students could easily understand the questions. The former questionnaire is for evaluating the awareness of reading strategies and it has 5 factors with 36 items. The latter questionnaire is for investigating how a student learns English and it consists of 6 factors with 50 items. The students were asked to rate the extent to which they agreed with the proposed item by using a five-point Likert scale (1 = strongly disagree, 2 = relatively disagree, 3 = neither agree nor disagree, 4 = agree to some extent, 5 = strongly agree). The average scores of each factor in these questionnaires were used for analysis.

Paired sample t-tests were then conducted to analyze the changes in the tests and questionnaires before and after educational intervention. These analyses were carried out using *Excel Tokei 2010*.

## 3. Results and discussion

**Table 1** shows how many words the participants read over 9 months. All of them read over 20,000 words (max. 120,704 words, min. 22,808 words and average 52,334 words).



### 3.1. General proficiency (RQ 1) and reading efficiency (RQ 2)

In order to investigate the effects of ER, the mean scores of the pre- and post- EPER Tests A and Test Level C were compared by paired sample *t*-tests. As shown in **Table 2**, the changes in general proficiency and reading efficiency were statistically significant. These results seem to indicate that ER encourages the students not only to develop the skills needed to understand English passages accurately at a certain speed but also to acquire a reading knowledge of grammar, expressions and usage. Thus, ER helped medical students improve their general English proficiency and reading efficiency.

### 3.2. Reading strategies (RQ 3)

Hirano<sup>17</sup> analyzed the 36 items of Carrell's questionnaire by factor analysis and extracted five factors. Each factor was labeled as follows: Factor I (Items 1, 2, 3, 4, 5, 6, and 17), confidence in one's ability to use top-down strategies; Factor II (Items 12, 15, 21, 22, and 25), bottom-up strategies focusing on sound-letter; Factor III (Items 20, 26, 27, and 28), top-down strategies that make reading difficult; Factor IV (Items 31, 33, 34, and 36), effective top-down strategies; and Factor V (Items 10, 13, and 18), bottom-up strategies focusing on word meanings.<sup>17</sup> According to her classification, **Table 3** shows the changes of average scores of each factor in reading strategies both before and after ER, compared by paired sample *t*-tests.

According to the results, changes in Factor I and Factor II were statistically significant, and Factor III, Factor IV, and Factor V were not achieved .05. The results show that ER had positive effects on improving the students' confidence in their ability to use top down strategies. The Tsudajuku group (1992) reports that good readers were more confident in using global or top-down strategies (Factor I),<sup>18</sup> thus, ER can help students to be good readers from the perspective of reading strategies improving their all-out performance. To be specific, the students were likely to recognize through ER that they could "anticipate what would come next in the text" (Item 1), "question the significance or validity of what the author said" (Item 4), and "focus on relating the text to what they had already known about the topic" (Item 17). In addition, as shown in **Table 3**,

ER discouraged the students from paying excessive attention to bottom up strategies relating to sound-

letters. Thus, the students changed their awareness of reading from bottom-up strategies to top-down strategies, as a result of ER.

On the other hand, there were no significant changes in Factors III, IV, and V in this study. Fujimori (2007) suggests that Factors I, IV, and V were affected by ER, and the changes in Factors I and V were shown in the earlier stages of ER but Factor IV was affected by ER in the later stages.<sup>11</sup> With regard to Factor V, the participants in this study were still likely to "look up unknown words in a dictionary" (Item 10) and "focus on understanding the meaning of each word in order to read effectively" (Item 13), although its average score was getting lower. This result might have been influenced by the lessons in medical terminology in class after each ER program, because, in those classes, students had to read difficult material with many unknown technical words. With regard to Factor IV, the results of this study could not be compared with those of Fujimori's study, because she revised Factor IV in her study. However, she suggests that the students understood their use of effective top down strategies when they had a certain amount of ER experience. This study is based on less input through ER than the research by Fujimori. Therefore, Factor IV in this study might fail to achieve significance. Further research is needed to examine these questions.

To sum up, the results mentioned above indicate that confidence in the use of global reading strategies is most likely to be positively affected by ER.

### 3.3. Learning strategies (RQ 4)

Oxford & Ehrman<sup>19</sup> composed a learning strategies questionnaire, divided into 50 items in six factors: Factor I, items 1~9, memory strategies; Factor II, items 10~23, cognitive strategies; Factor III, items 23~29, compensation strategies; Factor IV, items 30~38, metacognitive strategies; Fac-

**Table 1. The number of words the participants read**

| number of words | number of participants |
|-----------------|------------------------|
| ~30,000         | 6                      |
| 30,001~40,000   | 16                     |
| 40,001~50,000   | 25                     |
| 50,001~60,000   | 30                     |
| 60,001~70,000   | 9                      |
| 70,001~         | 13                     |

**Table 2. Changes in general proficiency and reading efficiency**

|                     | <i>n</i> | Pre      |           | Post     |           | <i>t</i> | <i>p</i> |
|---------------------|----------|----------|-----------|----------|-----------|----------|----------|
|                     |          | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> |          |          |
| General proficiency | 99       | 74.24    | 128.14    | 80.32    | 131.01    | -6.81    | .00      |
| Reading efficiency  | 99       | 41.70    | 334.49    | 45.91    | 466.20    | -2.02    | .02      |

tor V, items 39~44, affective strategies; and Factor VI, items 45~50, social strategies.<sup>16</sup> **Table 4** shows the changes in average scores of each factor in learning strategies before and after ER according to her classification, compared by paired sample *t*-tests. All the factors except for metacognitive strategies were significant statistically, and the students could use various strategies of learning English to develop their knowledge and abilities of using English through ER. Specifically, the students could “learn words by grouping, imaging, and structured reviewing” (Factor I), “try to understand the passage in English by reasoning, analyzing, and summarizing” (Factor II), “guess the meanings for the text and use gestures and synonyms” (Factor III), “try to motivate themselves to learn English by anxiety reduction, self-encouragement, and self-reward” (Factor V), and “become culturally aware and cooperate with native speakers of English” (Factor VI). In particular, significant positive changes in terms of Factor II and III were shown, which were factors significantly related to second language (L2) proficiency presented by Oxford & Ehrman.<sup>19</sup>

On the other hand, the changes in Factor IV, metacognitive strategies, such as consciously searching for practice opportunities, planning for language tasks, and monitoring errors, had no significance. This result may imply that the students maintained passive attitudes toward learning English. However, Oxford & Ehrman<sup>19</sup> suggest that Factor IV is also a strong predictor of L2 proficiency. As Oxford & Shearin<sup>20</sup> suggest that learners’ goals with feedback stimulate L2

learning motivation,<sup>20</sup> ER with goal setting and self-monitoring instruction may be effective in improving the abilities tested in Factor IV.

Ötsubo<sup>21</sup> reports that, using Oxford’s strategy inventory for language learning, an average of 3 points in each factor is thought to mean that students have well-balanced knowledge and skills of English.<sup>21</sup> As shown in **Table 4**, the average scores in this study moved closer to Ötsubo’s 3-point benchmark as a result of the ER program.

## 4. Conclusion and further studies

The results of this study provide evidence that ER can help medical students improve their general English proficiency and reading efficiency, and acquire effective strategies for reading and learning English. According to Antic (2007), English for Medical Purposes’ (EMP) classes should develop the students’ awareness of the learning process and build positive attitudes for learner autonomy.<sup>1</sup> This study shows that ER is an effective way for EMP classes not only to develop the students’ knowledge and skills but also to build constructive attitudes toward reading and learning English.

However, some limitations still remain in this study. First, a control group, non-ER group, could not be formed for educational considerations. To more closely examine the effectiveness of ER, the comparison between ER groups and non-ER groups must be discussed in further research. Sec-

**Table 3. Changes in reading strategies**

| Factor | Reading strategies                                     | <i>n</i> | Pre      |           | Post     |           | <i>t</i> | <i>p</i> |
|--------|--|----------|----------|-----------|----------|-----------|----------|----------|
|        |  |          | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> |          |          |
| I      | Confidence in one’s ability to use top-down strategies | 99       | 3.48     | 0.35      | 3.74     | 0.24      | -4.59    | .00      |
| II     | Bottom-up strategies focusing on sound-letter          | 99       | 3.14     | 0.49      | 2.86     | 0.45      | 4.33     | .00      |
| III    | Top-down strategies that make reading difficult        | 99       | 3.74     | 0.42      | 3.68     | 0.61      | 0.74     | .22      |
| IV     | Effective top-down strategies                          | 99       | 4.38     | 0.34      | 4.29     | 0.49      | 1.06     | .15      |
| V      | Bottom-up strategies focusing on word meanings         | 99       | 3.63     | 0.76      | 3.55     | 0.79      | 0.82     | .21      |

**Table 4. Changes in learning strategies**

| Factor | Learning strategies      | <i>n</i> | Pre      |           | Post     |           | <i>t</i> | <i>p</i> |
|--------|--------------------------|----------|----------|-----------|----------|-----------|----------|----------|
|        |                          |          | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> |          |          |
| I      | Memory strategies        | 99       | 2.69     | 0.33      | 2.93     | 0.30      | -4.64    | .00      |
| II     | Cognitive strategies     | 99       | 2.80     | 0.40      | 3.12     | 0.30      | -6.32    | .00      |
| III    | Compensation strategies  | 99       | 3.26     | 0.43      | 3.52     | 0.28      | -4.59    | .00      |
| IV     | Metacognitive strategies | 99       | 3.08     | 0.47      | 3.04     | 0.43      | 0.57     | .28      |
| V      | Affective strategies     | 99       | 2.45     | 0.37      | 2.65     | 0.40      | -2.98    | .00      |
| VI     | Social strategies        | 99       | 2.55     | 0.57      | 2.87     | 0.51      | -3.96    | .00      |

ond, the results gained in this study are likely to be affected by the amount of input, so a longer-term study is needed. Finally, the relationship between ER and EMP, should be studied more closely in the future.

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# Style Guides and Reality

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This paper examines linguistic prescriptivism, its history within the English language, and its influence on modes of education and research. In particular, it considers the impact of prescriptivist style manuals on medical research and suggests prospective authors of research papers use a common sense approach towards their use.

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On p. 391 of the *AMA Manual of Style*, appears the following admonishment:

*Patients themselves are not diagnosed but their conditions may be diagnosed.*

Note the style manual does not state ‘patients themselves are not usually diagnosed’, ‘good academic writing prefers that patients themselves are not diagnosed’, or the like. Instead, we have an outright prohibition, followed by the following example sentence marked, bluntly, as ‘incorrect’:

*The patient was diagnosed as schizophrenic 4 years ago.*

How does this stylistic embargo square with reality? The British National Corpus (Medical) records the following examples, amongst a myriad of others:

*A 24 year old woman had been diagnosed five years previously...*

*...the study of patients with a history of having been diagnosed with cervical cancer...*

*Increasing numbers of patients, however, are being*

*diagnosed in the elderly.*

*Of the 47 patients diagnosed as having malignant bile duct strictures...*

*Group 3 comprised biopsies from patients previously diagnosed as having coeliac disease...*

The following example sentences appear in dictionaries:

*A new doctor with little experience diagnosing patients.* (Merriam-Webster)

*She was diagnosed with/as having diabetes.* (Cambridge Advanced Learner’s Dictionary)

*...was diagnosed as being schizophrenic.* (Nanzandō’s Standard English-Japanese Medical Dictionary)

Further, an advanced Google search records 1.50 m hits for ‘diagnose (d) me/him’.<sup>1</sup> Although a comparison is naturally difficult, searches for individual common diseases or conditions typically return smaller figures: ‘diagnose (d) cancer’ 0.56m; ‘diagnose (d) diabetes’ 1.45m; ‘diagnose (d) heart disease’ 0.36m, etc. Clearly, the *AMA Manual of Style*’s advice, in this and other cases, runs counter to the linguistic reality. Why has this gulf between ‘linguistic practice’ and ‘stylistic theory’ come about? Moreover, why do many practitioners and students of medicine seek to follow

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<sup>1</sup> Total for the 4 exact word or phrases ‘diagnose me, diagnosed me, diagnose him, diagnosed him’. ‘Diagnose (d) her’ is not considered since ‘her’ is both a pronoun and possessive (e.g. diagnose her disease but \*diagnose him disease).

the advice of this and other style guides; seek to follow a content which receives, in many cases, little or no corroboration from corpus linguistics, dictionary editors, or online usage?

It is a universal linguistic truth that all human languages undergo change. Some have changed more slowly than others (e.g. Icelandic in the last 500 years), others more rapidly (English in the early second millennium CE). Within the history of any one language, the speed of change accelerates and decelerates, driven chiefly by a range of sociolinguistic and sociohistorical factors. But no language stands still. If you are a grandparent you will notice subtle differences between your speech and that of your grandchildren.

This is, however, less likely to be the case for your writing and the writing of your grandchildren. For those languages for which we have written records, another universal linguistic truth is that the change evinced by an orthography lags behind that evinced by the spoken word. This is especially the case where an orthography is employed to write a sacred text widely read in the community (Arabic, Hebrew, etc.), or where an orthography serves to hold together a number of extremely divergent 'dialects' (Mandarin, Arabic again, increasingly English, etc.).<sup>2</sup> Here, the gap between the spoken and written word can be so vast as to impair literacy. Similarly vast divergences can be found for other reasons, as was the case with Japanese until the late 19th century and the rise of the *genbun'itchi* movement.

All speakers of a human language (i.e. the vast majority of the human race) are conscious to some extent of the linguistic change going around them, though the vast majority pay it little or no attention. Those who do may be broadly divided into two camps. Those who accept linguistic change as an inevitable fact of life, as inescapable as social, economic or environmental change; and those who dislike the linguistic change going on around them as much as they dislike a change in the status quo of any other facet of their life. Such attitudes may be likened to political liberalism versus political conservatism and, of course, since neither politics nor language exists in a vacuum, the two are not necessarily mutually exclusive. The two camps also have their extremist fringes: *über laissez-faire* 'liberals' advocating complete linguistic non-intervention, inter-generational communication breakdown be damned; and ultra-reactionary 'conserva-

tives' railing against every misplaced apostrophe, split infinitive or mischosen *kanji*.

In the academic discipline of linguistics, the terms 'liberal' and 'conservative' are not employed to designate the two camps described above. Instead, the terms 'descriptive' and 'prescriptive' are used. 'Descriptivists' do not seek to judge the change they study, instead they objectively describe it — from any number of different theoretical viewpoints. On the other hand, 'prescriptivists' prescribe, sometimes proscribe, the change they study. In general, they recommend the continuing use of traditional grammatical or orthographical forms which the youngest generation no longer favours, or even advocating syntax and spellings that have never been part of the language.

Most prescriptivists are not professional linguists. Linguists tend overwhelmingly towards viewing prescriptivism as heterodoxy. To the linguist, there should be no place in any academic discipline for emotion to win out over cold scientific analysis. To the linguist, prescriptivism is largely an anathema, a blot on the linguistic landscape, an embarrassment to the discipline best kept locked away in the basement. However, just as with politics, with language issues too it is the conservatives — the prescriptivists — who generally shout the loudest. It is most often their view that filters through to a general public largely disinterested in, or blithely unaware of, the linguistic change occurring around them. The media, especially letter columns in the press, have a major role to play in the dissemination of prescriptivist views (in Japan, for example, such letters often deplore the 'flooding in' of foreign borrowings or the use of so-called *ranuki* verbs). A major role is also played by government-sponsored or government-funded language 'councils', 'panels' or 'academies', such as the Académie française in Francophone countries. This body has long been involved in seeking to outlaw foreign borrowings and has even protested against the French government attempting to give constitutional protection to minority languages such as Breton and Basque. But perhaps prescriptivists' most potent weapon is the style guide.

The begetter of modern style guides was the 'English grammar'. Though dating as far back as the 16th century, the English grammar rose to prominence in the late 18th with the publication of two hugely influential works: the Oxford don and bishop of London, Robert Lowth's, *Short Introduction to English Grammar* (1762) and the New York lawyer and businessman, Lindley Murray's, *English Grammar; adapted to different classes of learners; With an Appendix, containing Rules and Observations for Promoting Perspicuity in Speaking and Writing* (1795).

<sup>2</sup> Many linguists would disagree that, in the case of Mandarin and Arabic especially, we are dealing here with dialects: 'languages' would be a more likely designation. However, the fact remains that most Mandarin and Arabic speakers view often mutually incomprehensible varieties of their 'language' as mere 'dialects', a view strongly reinforced by a single unified overarching orthography. Ultimately, it is the native speakers who must have the last word.



Lowth's volume had run to 45 editions by the turn of the 19th century, while Murray's became the second best-selling work in the English-speaking world, selling more than 20 million copies. 'Rules' advocated by these grammars included:

- (1) Condemnation of the multiple negative (e.g. *I haven't never spoken nothing to no one*), despite many examples in, for example, Chaucer or Shakespeare (*I cannot go no further*, As you Like It). In fact, such constructions in Old and Middle English were the norm, with multiple use indicating emphasis (as it still does for many speakers who use such constructions in the modern language). Lowth's and Murray's condemnation was based on Latin usage (*nullus non venit* 'someone definitely came') and on mathematics: since two negatives equal a positive, *I never said nothing* = *I said something*. But even this logical inference is wrong, as *she is not unattractive* ≠ *she is attractive*.
- (2) A distinction between *will* and *shall*. These have future meaning only in certain persons; otherwise *will* indicates 'promise' or 'resolution' in the first person singular and throughout the plural; while *shall* indicates a 'command' or 'threat' in the second and third person. Thus, the 'correct' forms of the future of 'go' are *I shall go, you will go, he will go, we shall go, you shall go, they shall go*. And Psalm 23 in the King James Bible (*Surely goodness and mercy shall follow me all the days of my life; and I will dwell in the house of the Lord for ever*) is wrong.
- (3) Since a preposition comes before, it must not come after. Thus, *Who servest thou under?* (Henry V), and many other examples, are wrong. Instead, we should use *Under whom servest thou?*. As Winston Churchill remarked many years later: *Ending a sentence with a preposition is something up with which I will not put*.

Lowth and Murray were not the only such grammars, and many of their prescriptions are taken from earlier commentators or authors. Their condemnations, along with later prescriptions, such as the split infinitive (*to boldly go where no man has gone before*), or *Mary and I* versus *me and Mary*, together do not amount to very many. Yet, as

David Crystal, the well-known commentator on the English language notes in his *The Stories of English* (2004), 'despite their paucity, th[is] set of rules... proved to be immensely powerful as class discriminators'. In the UK, even today, ideas of what are 'standard' or 'correct' English are still bound up with notions of class, and for this reason are not a simple matter than can be decided based on mathematics (double negatives) or etymology (prepositions).

As Crystal also notes, grammarians in the 18th century and authors of style guides even now exhibit the following broad mind-set: unless pushed, even the educated will not write correctly → manuals and guides are thus needed to put them on the right path → since even the great authors can break the 'rules', lesser mortals are even more likely to fall into the same path. These 'lesser mortals' include the doctor or medical student, who is lazy, unlettered, clearly hasn't two brain cells to rub together, and who must therefore not only make copious and liberal use of the medical style guide, but worship it as his god and master, font of all knowledge, never to be criticized.

And this takes us back to the *AMA Manual of Style*. To be fair, it does note that, in some cases, 'clarity is better served by the split infinitive' and that 'the use of a double negative to express a positive is acceptable'. Yet, we find admonitions urging against 'euphemisms', such as 'pass away', while elsewhere we are urged to avoid direct terms judged to be politically incorrect, such as 'stewardess', 'mankind', 'diabetics' and 'homosexuals'. Who has decided, and why, that direct reference to death is acceptable, while direct reference to 'homosexuals' should be replaced by 'lesbians and gay men'?

I do not urge the proscription of style guides. Many contain useful information and may even lead you to rethink what you have just written. But they should not lead you to unthinkingly rewrite what you have just written. Style guides are merely the collated subjective opinions of an editorial group, often the updated versions of earlier style guides based on the subjective opinion of just one author. They should never be the objects of blind worship and their advice should be tempered with a large dose of reality and common sense.

# Toho University School of Medicine

## Department of English

東邦大学医学部の医学英語教育は、学生が受講している日本語での講義と、時期と内容を呼応させている。人体構造と機能を学ぶ2年生は、それらの専門用語を英語で学習する。臨床医学各科について器官・機能系統別に学ぶ3・4年生は、病因・病態・治療などについての英文の読解と、問診英会話を学んでいる。この医学英語プログラムは、医学教育の国際的な互換性を念頭におき、大学全体の要請として2012年度に始まったものである。

### 1. Introduction

While Toho University has had a substantial English program for many years, prior to 2011, students studied general English as a required subject for 112 hours in the 1st year but did not have any required English courses after the 1st year. Students could still choose to study English in various elective courses up to the 4th year. In 2011, the hours for 1st year general English were cut in half to 56 and, in their place, clinical medicine English became a required subject in the 3rd year. In 2012, the remaining part of the new curriculum commenced, with general English in the 1st year and English for Medical Purposes as a required subject in the 2nd through 4th years. Because the full medical English curriculum has only been in place since April of 2012, the contents, goals and methods of the program are still embryonic.

### 2. Toho University English Department Faculty (as of January 2013)

3 Full-time instructors

- Izumi Nonaka (Associate Professor)
- Rod Turner (Assistant Professor)
- Alan Hauk (Associate Professor)

4 Part-time English instructors

- Jo Ann Leyte (Lecturer – elective courses)
- Alastair Holland (Lecturer – required courses)
- Makoto Goshi (Lecturer – required courses)

- Brent Fialka (Lecturer – required and elective courses)

### 3. Toho University English Program

#### 3.1. Program Objectives

Toho University takes the position that English is crucial to the future of medicine in Japan and, therefore, aims to prepare students to function in a medical English environment. This includes interacting with foreign medical personnel in Japan or abroad, reading, presenting, and communicating with patients.

#### 3.2. Program Structure (required courses)

- **1st year:** General English. Tuesday 1st & 2nd periods.  
6 classes divided by TOEFL score. 14-21 students/class. 70 minutes x 56 sessions/year.
- **2nd year:** Basic Medical English. Thursday 1st period.  
6 mixed-level classes. 18-21 students/class. 70 minutes x 22 sessions/year.
- **3rd year:** Clinical Medicine English I. Every other Thursday 2nd & 3rd periods.  
6 mixed-level classes. 17-20 students/class. 140 minutes x 14 sessions/year. Teachers rotate every class session in order to ensure that all the students have a similar learning experience and can enjoy a wide variety of teaching styles.
- **4th year:** Clinical Medicine English II. Every other Thursday alternating with the 3rd year



classes 2nd & 3rd periods.

6 mixed-level classes. 17-20 students/class.

140 minutes x 8 sessions/year. As in the 3rd year, teachers rotate every class.

### **3.3. Program Curriculum and Materials**

The 1st year general English program teaches standard English skills such as speaking, writing, and presentations. The instructors create their own syllabuses and choose or make materials according to department guidelines.

The curriculum for the 2nd through 4th year medical English program was accepted by the university's Curriculum Committee to reinforce what the students are studying each week in their regular medical lectures. However, the broad topics chosen by the Curriculum Committee leave considerable leeway regarding what materials and contents to include in each class.

For the 2nd year classes in 2012 we used Barron's E-Z Anatomy and Physiology as the class text. This book was chosen because it covers almost all of the topics decided on by the Curriculum Committee and contains the target vocabulary. However, it was selected only as a temporary measure until we have time to develop the 2nd year program further. A few topics at the end of the 2nd year, microbes, pharmacology and pathology, are not covered by the textbook, so we had to write original materials for those lessons. In the future we plan to replace this book with our own materials.

In the 3rd and 4th year clinical medicine English classes we use original teaching materials developed within the department in consultation with the clinicians who teach the medical classes. Some of the clinicians are very enthusiastic about the medical English program, providing supporting material and sometimes even observing our classes.

Our teaching materials usually consist of short texts synthesizing and summarizing information gleaned from various sources such as *Cecil Essentials of Medicine* or *Harrison's Principles of Internal Medicine*. Care is taken to properly paraphrase these texts. The 3rd year materials cover vocabulary and reading comprehension, while the 4th year materials focus more on doctor-patient interviews. We teach basic interview



Mr. Rod Turner with Dr. Keigo Takagi of the Department of Chest Surgery making comments on students' English presentations.

questions in the first several sessions in the 4th year, and then move on to specific medical situations. For example, when the students study urology, we have them practice asking questions related to lower urinary tract symptoms. The 4th year classes exceeded our initial goals, with many of the students showing proficiency at basic medical interviews by the end of the year.

### **3.4. Evaluation**

Students are evaluated by class grades and end-of-semester written exams in all 3 years of medical English. In the 2nd year, the main class evaluation is a quiz given at the beginning of each class based on the previous lesson's contents. In the 3rd year, students are graded according to their performance on class activity worksheets. In the 4th year, students are graded based on their performance in doctor-patient role-plays.

### **3.5. Student Reaction**

Student feedback for our new program has been positive. In particular, the 4th year students conducted their own survey about the English program, which indicated that they wanted more hours devoted to medical English.

## **4. Extracurricular Activities**

In addition to regular classes, the English Department cooperates with the Department of Chest Surgery at Omori Hospital by helping with case study presentations. The 5th year students

are required to give case study presentations in English during their chest surgery rotation. The English department helps them prepare their presentations, and one or two of our instructors also attend these presentations every week to give comments and advice. In addition, the doctors in the Department of Chest Surgery have their own English presentation sessions, and we often have one of our instructors attend these as well.

## 5. The Future

Since our department has only just completed its 1st full year of the new medical English curriculum, we are still developing our methods and contents, sometimes changing them drastically as we gain more experience. In the 2013 school year we plan to revise our 2nd year program to make it more communication-based. We also plan to introduce more medical interview practice into the 3rd year to make it more like the 4th year. Hopefully, our program will reach its mature form in a few more years.

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## From *The Write Stuff*

Starting in 2006, Alistair Reeves published 8 articles titled: Myths about English. The first 7 articles were published in *The Write Stuff* whereas the 9th and (to date) final one was published in the same journal under its new name, *Medical Writing (MEW)* last year.

Alistair gave us permission to publish all 9 articles, for which we thank him. The editors decided to do this in two installments. In this edition our readers will find the first four articles and we shall be publishing the last four in our October issue.

# Myths about English

Alistair Reeves

1 [Reprinted with permission from *The Write Stuff*, Vol. 15, No. 1 (2006) pp. 22–24.]

Theodore Bernstein, well-known among writers for his entertaining and pragmatic publication ‘The Careful Writer’ [1], published ‘Miss Thistlebottom’s hobgoblins: the careful writer’s guide to the taboos, bugbears, and outmoded rules of English usage’ in 1971 [2]. Miss Thistlebottom was a school teacher who had rigidly taught the same for her entire professional life, had some outdated ideas, knew absolutely everything about the English language, and knew how to enforce this knowledge—assertively.

Most British (and, I think, American) people carry with them in the back of their minds the spectre of such a fearsome but caring, probably bespectacled, most likely not made up, sensible flat-shoe-wearing, impassioned and learned Miss Thistlebottom expounding on English grammar at the front of the classroom and rapping them on the knuckles with a blackboard duster for putting a comma before ‘and’, or some other unforgivable grammatical transgression. My Miss Thistlebottom was actually called Mrs Whitfield in York many years ago (she fulfilled all attributes, except she wore very high heels), and I fell in love with her when I was 8 because she taught us French and English and I was captivated from the word ‘Go’ by her enthusiasm for language. I have rejected or modified many of her rules since my primary school days, but if Mrs Whitfield hadn’t existed, I wouldn’t be writing this now. Mrs Whitfield ensured that these rules hovered over me like the sword of Damocles for many years—and it even still pricks me in the back of the neck now and again. But (Mrs Whitfield: “Alistair! Never start a sentence with but!”) she was also a splendid teacher and encouraged us even at that age to form our own opinions and defend them—not, however, about commas before ‘and’.

You enter the world of writing and find that many writers appear to have successfully shaken off the spectre of their Miss Thistlebottom (although that blackboard duster does

still hover in the background), were never subject to ‘Close-Encounters-Of-The-Miss-Thistlebottom-Kind’, apparently learned rules that you never heard of from a ‘reliable’ source, or are just very laid back about the whole thing. Sometimes I think that the laid back attitude is the best as far as English is concerned: provided you remain consistent and true to your own convictions—although these may change (see Myth 2 below)—this is all right. One thing I can assure you of: ask native-English-speaking writers, and they will tell you they are glad that they never had to learn English as a foreign language.

It’s all a matter of building the confidence within yourself to listen to the different possibilities, decide—if you have the choice—what you want to do, remain consistent, and retain the necessary flexibility to stay out of any time-wasting and ultimately frustrating discussions on whether, for example, ‘in vivo’ should be italicised or not—unless you win, which you probably won’t.

The 4 myths below are amongst the most common questions I receive about English in our context. Almost all are ‘agree-to-differ’ issues, where gaining consensus is practically impossible. It’s not worth making enemies or losing your job about any of them. I make no claims to being a Miss Thistlebottom and hope what I have to say helps you in your daily work.

The points are problematic because:

- It is often claimed that they are governed by rules, and they are not. Conventions do exist, but the thing about conventions is that they—like guidelines—are not rules, and depending on where you are in the world or which style guide you consult, different conventions prevail.
- Because they are not governed by rules, they are also subject to personal preference. Frequent usage of a formulation often makes it ‘sound right’.
- They are often not apparent when speaking. Many liber-

ties with language can be taken when speaking, but there is a great gap between the spoken and written word, as reflected by Georges Louis Leclerc in his inaugural address on being received into the Académie Française in 1753 [3]: “...ceux qui écrivent comme ils parlent, quoiqu’ils parlent très bien, écrivent mal”.<sup>1</sup>

My approach is always to pick the easiest option to make writing (and checking my texts) easier for me and, I hope, to make reading easier for the reader.

### **Myth 1 : You should never start a sentence with digits**

I would like to banish the myth entirely that this is governed by rules. There is no rule that states that numbers at the beginning of sentences have to be written out as words (e.g. ‘Fifteen subjects were enrolled’). Likewise, there is no rule that elsewhere in text, numbers smaller than 10 (or 11 or 12) should be written out and that digits should be used for greater numbers. There are conventions. These vary according to company, style guide, publishing house, personal preference and—like many things as far as language is concerned—mood.

We all have our personal preferences, and this is one area where my preference is difficult to suppress, because I think that the choice I have made makes writing easier and helps maintain consistency. If I have my own choice, I always use only digits, whether at the beginning of a sentence or in text. There is absolutely no reason in medical and scientific writing why you should not, with two exceptions: ‘one’ often looks better than ‘1’ (but no other digits); and when digits immediately follow one another and there is potential for confusion.

Consider the following:

‘1 23-year-old man was withdrawn from the study because of...’. Here you have the choice of saying ‘A 23-year-old man...’ if the reader has no previous knowledge of this man. If the statement ‘1 23-year-old man...’ is preceded, for example, by ‘3 subjects discontinued because of adverse events’, i.e. the reader knows that the man in question was 1 of 3, then you have to say ‘1’ because the indefinite article would not be appropriate because you are enumerating. In this case, it is clearly better to say ‘One 23-year-old man...’, to avoid the ‘1’ and the ‘23’ being read together, even if reaching the age of 123 years is still unlikely.

And consider the following:

‘... was poured into 2 5-mL tubes.’ Even despite the

hyphen (which I think is unnecessary) and the space between the ‘2’ and the ‘5’, eyes scanning a page may read this as ‘25-mL’ tubes or ‘2.5-mL’ tubes, so it is clearly better to write ‘...two 5 (-)mL tubes’.

It is possible to think of quite a few other rare situations where potential for misunderstandings may occur. This is always the case. Face those situations as you come to them and find a common-sense solution.

We are in the business of getting the message across, so consider the following:

Two hundred and twenty-seven subjects were enrolled.

OR

227 subjects were enrolled.

Which hits you in the eye better? And don’t you dare be tempted to put ‘A total of’ before ‘227’ (see below).

Message: if you are an employee, do what your company wants. Depending on your employer, you may be able to do what you want. If you are a freelancer, do what your client wants (one of mine wants everything below 13 written out—so what! At least I know what they want). If you have the choice, do what you want and follow the golden rule: **be consistent**. But be aware: if you write out digits up to a certain number, you will have to do an awful lot of checking that you have done it consistently.

It is worth mentioning here that the misconception that a sentence should not start with digits has led to the widespread use of at least 3 of the greatest redundancies in writing in general to start sentences: ‘a total of’, ‘in total’ and ‘overall’. ‘A total of’ might be justifiable in the following sentence: ‘45 patients were enrolled in study 1, 43 in study 2, 41 in study 3, and 6 in study 4; thus, a total of 135 patients were treated’. But I would still far rather read: ‘135 patients were treated: 45 in study 1, 43 in study 2, 41 in study 3, and 6 in study 4’. **Get rid of ‘a total of’!**

### **Myth 2 : There is never a comma before ‘and’ in lists with more than 2 elements**

Oh yes, there is! In English, you almost always have choices. Here you have 4 (or more?) choices and good arguments can be presented for all. I do express a preference below—for my usual prime reason: to make writing easy and maintain consistency, without endless checking— but you should form your own opinion.

Choice 1. Never put a comma before ‘and’ in lists with more than 2 elements.

Choice 2. Always put a comma before ‘and’ in lists with more than 2 elements. This is called using the ‘serial comma’.

Choice 3. Put a comma before ‘and’ in lists with more than

<sup>1</sup> “...those who write as they speak—although they may speak very well—write badly”.

2 long elements; do not put a comma before 'and' in lists with more than 2 short elements.

Choice 4. Use a semicolon like the serial comma in lists with more than 2 long elements, including before 'and'; use the serial comma or do not put a comma before 'and' in lists with short elements.

After starting out in life with Choice 1, Choice 3 was my preference for a long time, but recently I have switched to Choice 2 and feel very happy about this. Why? First, because it took me a long time to shake off the spectre of Mrs Whitfield. Second, because now I never have to clutter my thoughts with this irksome question, it makes things dead easy, and it is much easier to remain consistent. The serial comma has its origins in American English. I think it's great! Despite this, if you opt for Choice 1, you will also have an easy life remaining consistent. With Choice 4, you will create much work and decision-making for yourself as far as being consistent is concerned, but if you manage to be consistent, you deserve only praise.

### **Myth 3 : Adding 'in order' before an infinitive sometimes adds meaning which would otherwise be lost**

Forget it. Feel free to use 'in order' before an infinitive all the time when you are speaking or when you write emails. Scrutinise texts from others and texts you write, step back into objective mode, and see if you think that 'in order' adds any additional meaning. I am sure that you will decide that it does not.

Does the first sentence here really tell you more?

- 1) In order to harmonise procedures across studies, a 90-day censoring rule was applied in all.
- 2) To harmonise procedures across studies, a 90-day censoring rule was applied in all.

Or the first here?

- 1) This review of the literature by Barnes and Mitchell gives an overview of important findings concerning sex differences in order to assist clinicians in treating women with bipolar disorder.
- 2) This review of the literature by Barnes and Mitchell gives an overview of important findings concerning sex differences to assist clinicians in treating women with bipolar disorder.

Eradicate it from your formal writing entirely. It adds nothing. Don't worry: you'll get used to it.

### **Myth 4 : Plurals of Latin and Greek words should be retained as in the original language**

The only difference between Latin and classical Greek and other languages is that they are amongst the languages that are still in use but are no longer spoken. When was the last time you used 'scenari' and 'fiaschi', the Italian plurals of 'scenario' and 'fiasco'? Chance has it that the plural of most of the French and Spanish words we use in English is the same as in English, except for those ending in 'eau', but these days 'gateaus' is just as acceptable as 'gateaux'. The uninflected plural of 'guru' in Hindi is 'guru', but I think most of us would choose to use 'gurus'.

I quote Edith Schwager from 'Medical English Usage and Abusage' [4]: "Most Latin words that have been thoroughly integrated into English can be pluralized perfectly legitimately by simply adding an 's' (or 'es' in my opinion) to the singular form: *stadiums*, *memorandums*, *curriculumms*. *Using stadia*, *memoranda*, *curricula* ... probably fulfils an honest human need—the need to appear learned". 'Addenda' is another example. For me, this also applies to Greek words, and my resolve to use the usual English plural was strengthened on seeing 'pig pancreata' in a report on the preparation of insulin. Times have changed, and most of us lack the solid grounding in Latin or Greek required to confidently use the correct plural, so one thing is certain: if you want to use the Latin or Greek plural, you should always look it up (you can't rely on the Internet for this) and not just assume that they all end in 'a' or 'ae': for example, the plural of 'locum tenens' is 'locum tenentes. It's a jolly sight easier to use 's' or 'es'.

Formulas or formulae? For me, of course, always formulas. For some words, you will find that dictionaries allow different plurals depending on meaning. Specifically for formula, those I have consulted say 'either-or' or that the 'ae' ending is *preferred* for the mathematical or chemical use of the word, not that it is right and 's' is wrong.

I have no doubt that the above points and many more will remain controversial. Next time you are standing in awkward silence looking for a good topic for small talk in the company of writers, pick any of the above points and innocently ask your companions: "What do you think about ...?". Make sure you have a firm opinion on the point chosen before you start and be prepared for vehement disagreement and a catalogue of conflicting 'rules', some of which will certainly make you scratch your head or sense that blackboard duster hovering above your knuckles. I guarantee that the silence will be broken and that 'big talk' will ensue: these actually trivial niceties of the English language cause more discussion, controversy and argument than they are worth!

Look out for more myths in the next issue!



## References:

1. Bernstein TM. 1985. *The Careful Writer. A Modern Guide to English Usage*. Atheneum New York.
2. Bernstein TM. 1971. *Miss Thistlebottom's hobgoblins; the careful writer's guide to the taboos, bugbears, and outmoded rules of English usage*. Farrar, Straus and Giroux New York.
3. Leclerc GL (Comte de Buffon). 1753. *Discours sur le style* (prononcé à l' Académie Française par M. de Buffon le jour de sa réception le 25 août 1753).
4. Schwager E. 1991. *Medical English Usage and Abusage*. Oryx Press.

2 [Reprinted with permission from *The Write Stuff*, Vol. 15, No. 2 (2006) pp. 58–60.]

In the last issue, I discussed 4 myths about the English language [1]. I promised to explode more myths in this issue, so without further ado, I do just that below. If you disagree with me, please let me know!

### Myth 5 : '...ize' is American and '...ise' is British; '...ize' is better (some people) and '...ise' is better (other people)

'...ize' is indeed American, and this is what American readers expect to see. Both can be used in British English, although British writers more often use '...ise'. Neither is better than the other. What is important—and this will be no surprise to you by now—is to be consistent. The following does not look good: 'To standardise our reports, we harmonized procedures for report preparation'. (This applies to mixed US and British spelling in general, but only within self-contained texts or documents, not across dossiers<sup>1</sup>.) The Oxford Dictionary lists '...ize' and '...ise' as 'variant spellings' in its introduction, and settled on '...ize' for all its entries, to be consistent. Many other British dictionaries list both, some with '...ize' first and some with '...ise' first.

By the way: not etymologically but phonetically related to '...ize' or '...ise': 'analyze' and 'catalyze' are correct in American English. The British English equivalents are 'analyse' and 'catalyse'. 'Analysis' and 'catalysis' are correct in both.

### Myth 6 : The number of the verb after 'none of' is always singular

Oh, for a rule as in German (and presumably many other well-regulated languages) that the number of a verb is always determined by its subject, at least when writing!

I have seen this one almost lead to fisticuffs. The subject of many pointless discussions is the claim that there is an incontrovertible 'rule' in English and that you must *always* follow 'none of' with the singular. Who says?

<sup>1</sup> Clinical reports and summary documentation often have the text in British spelling and the 'end-of-text' tables or appendices in US spelling, or vice versa. Don't worry about this. Just make sure that all of the text and all of the tables are consistent within themselves, even if they differ.

What's the story on 'none of'? Here we go: it's all to do with 'countable' (concrete) and 'uncountable' (abstract nouns) and whether you mean 'not part of a whole' or 'not one of a group'. It is complicated by 2 things: we unfortunately have a lot of 'mixed' nouns that are used both countably and uncountably, e.g. 'medication'; and you often cannot distinguish between the number of a verb in the simple past in English, e.g. 'None of the subjects developed rash'—the verb could be singular or plural here as the verb form in the simple past is the same. In many other languages, the number of the verb can always be recognised by different endings—a linguistic luxury unknown to native English speakers unfamiliar with other languages, except when using the verb 'to be'.

What follows are not rules, they are just my pragmatic suggestion to give some guidance on this.

**Countable noun used in the singular.** Assume that a bolus injection was to be given over several minutes. You are talking about only 1 injection, even though the word 'injection' is countable (i.e. it can be used in the plural). In the report you are writing, it is important to document whether all or only part of the injection was given, or if it was not given at all. The injection was not given and you decide to use 'none of'. You write: 'None of the injection was given'. Fine. The singular is the only possibility here because you are talking about part of a whole, i.e. only 1 injection. Of course, you could have said: 'The injection was not given', but this is not always what you want to say.

**Countable noun used in the plural.** A patient was due to receive a series of injections over 1 week. The patient decided to withdraw from the study before treatment started. To document that the patient received no injections, you decide to use 'none of'. You have the choice between 'None of the injections was given' and 'None of the injections were given'. Both are correct. There is a *well-established convention* amongst British writers to opt for the second possibility, using the plural—and this now 'sounds right' to most. My impression is that American writers more often opt for the singular, but plenty of them do use the plural. If

your house style, your boss or your client requires the singular, use it. If I have my choice, I prefer to use the plural. Don't let anyone tell you that the singular *must* be used.

I have to add here that, as in the first example, you could write: 'The injections were not given' and avoid the problem entirely!

If the discussion on 'none of' gets too heated, suggest a rewrite or avoidance of the verb 'to be'.<sup>2</sup>

**Uncountable nouns.** These have no plural, e.g. 'information' and 'advice', so it follows that if they can only be used in the singular, the verb following 'none of' must always be in the singular: 'None of the advice was heeded', 'None of the information was collected'.

Speakers of German, and I suspect other North-West European languages and Slav languages, please note: 'informations' and 'advices' do not exist. To render both in the plural, you have to say 'pieces of'. That's just how it is.

Thanks to the evolution of language, many nouns that were once only uncountable are now used countably, e.g. 'medication'. If you considered the series of injections in the second example above as the 'study medication' (using this as an uncountable noun), then you would write: 'None of the study medication *was* given' as opposed to 'None of the injections *were* given'. If the series of injections consisted of 2 injections of *different* drugs at each time point, you might choose to say: 'None of the study medications *were* given', but you could just as well say: 'None of the study medication *was* given'. I am not keen on using medication as a countable noun, but many writers like to use it this way.

### Myth 7 : The number of the verb after 'a number of' is always singular

Another instance where I wish for an 'Académie Anglaise' to settle this sort of question. Like the number of the verb after 'none of', this one also leads to endless (and equally pointless) heated discussions. This is governed by the use of the definite (the) or indefinite article (a) before the word 'number'.

Consider the sentence: 'A number of variables *were* stud-

ied'. The word 'number' is clearly not plural, but the message conveyed by the phrase 'a number of variables' when it is used as the subject of a sentence clearly means 'more than 1', and 'a number of' has come to mean an indeterminate small number, 'some' or 'several' that you do not need to count. The accent here is therefore on the plural word 'variables' as the determinant of whether the verb is in the plural or singular. This is the reason why there is a **well-established convention** that 'A number of' is constructed with the verb in the plural. Again, there is no rule here, it 'sounds right'. But if you wish to persevere with the singular, nobody can tell you that you are wrong. Decide what you want to do, or do what your company or client wants you to do, and you never have to think about it again! Just be consistent.

'The number of' is different. 'The number of variables in this study *was* too high' is correct, and to use 'were' would be incorrect. 'The number' in this sense does not indicate an indeterminate number, but a definite number you have probably counted. The accent here is therefore on the singular word 'number' as the determinant of whether the verb is used in the singular or plural.

By the way: 'The majority of ...' constructed with the singular now sounds wrong. Not 'The majority of patients was enrolled before Amendment 1', but 'were'. Government is a difficult one: official 'BBC language' is still to say 'The government are ...', so this is heard every day in the UK and plenty of people use this. I have always preferred 'The government is ...', and plenty of people use this too.

### Myth 8 : 'Prior to' is better than 'before'

Writers—particularly those from American English-speaking areas—seem to have forgotten that the word 'before' exists, and that 'prior to' can **always** be replaced by 'before'. As is often the case, good (and bad) American English usage often eventually creeps into British English usage, and this is definitely happening with 'prior to'. I have heard claims from both native speakers from the US and the UK and non-native speakers that they have been told that 'prior to' is 'more correct' because it means 'really before' or that it is 'more scientific'. One wonders where these misconceptions come from. 'Before' really does mean 'really before' and 'prior to' does not improve upon it. As a minimalist as far as language is concerned, I prefer 'before', simply because it is a single word and has only 2 syllables. Please don't ever write 'prior to' again—but use it to your heart's content when you speak!<sup>3</sup>

A recent unfortunate development amongst non-native speakers of English and, I hate to say, some native-speakers

<sup>2</sup> Speakers of Romance languages please note: English speakers will almost always write 'No injections were given' and not use a singular subject or verb when referring to a situation where it was intended to have given more than 1 injection to a group of patients or a series of injections to 1 patient. If you are describing a situation where a patient was due to receive 1 injection at a particular time and the patient did not receive it, you could write: 'The injection was due at 18:00. No injection was given and the patient was therefore withdrawn from the study'. Otherwise, the plural 'sounds right'. I have been looking for an explanation for this for years. If anyone has one, please let me know! Similarly, if no adverse events occurred in a group or study, the plural is used: 'No adverse eventS occurred in Group 3', and not 'No adverse event occurred ...'.



when writing, is to use *prior* as a preposition: ‘Prior the study...’ or ‘Prior the investigation...’ instead of ‘before’. ‘Prior’ without the ‘to’ here is definitely wrong, because ‘prior’ is an adjective (‘In a prior study, we investigated ...’). To use it prepositionally (see above) or adverbially, it needs the ‘to’: ‘He did it prior to me’ (‘before’ is better anyway!).

### Myth 9 : ‘Following’ is better than ‘after’

‘Following’, when used to mean ‘after’ at the beginning of an adverbial phrase, should always be replaced by ‘after’. Following is not better and does not add any extra meaning. Except perhaps ambiguity: ‘Following the guidelines, they published a report on their findings’. Does this mean that ‘They followed the guidelines to produce a report on their findings’ or ‘After they published the guidelines, they published a report on their findings.’? Because ‘following’ is a participle formed from a verb, your readers will very quickly want to see a subject they can relate to ‘following’. In this case, it can only be ‘they’ and can only mean ‘They followed the guidelines to produce a report on their findings’. If you want to express the idea of the second option and want to start with the adverbial phrase, ‘after’ is necessary, even if you think it is clear from the context.

It is interesting that in our area of writing ‘subsequent to’ (which also just means ‘after’ and can also always be replaced by ‘after’—it does not mean ‘as a consequence of’)—does not seem to have gained such wide currency as ‘following’ used incorrectly or ‘prior to’. Maybe that it still to come!

### Myth 10 : ‘In vitro’, ‘in vivo’ and ‘ex vivo’ should always be italicised

I give workshops on punctuation. One of the questions I ask participants is whether ‘in vitro’, ‘in vivo’ and ‘ex vivo’ should be hyphenated (see below) and I put up a few questions about this on the screen. I can guarantee that one participant per session will say: ‘Yes, but isn’t there a rule that “in vivo” must be italicised?’ Not that I have heard of. This invariably causes more discussion than whether it should be hyphenated. I can’t express my feelings on this better than Edith Schwager in ‘Medical English Usage and Abusage’ [2]:

“In vitro and in vivo are not italicised in American English

[脚注]

<sup>3</sup> A note for users of ‘prior to’ : ‘before starting X’ is a good substitute for ‘prior to the commencement of treatment with X’ and sometimes even just ‘before X’ is enough!

usage, although they used to be. Their italicization in current American medical journals is a sign that the person in charge is not au courant or is intransigent”.

As far as I am concerned, this also applies to British English. Not italicising these terms means that you never have to check that you have always italicised them—and why bother, when scores of other Latin and Greek terms are not italicised?

There are, however, 2 principles to follow:

- If a journal, your boss, your client or your conscience wants them in italics, just do it! Don’t even think about it. But make sure you are consistent. This will give you hours of fun checking with ‘Search and replace’, especially if you are also required to italicise ‘et al’, ‘i.e.’ and ‘e.g.’ (which is actually equally inappropriate). If you are a freelancer, make sure you add the time to your invoice; if you have an employer, make your employer aware that this is wasting your valuable time, but don’t argue too much!
- If you have a choice, decide what you want to do and also be consistent.

A note here on hyphenation of ‘in vivo’, ‘in vitro’ and ‘ex vivo’: it should never be necessary and **there is no rule**, whether you use them as modifiers (‘in vivo investigations’) or adverbially (‘This was demonstrated in vivo.’). If you have the formulation ‘We demonstrated in in vivo investigations that...’ you might feel the need to hyphenate it thus: ‘...in in-vivo investigations...’ because of the successive ‘ins’. Expend some energy on avoiding this rather than using the hyphen. Possibilities here are: ‘We demonstrated in vivo that ...’; or ‘In vivo investigations showed that ...’.

*Streptococcus faecalis* and all similar names (genus plus species) are italicised. This is one of the best accepted conventions throughout the world. I have yet to hear anyone object to it! This does not apply, however, to the general use of a genus in the plural (streptococci) or adjectives derived from a genus (streptococcal). Another ‘by the way’: ‘*Haemophilus*’ retains the ‘a’ in American English because this is its official name.

More myths in the next issue!

### References:

1. Reeves A. 2006. Myths about English. *TWS* 15(1):22–24.
2. Schwager E. 1991. *Medical English Usage and Abusage*. Oryx Press.

I promised you more myths about English [1, 2] after my first 10 (if you would like to know why I wrote a digit here and not ‘ten’, see ‘Myth 1’ [1]). Here are a further 5. More will follow. The list is not short!

### **Myth 11 : ‘e.g.’ and ‘i.e.’ must be followed by a comma**

Eagle-eyed readers of my previous two ‘myths’ articles will have noticed that I do not put a comma after ‘i.e.’ or ‘e.g.’. If anyone can give me a good reason why they **must** be followed by a comma, other than a questionable convention, I am prepared to revise my opinion that the use of the comma after both is a complete waste of time. This may be because I still prefer to use both with full stops. ‘E.g.’ means ‘for example’ (‘exempli gratia’ in Latin) and ‘i.e.’ means ‘in other words’ (‘id est’ in Latin) or similar. When I write ‘for example’—and on the extremely rare occasions when I use ‘in other words’—they may well be followed by a comma, but this not reason enough to follow ‘e.g.’ or ‘i.e.’ with a comma: full stops at the end of both obviate the need for a comma as far as I am concerned. There is also my usual good reason for not using a superfluous punctuation mark here: if you don’t do it, you don’t have to check you have done it every time! But if your boss wants it, put it!

By the way: I think it is still preferable to use two full stops or periods with ‘e.g.’ and ‘i.e.’. Some writers and journals are proponents of ‘eg.’ or ‘eg.’ and ‘ie.’ or ‘ie.’. I don’t like either of these aberrations, but say: ‘Live and let live’—just be sure you are consistent.

Also, every time you use ‘e.g.’ or ‘i.e.’ check carefully that it is correct. I often see them confused, and have to check myself that I have not mistakenly used ‘i.e.’ when I actually wanted to say ‘e.g.’.

### **Myth 12 : ‘Utilise’, ‘make use of’ and ‘employ’ should be preferred to ‘use’ in certain contexts**

My advice: **always use ‘use’!**

The reader will understand exactly the same if you give preference to ‘use’ in almost all situations. Consider the following:

- We decided to **use/utilise/make use of/employ** her extensive experience with manic-depressive patients when formulating our new guidelines.
- How did you **use/utilise/make use of/employ** your results?

- We **used/utilised/made use of/employed straight-sided** titanium crucibles.

The very fact that ‘use’ has only one syllable is enough to put many writers off. It sounds just too plain and simple. But why use a polysyllabic word or phrase when a mono-syllabic word does **exactly the same job**? Our business should be simplicity. This is rather like saying ‘to initialise a study’ when you just mean to ‘start’ it.

Dictionaries tell you that utilise means ‘to turn to use’ (whatever that means), ‘to make practical use of’ (that’s a little better), or ‘to use effectively’ (at least this means something, but if you ‘use’ something, don’t you expect it to have an effect?). There are those who claim that ‘utilise’ is therefore sometimes better than ‘use’ and that the subtle difference I don’t seem to be able to appreciate. Don’t ever write ‘make use of’ in our context. Reserve ‘employ’ for when you pay a person to do something. And it should not be necessary to worry whether ‘use’ might be misunderstood to mean ‘take advantage of’ or ‘exploit’ (an argument often used against ‘use’ by ‘utilisers’), because if this what you want to express, in our context at least, you should be using ‘take advantage of’ or ‘exploit’. And remember: ‘exploit’ is not always negative!

### **Myth 13 : It is better to write ‘First’, ‘Second’, ‘Third’... rather than ‘Firstly’, ‘Secondly’, ‘Thirdly’... when enumerating points**

It is not better. Some say avoid this altogether, but sometimes it is quite important to enumerate in this way. The reader understands exactly the same thing, whether you use the adjective (functioning here as an adverb) or adverb (-ly). It is pompous to insist that the adjective is linguistically better (it **is** shorter though, and I’m always in favour of that, as you know by now). Remain consistent. Don’t go beyond ‘thirdly’ (‘fourthly’ and above start to sound progressively ridiculous). Be sure that you are actually enumerating one point, then another, and then another (if you write ‘Second (ly), ...’, make sure you have a ‘First (ly)’, otherwise you put the reader in the annoying situation of having to back-track to count). This is rather like making the reader hunt around for the ‘one hand’ when you use ‘on the other hand’ without making sure that you have mentioned the first hand beforehand. Or the reverse! Watch out for this one too. If I have my choice, I don’t use ‘on the one hand’ and ‘on the

other hand' when writing.<sup>1</sup>

#### **Myth 14 : Generic names of pharmaceutical products are written with lower case letters**

This is dead simple. US English uses upper case for generic names (e.g. Ramipril) and British English uses lower case (e.g. spironolactone). But maybe it's not so simple: I have no idea what writers in other English-speaking areas do, such as the Irish, Australians, Canadians, and South Africans (I suspect usage is inconsistent everywhere). Please let us know!

#### **Myth 15 : British English is better than American English**

The only answer to this is a resounding NO IT IS NOT! I include this myth because I was recently confronted again by the naïve opinion that we British have a monopoly on good English. This once got me into a very embarrassing situation. A German-speaking colleague asked my Irish room neighbour at work how to say something in English, and got a perfectly good answer. Then, with the Irish colleague in tow, went to an American colleague in our building and asked the same question. The American colleague also gave a perfectly good—but different—answer. Then the German colleague came to me, with both in tow, having said (the Irish colleague told me afterwards): 'Jetzt gehen wir zu Herrn Reeves—er ist ein richtiger Engländer' (*Now we'll go*

*and ask Mr Reeves—he's a real Englishman*). If ever the diplomacy required of a medical writer was 'heavily challenged', this was one of those situations. I deliberately opted for a different solution so as not to pique either the Irish or American colleague, but left the final decision to our German colleague, reminding him that all three solutions were just as good as each other.

Just whose language is English these days? OK—so the spelling in US and British English differs (I would switch to American spelling tomorrow. When I say this, some of my British colleagues throw up their hands in horror. But we are only talking about black marks on paper to convey a message, or nowadays a computer screen). The fact is: whoever writes English, if they write well, it is good. And if it is written well, you will hardly notice a difference, whether it is written by a person who grew up in Britain, the USA, Canada, South Africa, New Zealand, those from Mumbai who first learn English, or by someone in Singapore, Malaysia or Hong Kong who had all their schooling in English, but may have spoken Mandarin or something else at home. The accent is on '**if it is written well**'. And those who grow up in Britain also have to **learn hard and long** how to write well. English in our context is also no longer the preserve of 'native English speakers'. I am sure there are more medical writers in Europe whose native language is not English who manage to do a perfectly good job, and there are people who can write very well, but not speak so well. Speaking is a very different matter!

#### **References:**

1. Reeves A. 2006. Myths about English. *TWS* **15**(1):22–24.
2. Reeves A. 2006. More Myths about English. *TWS* **15**(2):58–60.

<sup>1</sup> Note for German speakers: do not use 'on the other hand' for 'dagegen' unless you have said 'on the one hand' before this. Best is to avoid any mention of hands at all.

4 [Reprinted with permission from *The Write Stuff*, Vol. 16, No. 2 (2007) pp. 84–86.]

Here are 5 more myths about English (if you would like to know why I wrote '5' here and not 'five', see Myth 1 [1]).

#### **Myth 16 : 'Localisation' is more precise than 'site'**

It is not. At first sight, the simplest and best reason to prefer 'site' over 'localisation' is that it has only 1 syllable and not 5, and does not put you in the quandary of wondering whether it should be written with an 's' or a 'z' (see Myth 5 [2]). But there is an even better reason not to use 'localisation' when you mean the place on the body where a patient developed a rash: quite simply, **it is wrong, and**

**does not mean 'site'**. 'To localise' means 'to restrict or assign to a particular place' (hence 'local' anaesthetic), 'to invest with the characteristics of a particular place' or 'to decentralise' something [4]. 'Localisation' (noun) is derived from 'localise', and it is the activity of localising, and **only** that.

Etymologically close relatives of 'to localise' are 'to locate' and 'location': 'to locate' is 'to discover the place of something' or 'to put something in a particular place' [4]. 'Location' means where something is or happens, and is therefore a possible substitute for 'site'; but because mono-syllabic 'site' is just as good, it should be given preference. 'Location'

also means the act of locating (like ‘finding’), and does have other meanings too, e.g. ‘a film location’. If you can’t quite manage to make the transition to ‘site’, ‘body site’ is fine too.

### **Myth 17 : ‘Contralateral’ is a useful word in our context**

In most cases, plain old ‘other’ or the opposite of ‘left’ or ‘right’ does a better job, because everyone understands these, and they are much shorter. Contralateral (the one on the other side), and the rarer ipsilateral (the one on the side you are not talking about when you refer to the other side), are used for body parts that occur in pairs on either side of the body—and there are quite a few such parts. Examples of the use of ‘contralateral’: *‘If blood samples are taken from the right arm, the blood pressure should be measured on the contralateral arm’* or *‘The contralateral breast should also be closely inspected for changes’*. But why bother with such a mouthful, even if it sounds good? ‘Left’ would have been just as good in the first instance, and ‘other’ in the second. Still worse is the ‘contralateral side of the body’—a tautology, because ‘lateral’ already includes the concept of ‘side’. It is often astonishing how writers will leap to use a complex word in written scientific texts when a simple one will do: after all, if you came into a room with two doors, one on either side, would you ever write: *‘I came in through that door and she came in through the contralateral door’?*

The use of contralateral is justified in the following and similar instances (title of a journal article): *Are men with testicular cancer at risk of developing a contralateral tumour?*

### **Myth 18 : ‘Post’ is acceptable as a preposition in our context**

I thank Chris Priestley of Accovion GmbH, Eschborn, Germany for drawing my attention to this one.

Using ‘post’ as a preposition in the following way is jargon, and should be reserved for speaking or medical notes:

- Post dosing, the animals showed ...
- Post hysterectomy, the patient had ...
- Patients should be mobilised within 24 hours post surgery
- Post end of treatment, 7 patients reported ...
- Post mixing, the malleable mass is transferred to a 450 L bowl.

We all know that post means ‘after’ and that the above examples will never be misunderstood, but ‘after’ is the preferable solution for all similar constructions in written English (‘After the...’ in number fourth). Watch out for the use of ‘following’: see Myth 9 [2]. In all the above cases,

‘post’ would never be hyphenated—and this is perhaps a good indicator of whether you can use it or not in formal writing: if you are not tempted to hyphenate it (i.e. are not using it as a prefix but a preposition), you will usually be able to substitute ‘after’. ‘Post’ has not yet entered the realms of written prepositional use, but is used as a prefix indicating ‘after’ or ‘behind’. Well-accepted examples are (hyphenation is up to you; I usually write them as one word): posttreatment, postinfusion, postpartum, postprandial(ly), postpubertal(ly), postnatal(ly), and anatomical terms such as postnasal(ly), postsplenic and postganglionic. Many instances where ‘post’ is used as a prefix cannot be found in medical dictionaries. Formulations like ‘The patient had post-dialysis concentrations of ...’ have been taking hold for years now, and it is beginning to sound pedantic to insist on: ‘After dialysis, the concentrations of ...’. But: ‘It is important to measure the blood pressure post dialysis’ is still not acceptable.

### **Myth 19 : ‘and/or’ has to be used to allow for all possibilities**

Described very fittingly by Anne Jones [5] as a ‘term of unfathomable meaning’, ‘and/or’ is always difficult to justify, and it is better to avoid it altogether.

The ‘and’ is almost always superfluous. This is one instance in English where native speakers have it easier: because we spontaneously just say and write only ‘or’, and this is almost always all that is needed (listen out for ‘and/or’ in conversation—you will hardly ever hear it). Many non-native speakers of English cannot render this with plain old ‘or’ in their own language (because ‘or’ is used ‘exclusively’ [see below], or they have other words), and this makes it difficult for them to cross the threshold of just using ‘or’ in English.

Consider the following: *‘If the patient develops vomiting or dizziness, the infusion will be stopped immediately’*.

Which brute is going to leave this poor woman on the infusion if she develops vomiting and dizziness?

And the following: *‘Space should be provided for the study participant and/or investigator to make notes.’* (in the instructions on the preparation of an informed consent form).

What does this actually mean? It means that we should allow for the following possibilities:

- The investigator might want to make notes, and we should provide white space entitled ‘Investigator notes’.
- The study participant might want to make notes, and we should provide white space entitled ‘Study participant notes’.

It is highly unlikely that we wish to provide for the ridiculous situation that the study participant and the investigator will actually want to hold the same pen and write the same note together on an area of white space entitled ‘Investigator and study participant notes’. The ‘and’ is therefore superfluous, and ‘*Space should be provided for the study participant or investigator to make notes*’ is quite adequate.

Another example (from an SOP): *As sponsor of a clinical trial, the University has the overall responsibility for the trial and may use the services of third parties (such as pharmaceutical companies, associations, foundations, and others), e.g. for the supply of trial medication and/or financial support.*

A daft ‘and/or’, if ever I saw one. Why? First, there is an ‘e.g.’, so you’re giving examples and there could be countless other ‘ands’ and ‘ors’. Second, why allow for the possibility that you may have only the trial medication from one source, only the financial support from a different source, or both from the same source (if this what the ‘and’ is supposed to mean here—probably not, I think it’s just sloppy and ‘overprecise’ use)<sup>1</sup>. Third, even if you just said ‘or’, it is so obviously not exclusive here, and clearly does not mean that the sponsor has to choose between either trial medication or financial support, or that there would be problems if the source of both were the same.

Finally, the daftest of all, which I leave without comment:

*Narratives are provided for all patients who died on study treatment and/or within 30 days of the last dose of study medication.*

Dispensing with ‘and’ and just using ‘or’ is called using the ‘inclusive or’, and obviates the use of ‘and/or’ completely. Most misused ‘and/ors’ fall into this category.

Why do so many native speakers use ‘and/or’ then, when writing, if we spontaneously use just ‘or’? I surmise that it is because they think it sounds more precise and have so often been bullied into writing this by pernickety colleagues from the ‘Ah-yes-but-what-if’-school that they feel the ‘and’ makes things clearer or ‘covers everything’. But it does not.

If the exclusivity of ‘or’ is important, it is either obvious from the context: ‘*You can pay for lunch or dinner*’—faced with this choice, who would pay ‘inclusively’ for both? Or there are linguistic devices available. This is why we have ‘either’ and ‘or’: ‘*If patients develop headache, they may*

*be treated with either paracetamol or ibuprofen*’. Whilst it would be impossible to prevent a patient being treated with both, implicit here is that a choice has to be made. If the converse is the case and combination treatment is allowed, you can always add ‘or both’: ‘*If patients develop headache, they may be treated with paracetamol or ibuprofen, or both.*’ To add an ‘either’ before the ‘paracetamol’ in this case would not be wrong, but is unnecessary. This, of course, means the same as: ‘*If patients develop headache, they may be treated with paracetamol and/or ibuprofen*’, and is one instance where some may try to argue for ‘and/or’. Not me: I still prefer the ‘or both’ solution, because the reader does not have to backtrack: I bet most people reading ‘and/or’ backtrack a little to be sure that they have understood the sentence properly: to make readers backtrack is to be unkind to them.

Is trying to avoid ‘and/or’ a lost cause? I hope not.

This use of ‘and/or’ also calls into question the use of the ‘slash’ in general, and its almost always ambiguous use. It is worth reading Stephen de Looze’s *TWS* article on this; Ann Jones also discusses this point [5, 6].

## Myth 20 : The correct abbreviation for litre is now ‘L’

Thanks to Anne Bartz, freelance translator and medical writer, Hamburg, Germany for telling me that she recently heard this was now a ‘rule’ in British usage and asking whether this is a myth, although not specifically a myth about English.

It may surprise you to read this (I was surprised, anyway), but litre is not an official *Système International d’Unités* unit [7]. This means there is no ‘official’ abbreviation for ‘litre’, so we can do what we want (Oh dear! No rule again!). There has been a trend towards writing ‘L’ for litre for a few years now, I suspect because of the possibility of confusion between ‘l’ and ‘1’, and this is probably due to all the fonts we have in word processing (i.e. the distinction used to be clear with the typewriter). The difference is obvious with ‘sans serif fonts’—Arial: ‘l’ or ‘1’—but not so obvious with ‘serif’ fonts (i.e. Times [Roman]-like fonts)—Times New Roman: ‘l’ or ‘1’. Sometime someone probably started using ‘L’ and it has gradually caught on. I responded to the trend and often now use ‘L’. Message as usual: be consistent in one text.

## Note on Myth 11 : No comma after ‘e.g.’ and ‘i.e.’:

I thank Diana Taylor, Parexel International, Berlin, Germany for supporting me in spurning the use of the comma

<sup>1</sup> The sloppiness and inconsistency of this text—although in an SOP—is shown by the author’s failing to use ‘and/or’ in the brackets before ‘others’ because it was felt necessary in exactly the same situation in the next clause. ‘Others’ is superfluous, anyway, because of the ‘such as’, and this only makes it worse.

after 'i.e.' and 'e.g.' [3]. Diana pointed out that this is also supported by Fowler's *Modern English Usage* [8], except for the following situation: 'He attacked reactionaries, i.e., it would seem, those whose opinions [etc.]...'. I am pleased to hear this, as I do not frequently consult Fowler (perhaps I should), but had I consulted Fowler on this one, this example would not have increased by readiness to revise my opinion.

#### References:

1. Reeves A. 2006. Myths about English. *TWS* **15**(1):22–24.
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4. Oxford English Reference Dictionary. OUP. 1996.
5. Jones A. *Ever-changing English. A translator's headache.* (<http://www.translationdirectory.com/article1060.htm>)
6. de Looze S. 2001. Slash the Slash. *TWS* **10**(4):89-93. (<http://www.emwa.org/Articles/Slash.pdf>)
7. <http://www.physics.nist.gov/cuu/Units/>

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## Writing Tips yet untitled

Reuben M. Gerling

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*'Vascular casts of the collateral network that supplies the spinal cord in young pigs—obtained via aortic infusions of methylmethacrylate—have revealed that the anterior spinal artery and a series of interconnected epidural arcades constitute only a small fraction of the total volume of the massive collateral network that includes the SAs'*

(Tex Heart Inst J > v.37(6); 2010)

It seems that the Texans decided to save on punctuation marks and embark on a one-sentence encompass all policy. If one were to read the article aloud, it would be a breathing exercise as much as a brain strainer. Try to follow this simple rule, one sentence, one subject. Use the full stop, or, if you insist the period, to end the one and start the next which will hopefully follow from the first. At the same time, it helps the readers if sentences differ in their length and style. If all sentences are of the same length and, as in many medical texts, are declarative, the result is rather tedious. At the same time, try to balance your sentences so that the parts will have equal value.

Avoid making your sentences into long lists, think of the poor person who may wish to read the paper, long lists do not make for exciting reading. Thus,

*Triamcinolone acetonide has been used for the treatment of pseudophakic macular edema [1], uveitis [2, 3], choroidal neovascularization [4], macular edema following diffuse diabetic macular edema [5], central retinal vein occlusion [6], and branch retinal vein occlusion [7, 8].*

should be re-written to make it more palatable.

A fourth pitfall to avoid when writing is repetition, especially within the same sentence.

*These three cases demonstrate the potential diagnostic challenges of diagnosing tracheobronchial aspiration.*

*Diagnostic challenges of diagnosing* is a repetition that makes the sentence cumbersome. The word diagnostic is superfluous and can be discarded improving the sentence.

*The examination of the asteroid bodies using FE-SEM with digital beam control RGB color mapping demonstrated that calcium and phosphorus were the main components of the asteroid bodies*

Here, the *asteroid bodies* are the perpetrators and one of them needs to be done away with.

*Using FE-SEM with digital beam control RGB color mapping demonstrated that calcium and phosphorus were the main components of the asteroid bodies*

Would probably do the job, but, for those insisting on a spelling out what was being mapped,



*Using FE-SEM with digital beam control RGB color to map the asteroid bodies demonstrated that calcium and phosphorus were their main components*

seems to be the way to go.

Considering the reader is the primary concern in writing and many, if not the majority of readers of medical journals may be speakers of other languages. Thus, clarity and simplicity should be the guiding principles of the writer. To do that, shorter, well balanced sentences that avoid unnecessary complications and repetition are the key ingredients.

Repetition: *The examination of the asteroid bodies using FE-SEM with digital beam control RGB color mapping demonstrated that calcium and phosphorus were their main components.*

Here, the *asteroid bodies* are the perpetrators and need to be mentioned only once.

*Using FE-SEM with digital beam control RGB color mapping demonstrated that calcium and phosphorus were the main components of the asteroid bodies*

Would probably do the job.

The first step in editing should be the elimination of repetition and inaccuracies, including those of meaning. This can be followed by a re-write of all sentences that include more than one subject, dividing them into either two sentences or by using a semicolon. Following that, writers can refine their editing by varying the length of sentences, providing better balance both to each sentence and to the paragraph as a whole. At that time sentences that look like shopping lists can be changed and declarative sentences altered.

## 編集後記

本号はやや論文数が少ない出版となりました。しかし、それぞれの論文は読み応えがあり、査読の労をいただいた先生方、論文を投稿し査読に対応していただいた著者の熱意に感謝いたします。

本号では言葉、文章についての論文がいくつか掲載されています。学術雑誌は一定の形式で文が構成されていますが、メディアの多様化で文章の書き方、言葉の使い方は大きく変わっています。電子診療録が普及してきましたが、紙に書いていた時代と書き方が変わっています。実社会でも、もう忘れ去られようとしています。ポケベルに始まり、PCメール、携帯・スマホメール、さらにラインやフェイスブックなどICTを介した文章は、紙に書かれた文章とは異なる体裁をとっています。学術論文もオンライン化が進んでいますが、オンラインのみのジャーナルと紙で出版されるジャーナルとは違うのではないかと思います。時代的な変化の一方で、本号のThe Write Stuffからの引用では、これまで論文を書くときの不文律のように思っていたことが、そうではないと教えてもらいました。

ますます複雑化する文章表現、その中で医学英語について様々な立場からの研究、報告、提言の場である本誌を是非盛り立てていきたいと思えます。次号が厚い、熱い雑誌となるよう投稿をお待ちしています。

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](mailto: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.
- 2.2. The manuscript should be prepared with MS Word.
- 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:

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

- 3.2. Authors' names and affiliations: 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.
- 3.4. Corresponding author: Write the name of the author (with job title, e.g., Professor, M.D.) who will handle correspondence throughout the editorial process with the university and department affiliation, full address, telephone and fax numbers and e-mail address.
- 3.5. If part of the paper was presented orally or as a poster at a meeting, put the title of the meeting, sponsoring organization, exact date(s) and the city where the meeting was held at the bottom of the title page.

### 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

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

## 6. Japanese

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.

## 7. Arrangement of the article

- 7.1. Divide your article into clearly defined and/or numbered sections. Subsections may be numbered 1.1 (then 1.1.1, 1.1.2) etc.
- 7.2. Each subsection should be given a short heading. Subsections are helpful for cross-referencing within the paper. Instead of just saying, “... as mentioned above,” try to guide the reader by saying “... as shown in 1.1.3 above” or “as aforementioned (1.1.3),” or “as explained under *Evaluation* above.”
- 7.3. Introduction: First, give the general topic or territory, of the research in one or two sentences.  
Example: *How to help students hone their English listening skills is a standing concern of teachers, and especially for those teaching medical students.* After that, explain your rationale and lead up to the problem the paper is addressing, then state the objective of your research or of your classroom approach. References are necessary in the introduction, but subheads are not (if you think subheads are needed, your Introduction is probably too long).
- 7.4. Methods: In the past tense, briefly describe your study design or classroom trial. Tell explicitly what was done, how many students were involved, what academic year they were in, what materials were used, how much time the study took (from when to when, if appropriate). Subheads are helpful in a lengthy methods' section.
- 7.5. Results: (Results and discussion may be a single division of the paper, depending on author's preference.) Although each result is stated in the past tense, the discussion and generalization of the results are in the present or present progressive tense.
- 7.6. Conclusion: The conclusion is usually the last subdivision or final paragraph of the discussion, but a separate conclusion is possible. The conclusion is not a repetition of the results but a (present-tense) generalization derived from the results.
- 7.7. Acknowledgments: If you express appreciation to someone for help with the data collection, analysis, manuscript or for a grant, a brief acknowledgments section is appropriate between the main text of the paper and the references.

7.8. Figure legends, tables, figures—in that order—may be collated at the end of the article, provided the text is marked to indicate the approximate location where each figure and table is intended. Number the tables consecutively according to their order of mention in the text and write a short title for each. Place table footnotes immediately below the table. Vertical lines are not necessary inside the table except in special cases. For figures embedded in the text, put the figure number and legend beneath each figure.

## 8. References

8.1. Switch off any automated reference manager, such as EndNote, ProCite or any other software you may have used, thus allowing editors to make stylistic conformation of the references if necessary.

8.2. The journal uses the Vancouver style of referencing. For details, please consult the following:  
<http://www.biomedicaleditor.com/vancouver-style.html>; or  
[http://www.nlm.nih.gov/bsd/uniform\\_requirements.html](http://www.nlm.nih.gov/bsd/uniform_requirements.html).

8.3. Japanese references: Preferred: If your article is written in English, then in your references put the Japanese author names in Roman characters and paraphrase the title of the article referred to. At the end, say *In Japanese* (Example 1). Alternative: Currently, the references may use either Japanese or Roman characters; even if you write the reference in Japanese characters (Example 2), enter it into the single list of References either by citation order or by alphabet and number.

Example 1. Hishida H and Hirano M. 2003. Teaching material using Web site information on nursing. *Medical English* 4(2): 41–44. In Japanese.

Example 2. 井上真紀, 佐藤利哉, 神田和幸. 2004. コミュニケーションから見た看護事情の改善の必要性. *Medical English* 5(1): 51–58.

8.4. Numbered references to personal communications, unpublished work or manuscripts “in preparation” or “submitted” are unacceptable.

## 9. Submission of the paper

9.1. A manuscript will be considered for publication with

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10.1. Articles prepared by students will be considered on a limited basis. All manuscripts are subject to the Guidelines for Authors, and the title page must include the name of a teacher, possibly a coauthor, who will serve as the contact person throughout the editorial process. Provide e-mail addresses and telephone and fax numbers where the editors might reach someone for consultation even after the student author has graduated.

10.2. Articles by student associations must include a title page listing a teacher and/or other contact person

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All manuscripts except Special Articles will be evaluated by 1 or 2 reviewers assigned by the editors. The Editorial Board members are responsible for selecting reviewers and their recommendations are an important part of the reviewing process.

#### **12. Proofreading**

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#### **13. Reprints**

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1. 下記のホームページで入会申し込みが可能です。

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

2. ゆうちょ銀行の振替口座（旧・郵便振替口座）に年会費を振り込んでください。

[平成 24 年度年会費]

個人会員 ¥9,000

学生会員 ¥1,000

賛助会員 ¥35,000

[ゆうちょ銀行 振替口座]

口座番号 00120-7-417619

口座名称 日本医学英語教育学会

※ 入会申込書の受領ならびに年会費振込の確認をもって、入会手続きの完了とします。

※ 学生会員の年会費には会誌(年3回発行)の購読料が含まれませんのでご注意ください。学生会員で会誌購入をご希望の場合は個別にお申し込みいただくことになります(1部2,000円)。

3. ご不明な点がございましたら、下記の事務局までお問い合わせください。

[問合せ先]

〒162-0845

新宿区市谷本村町2-30 メジカルビュー社内

日本医学英語教育学会 事務局 (担当: 江口)

TEL 03-5228-2274

FAX 03-5228-2062

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

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

1. Prospective members can fill the forms and submit them online at:

<[http://www.medicalview.co.jp/JASMEE/nyukai\\_e.shtml](http://www.medicalview.co.jp/JASMEE/nyukai_e.shtml)>

2. Please transfer the Membership fee through the Japan Post Bank (post office).

Annual fees are ¥9,000 for individual membership, ¥1,000 for student membership and ¥35,000 for supporting membership.

**Japan Post Bank**

**Account No. 00120-7-417619,**

**Account Name “日本医学英語教育学会”.**

Please note that individual membership fee includes three issues of the Journal, but that student membership fee does not include the journal which is available at an extra payment of ¥2,000 per issue.

3. Inquiries and postal applications, including application forms should be addressed to:

**The JASMEE Secretariat (Attn: Mr. Junji Eguchi)  
c/o Medical View**

**2-30 Ichigaya-hommuracho, Shinjuku-ku,  
Tokyo 162-0845, Japan**

**TEL +81-3-5228-2274**

**FAX +81-3-5228-2062**

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

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