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

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第17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・医療関係者が参加し研究･事例を報告します。平成26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17回医学英語教育学会学術集会

日　時：平成26年7月19日（土）～20日（日）

会　長：西村月満（北里大学一般教育部）

会　場：東京ガーデンパレス（〒113-0034　東京都文京区湯島1-7-5）

演題募集：平成26年2月1日正午～4月20日 正午

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

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First Announcement

The 17th 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 17th JASMEE academic meeting will include plenary lectures, oral 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 19 (Saturday) to July 20 (Sunday), 2014

Venue: Tokyo Garden Palace
1-7-5 Yushima, Bunkyo, Tokyo

President: Tsukimaro Nishimura
(Kitasato University College of Liberal Arts and Sciences)

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

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

Good Bye and Good Luck

I was appointed editor-in-chief of this journal together with Professor Toshimasa Yoshioka. For a while we were joint editors until the system changed and the editorial committee was established. It was, in fact Professor Yoshioka who was in charge of drafting the new constitution, which called for regular elections and the establishment of committees to run the society's affairs.

Professor Yoshioka then acted as the associate chair. He was, of course, in charge of all the Japanese papers we received, but his assistance extended well beyond that role. When first appointed, Professor Yoshioka was the editor-in-chief of the journal of the Japanese Medical Education Society. He brought with him the experience he had gained in that role and provided invaluable help in the editing of our journal.

Always positive in his comments, cooperative in his attitude and work, and ready to listen and advise, Professor Yoshioka's contribution to the journal proved instrumental.

As one of the foremost figures in the field of medical education, Professor Yoshioka was also in the right position to judge the educational worth of the works submitted to the journal. His help and advice were always first rate and of great value.

In April of this year, Professor Yoshioka was appointed Chancellor of Tokyo Women's Medical University. His new position demands all his time and energy and, for that reason, he had to step down as associate editor of our journal. Although we are sorry to see him go, we wish him the best of luck in his new position and are certain that Tokyo Women's Medical University will benefit greatly from his insight and expertise.

At the same time we extend the warmest welcome to Professor Tim Minton of Keio University, who has joined us as the new associate editor, and to Professor Takatomi Taira of Tokyo Women's Medical University, who will be the new Japanese-language editor of the journal.

Journal of Medical English Education

Editor-in-Chief

Reuben M. Gerling

Japanese Doctors at International Conferences: Why the worry?

Michael Guest
University of Miyazaki, Faculty of Medicine

This preliminary study outlines results derived from a survey of forty-three Japanese doctors regarding their perceptions of their abilities to present and actively participate in English presentations, poster sessions, and symposia/discussion groups at international medical conferences. Six of these doctors were further interviewed in order to expand upon the results derived from the survey. The goal of the survey was to uncover exactly which aspects of English presentations, conferences, and symposia doctors considered themselves to be both weak in, and anxious about. Results indicated that question and answer sessions, open discussion, and strategic skills such as questioning and confirming the data of other presenters were considered to be the weakest and most anxiety-inducing. Moreover, this sense of anxiety increased the more the event context moved away from Japan (and Asia) and into the so-called 'inner circle' of English-speaking nations.

J Med Eng Educ (2013) 12 (3): 47–55

Keywords academic presentations, international conferences, medical English, Japanese doctors, survey, public speaking anxiety

1. Introduction, Background and Objectives

There exists a widespread belief that Japanese professionals often fail to contribute to their fields of knowledge and practice not because their research fails to meet international standards but because they lack the English skills necessary to convey it accurately and/or sufficiently.[1, 2]

Beliefs and perceptions about one's own English presentation skills can and do affect performance, the causal relationship between self-confidence and positive performance being well established in both in both self-efficacy and self-perception theories of psychology.[3,4] Thus, this study is concerned with the degree and type of anxieties Japanese doctors feel regarding their own English presentation skills. Discovering whether these beliefs are in fact accurate representations of how successful Japanese doctors are in expressing themselves at international conferences is not the aim of this preliminary portion of the study.

In order to uncover these perceptions, a survey and a series of interviews was conducted from August to October 2012 at the University of Miyazaki Hospital in order to establish how doctors perceived their own abilities and performances in English presentations and symposia at international conferences. It is believed that these results should influence the pedagogical focus of ESP teachers by addressing the needs and perceived weak points of Japanese doctors, both in-service and in training. However, very little research on presentation performance anxieties among EFL speakers at academic conferences has been conducted. Lien conducted a survey among Vietnamese technology students regarding English presentation difficulties and anxieties[5] but the focus in that research was upon external qualities such as lacking access to resource materials or general lack of presentation skills. Our study focused almost entirely upon affective factors, those that induce performance anxiety.

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2. Methods

A survey on doctor's experience and perceptions regarding English performance at international conferences was first established in English, and then translated into Japanese. The survey (containing 16 items divided into four sections) is described below and also appear as appendix 1 (Japanese) and appendix 2 (English). This survey was distributed throughout four different medical 'ikyoku' (medical departments) at the University of Miyazaki: obstetrics and gynecology, dermatology, pathology, and ophthalmology,

as well as to several individual doctors from miscellaneous departments (eleven departments were represented in total).

This university hospital was chosen not only for physical convenience and the utilization of existing networks between the researcher and the affiliated hospital but also because this hospital acts as a conduit or nerve center connected with nearly every hospital or clinic in the prefecture, and because staff, of various ages and experience are recruited from schools and hospitals all over Japan. Having a full roster of departments, with a large number of medical personnel rotating between this hospital, other nearby hospitals, and private clinics, conducting the survey at the university hospital allowed the researcher to gain a wider overview.

A representative doctor from each of the four above-mentioned departments was asked to distribute the survey to other doctors in the same department with the instruction to try to maintain a balance between new and veteran, young and old, male and female, part-time and full-time physicians.

Fifty-eight surveys were distributed with forty-three returned, containing a balance from all four departments plus responses from individuals in a further seven departments. Since this initial survey is intended to serve as a springboard to further analysis of actual conference performance and is not intended as an end in itself, the number of participants was limited.

2.1. Survey

The survey was divided into four sections. The first section established the number of English presentations the doctor had given at international conferences according to type (presentations, poster sessions, and symposia/discussion groups) and location. Location was considered important in determining whether the doctor's anxieties were correlated to locale.

The second section checked doctors' general English skills and presentation skills in Japanese using Likert scales of 1 to 10. This allowed the researcher to note whether, or to what degree, performance anxiety was rooted in a lack of confidence in general English skills as opposed to more general anxieties based on public speaking/discussion in any language, including mother tongue.

The third section and fourth sections both used Likert scales (1 to 5) to measure anxiety according to event location, and to identify those English events or situations that were most anxiety-inducing.

Respondents were also encouraged to add notes regarding any of the items contained in the survey or additional points that they wished to express. The survey was completely anonymous.

2.2. Interviews

Follow-up interviews were conducted with six doctors, all of whom had completed the survey. These six were chosen because they had indicated their willingness to hold an extended interview to the researcher or through the research assistant. Only two of the six were at all personally familiar to the researcher. These interviews were conducted in a mixture of both Japanese and English. The purpose of the follow-up interviews was to expand upon the reasoning behind the most significant results from the survey, as well as to discuss more deeply the source of individual doctors' anxieties and perceived shortcomings in using English at international conferences. Five of the six doctors chosen for interviews were among the most experienced survey respondents in terms of giving English presentations.

Among the questions asked to all six interviewees were:
What advice would they give to medical students or doctors-in-training regarding making successful English presentations?
What did they consider to be their own weak points in English in general?
Exactly what aspects of post-presentation question-and-answer sessions caused them most anxiety?
How did they manage to deal with the most anxiety-inducing aspects of presentations, poster sessions, or symposia/group discussions?

The interviews were not conducted for the purpose of establishing a statistical model but rather to add color and elaboration to the results gleaned from the survey, allowing the researcher to make more accurate and meaningful interpretations of the survey results. None of the interviews were recorded, but notes were taken.

3. Results

Some of the more significant statistical results can be seen in appendix 3. Four particularly significant results arising from this preliminary study are outlined below:

a. Performance anxiety increased the further participants were away from home ground. While most felt confident giving presentations or manning posters in Japanese (6.7 out of 10) this fell to 2.2 (out of 5) when asked about English presentations at international conferences in Japan, to 2.0 elsewhere in Asia, to 1.7 in English 'inner circle' countries.
b. The factors that were said to be the least anxiety-inducing were, 1) specialist terminology at 3.1, and 2) English content in slides/posters (grammar, syntax, and other structural features) 2.6.

c. The most anxiety-inducing factors were said to be, 1) question and answer sessions, 2) open discussion, 3) asking questions, and 4) checking and confirming information. The corresponding numbers were 1.6, 1.6, 2.0 and 2.1, (scale of 1 to 5) respectively.
d. The negative affective factors and perceptions remained largely the same whether the doctors were inexperienced in presenting at international conferences (under 6 presentations, n=18) or veterans (6 or over, n=25). The single notable exception was that less experienced doctors cited anxiety in presentation opening and closings more frequently.

Since results from the interviews are more anecdotal in nature they have been included in the discussion section below.

4. Discussion

4.1. Location factors

The results from the survey appear to indicate that the further the doctor is removed from a Japanese setting, the more anxious he feels, with the greatest degree of anxiety experienced when presenting in inner circle English locations.

Based upon follow-up interviews this may stem from an underlying belief that English belongs to native-speakers and that the approximation of its standards represents the ultimate goal of English proficiency. This may cause the Japanese doctors to feel that they are disadvantaged from the outset, magnifying the sense of distance from the discourse community of English-speaking doctors, and thus increasing anxiety. As one interviewed doctor said, "I worry that making a mistake in front of native-speakers might make me look less intelligent in their eyes and thus discredit my research. With other Asians, I know we are all making some mistakes in English so that is not a concern."

Utilizing Asian non-native standards as an English learning and practice model (Asian English as a Lingua Franca) could be effective in reducing or resolving this sense of distance from the community. Dispossessing doctors of the notion that real English belongs to the inner circle of native speakers could offer psychological benefits to doctors who may well feel more comfortable looking to Korean, Vietnamese, Thai, or Chinese doctors in international conferences as English role models.

4.2. Areas of confidence

Most doctors were satisfied with their performances in terms of using professional terminology, slide content in English, including more formal English skills such as grammar and syntax, and pronunciation/intonation.

When asked how and why they had developed competency and confidence in using terminology, the standard response was that technical terms had become embedded in their daily Japanese discourse as a matter of workplace attrition. As one doctor put it, "We came across some of the terms while students and during practicum but while some items had appeared on course tests, I had never really absorbed these items because I didn't have to actually use them. Once I became a ophthalmologist however, specialist terms were used constantly, as if they were Japanese. It took all of two or three days to absorb most of them."

This should, to some degree, dissuade ESP/EMP teachers from believing that 'teaching' specialist terminology is really at the core of ESP/EMP teaching. Although professionals do have to learn these at some point, their English usage is so ubiquitous in the field it may be that they are absorbed by near osmosis and thus need not be taught explicitly.

Slide construction, including flow and order, was also said to be a skill that is largely transferable from the first language and, since the presenter has sufficient time to construct, check, and revise their English slides for both accuracy and propriety, this becomes less of a worry during performance.

Most doctors also felt that their fundamental grasp of English vocabulary and grammar was sufficient yet still worried about surface mistakes. Addressing this apparent incompatibility in the interviews one doctor, making a statement echoed by three others, said, "I'm not worried about basic syntactical mistakes but rather by transitional phrases or markers. I overuse 'so' 'then' and 'but' and it sounds rather elementary compared to more proficient speakers. These terms lack the impact I want to express." Another said, "I know of common rhetorical markers like 'Given that ...' or 'Due to the absence of...' but I lack versatility in using them properly so I end up using simpler phrases, which means that my presentation appears a little less...well...scientific or rigorous."

Chinese researchers have also emphasized the use of cohesive devices used in academic medical English and make particular note of the widespread use of hypotaxis in academic medical English,[6] in contrast to the more paratactic Chinese approach. Although this research focused upon the written language, our study indicates that this may not be true of Chinese to English transitions alone, but also from Japanese to English.

It was noteworthy that while some inexperienced doctors expressed slight anxiety about pronunciation/intonation, this was not a significant factor for veteran doctors, one of whom stated that, "Everyone at these conferences has an accent and I'm certain that many are less understandable

than my standard Japanese English accent."

4.3. Areas of anxiety

Managing the question-and-answer sessions was consistently cited as the most anxiety-inducing factor in both the survey and interviews, followed by open discussion, and formulating questions to others. These factors are, of course, connected by the fact that they are dynamic, open-ended, unpredictable, real-time exchanges.

One would naturally expect non-native speakers of any language to feel more comfortable with prepared or more mechanical interactions, but precisely what is it about such interactions that provokes so much unease? In fact, the feeling was so prevalent that one interviewee stated that when a visitor dropped by to see their poster session, the doctor pretend to be concerned with some paperwork or other matter so that they didn't have to engage the visitor in conversation.

Interviews revealed a common theme. What five of the six interviewees cited as the most salient fear was not being able to adequately understand a question being posed to them, which they believed would be both annoying to the questioner and also manifest their own lack of English proficiency. The same five doctors did not fear criticism in the question-answer session, as they had confidence that their research data would hold up under questioning. Rather, they feared looking foolish or coming across as lacking knowledge by not fully understanding the question or comment. Interestingly, the one exception in both cases expressed extreme confidence in understanding the questions but was highly sensitive about being criticized. Perhaps significant was the fact that this doctor was also the most experienced, in terms of total English presentations, interviewee.

4.4. Strategic competence

An interesting response on question-answer sessions from one doctor was as follows: "I can usually anticipate and understand the question well enough but if the question is rambling, indistinct, or more of a comment, I have no idea how I'm supposed to respond or what's expected of me in such cases." The issue as to how to manage dynamic exchanges, when there was some apparent communicative breakdown, came up during all interviews. Two doctors interviewed relied heavily on small notebooks containing lists of stock phrases for such situations that they had memorized, although they admitted that they often defaulted to a simple, "I agree with you" response. This helpful signaling role that formulaic sequences play in developing and performing specialist presentations in a foreign language for all levels of competency has been further discussed by Dickinson,[7] with particular regard to Japanese presenters using English.

Three of the most experienced presenters were quite forthcoming about how they managed breakdown. As one stated, "I always say in such cases 'Sorry. I'm not a native speaker of English so I didn't quite understand. Could you speak more slowly'? Or, 'Could you re-state your question?'"

The strategies involved in opening, maintaining, or closing interactions in poster sessions also came in for extended discussion. Many felt that while they had confidence in explaining the contents of their posters, they did not feel natural in initiating the interaction or closing it adequately. As one said, "Hello and goodbye sound like something an elementary school child says in such a situation, but that's what I end up saying."

The lack of confidence expressed in questioning others or confirming data was also expounded upon in the interviews. A significant comment made by one doctor was, "I hesitate to ask questions in discussions and symposia because I worry that my question has already been dealt with or is not relevant to the discussion because I have missed some nuance earlier in the discussion." This was echoed by several others. Another stated, "I know I should check and confirm but I feel that interrupting others just to check my comprehension is not only rude but might mark me as being incompetent."

5. Implications and Conclusions

Since the sample used in this study is quite small, a wider locus of research may be needed to determine to what degree our findings are truly representative of Japanese doctors' feelings regarding their performance in international academic conferences. We are also aware that individual, subjective perceptions regarding weaknesses and strengths may not be entirely accurate, that some respondents may offer an expected or popular, but not deeply examined, response. Due to these considerations, the next stage of research involves actually observing Japanese doctors at international medical conferences to confirm, from an ESP specialist's standpoint, to determine whether their claims are mirrored in reality or if some salient factors have gone unnoticed or are underappreciated.

Regardless, based on the research conducted thus far, there are four tentative points to be made regarding pedagogical implications for ESP teachers.

1. Medical students and doctors wish to, and need to, develop skills in dynamic, open-ended discussions, and question-answer sessions. This does not mean merely providing a list of stock phrases but also developing abilities and increasing confidence in con-

firming and expanding upon content. The ability to summarize and predict would also allow doctors to manage such exchanges more confidently.

2. Medical students and doctors should develop greater strategic competence skills in order to manage or minimize breakdowns without retreating into silence or avoiding the issue with set responses. Management of exchanges in which a lack of clarity or misunderstanding is common should be extant in teaching materials and practiced in the classroom.
3. Higher-level medical students and practicing physicians need less input or help from ESP teachers regarding more general grammar/syntax or specialist terminology, which they are likely to acquire elsewhere. However, the ESP specialist should be cognizant of deficiencies that do not strictly come under either the rubrics of grammar or lexis, but rather in the functional combination of the two, or those regarded as lexico-grammatically significant forms. These would include a heightened focus upon openings, closings, and transitional phrases and markers, which enable seamless flow between content sections in both set, formal presentations and in real-time communication management with other individuals.
4. Teachers should dissuade medical students and doctors from the perception that native-like proficiency is the only goal and standard used in the profession. A focus upon how non-native English speaking doctors, particularly those in Asia, utilize a different standard that might be more compatible with the expectations, skills, and even cultural interactional norms of Japanese doctors might well ease some of the burdens that Japanese doctors feel when engaging others in English at medical conferences. Classroom models based on English as a Lingua Franca (ELF) corpora should be introduced and utilized in teaching materials.

Developing presentation skills in English is widely regarded as one of the fundamental goals of English education in medical faculties throughout Japan.[8–10] In fact, when our surveys were distributed, three of the four department representatives stated that every doctor who had been practicing for over four years in their department had given at least one conference presentation in English. Moreover, skilful presentations in international settings were said to be tied to department prestige and act as a possible catalyst for international collaborative research and further financial support. These should act as motivating factors for improvement.

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Appendix 1. Japanese version of survey（2 pages）

医師の皆様【アンケートご協力のお願い】

英語科教員のマイケル・ゲストと申します。**医学系国際会議における、英語の使用実態に関する研究**を行っています。医師の皆様は、国際会議において、英語で発表や議論をする際、どのような点でお困りでしょうか。皆様の生の声を、プロジェクトの基礎的なデータとさせていただきたく思っております。このプロジェクトに基づき、以下を予定しております。

・「国際学会での英語コミュニケーション」に関するセミナーの開催

・「英語で発表をする際に使えるスキルブック」の作成

アンケートは無記名で、設問はおよそ30問です。答えにくい質問は、空欄にしていただいて構いません。ご協力いただきますことを、心より御礼申し上げます。

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①専門分野は何ですか。（参加している学会の名称など）＿＿＿＿＿＿＿＿＿＿＿＿

②差し支えなければ、役職名、肩書きを教えてください。＿＿＿＿＿＿＿＿＿＿＿＿

③医師になって何年目ですか。＿＿＿＿年目

■国際学会や国際セミナーについて

④現在、年間およそ何回参加していますか。＿＿＿＿回

⑤これまでに参加した回数の総計を教えてください。（おおよそで構いません）＿＿＿＿回

そのうち、

・英語で発表（プレゼンテーション）を行なった回数＿＿＿回

・英語でポスターセッションを行なった回数＿＿＿回

・英語での少人数セミナーやグループディスカッションに参加した回数＿＿＿回

⑥どこで行われましたか。開催地の割合を教えてください。

アメリカ＿＿＿%　その他英語圏＿＿＿%　ヨーロッパ＿＿＿%

アジア（日本を除く）＿＿＿%　日本＿＿＿%　その他非英語圏＿＿＿%

■語学スキルについて

⑦「英語を話す能力」について、次の１－10段階で評価してください。

（１：苦手　10：ネイティブレベル）

1　2　3　4　5　6　7　8　9　10

⑧「日本語で発表をすること」について、次の１－10段階で評価してください。

（１：苦手　10：得意）

1　2　3　4　5　6　7　8　9　10

■以下の状況で、どのくらい不安を感じるか、次の１－５段階でお答えください。

（１：ものすごく不安　５：まったく不安はない）

⑨あなたの専門分野についての10分間の発表を**日本国内の会場で、日本語で**する時

1　2　3　4　5

⑩**日本国内の会場で、聴衆（日本人と外国人が混在）に対し、英語で**発表をする時

1　2　3　4　5

⑪日本以外のアジア圏の会場（例えば中国や韓国）で、英語で発表をする時

1　2　3　4　5

⑫**英語圏の会場で、英語で**発表をする時

1　2　3　4　5

■**英語での発表**に参加する際の不安について、以下のA～Jに対し、次の１－５段階でお答えください。

（１：ものすごく不安　５：まったく不安はない）

⑬**発表をする**時

A：発表の冒頭（始め方）や、話の切り出し方について　1　2　3　4　5

B：発表中、話題を変えたり、次のトピックに移行する際の言い方について

1　2　3　4　5

C：作成資料の英語の正確さ　1　2　3　4　5

D：英語の発音　1　2　3　4　5

E：専門用語　1　2　3　4　5

F：質疑応答　1　2　3　4　5

G：ディスカッション　1　2　3　4　5

⑭発表を聞く時

H：質問をすること　1　2　3　4　5

I：聞き漏らした内容を確認すること　1　2　3　4　5

⑮その他

J：発表会場におけるちょっとした会話などの気軽なやりとり

1　2　3　4　5

⑯上記のA～Jの10項目について、「日本語であれば不安はないのに、英語だと不安である」という項目の「上位３つ」を教えてください。 _____

■国際学会や国際カンファレンス、国際セミナーに参加したり、発表をする上で、困った経験や、不安な事柄がありましたら、なんなりとお聞かせください。

〔　　〕

■このアンケートや研究内容について、ご意見やご提案などがありましたら、どうぞ自由にお書きください。我々は、実地に即した研究をしたいと考えておりますので、助言を求めております。

ご協力ありがとうございました。

〔　　〕

Appendix 2. Original English version of survey

Dear Doctors,

We have acquired a scientific-in-aid grant in order to better understand how Japanese doctors feel about their English-language strengths and weaknesses when presenting or participating at international medical conferences. Our ultimate goal is to diagnose areas of weakness and develop learning/teaching materials to address these. In order to help us carry out our investigation we would like to ask you to fill out the questions below. No name is required. Also, if you do not wish to answer a specific question you may choose not to do so. Thank you for your help and cooperation.

Yours,

Michael Guest,

English Section, Department of Social Medicine, Faculty of Medicine

General questions

Your department:

Your title:

Number of years' experience as an MD:

Experience

Number of international conferences/seminars attended in total (approximate):

____0 ____1-3 ____4-10____ 10-25____ over 25

Number of international conferences/seminars attending per year on average:

Location of these conferences (by percentage):

Asia (except Japan)____ Europe ____ North America ____ Other (Australasia/S. America) _____ in Japan _____

Approximate percentage of conferences attended at which you have presented in English:

Number of posters sessions you've carried out in English:

Number of times attending English-based general meetings, working seminars, or symposia at conferences (rough estimate):

English skills

How would you rate your spoken English ability on the following scale?

1 Very poor 2 3 4 5 6 7 8 9 10 Native-like

How would you rate your JAPANESE presentation/poster session abilities?

1 2 3 4 5 6 7 8 9 10

Anxiety

1. How much anxiety would you feel in doing a 10 minute presentation on your specialty in Japanese in Japan?
   1 none at all 2 3 anxious but not too much 4 5 extremely anxious
2. ...doing an English presentation in Japan (mixed audience of J and Non-J) 1 2 3 4 5
3. ...English presentation in another Asian country such as China or S. Korea
   1 2 3 4 5
4. ...English presentation in North America or the UK 1 2 3 4 5

Presentation performance

How anxious do you feel about the following at English conferences?

1= almost none 2 slight anxiety 3 some anxiety 4 quite anxious 5 extremely anxious

1. Presentation/poster openings and closings
2. Connecting and transition language in presentations
3. Powerpoint slide English content (basic English structure/syntax)
4. English pronunciation
5. Use of English technical/professional terms
6. Question and answer time

7. Dynamic discussion/opinion sharing at poster sessions, seminars, or symposia
8. Asking questions to others at their presentations
9. Checking, confirming or repairing your understanding at a seminar or symposium
10. Casual English conversation at conferences

In which category/categories above do you think there is the greatest gap between your English skills and your Japanese skills? Choose no more than three.

Please feel free to tell us any other common worries or anxieties you have regarding doing English presentations, poster sessions, seminars or symposia at int'l conferences below:

Please give us any other suggestion or information that may help us complete an accurate survey:

Appendix 3. Selected survey results

a. General
Total number of surveys returned: 43
Number of departments represented: 11
Years working as a physician: Range- 3-32. Average: 13.3
Number of presentations per year: Average 1.4
Total number of presentations: Range from 0-to over 100. Average: 9.4
Ratio of poster sessions to presentations: 2.2 to 1.0
Ratio of presentations to symposia: 2.4 to 1.0

b. Location
Location of presentation percentages by area:
N. America avg. 57.1%, Japan 15.4%, Other Asia 22.3, Others 5.2%
English performance confidence by location average (scale of 5):
Japan 2.2, Other Asia 2.0. Europe/N. America 1.7, (Japanese in Japan 3.8.)

c. Ability self-estimate averages (scale of 10):
English level (general) 3.3.
English presentation level 3.8.
Japanese presentation level 6.7.

d. Skill confidence in presentations/poster sessions/symposia (scale of 5 avgs.):
Openings/closings 2.4
Transitions in presentation 2.4
Slide content (structure/syntax) 2.6.
Pronunciation 2.1.
Technical language 3.1
Question and answer 1.6
Discussion/open ended 1.6
Asking questions 2.0
Checking and confirming 2.1
Casual conversation (non-formal settings) 2.5
Gap between Japanese and English abilities (top three number of selections):
1. Open-ended discussion- 24
2. Question/answer- 22
3. Asking questions- 21

Medical Humanities Database Japan: Motivating medical students and professionals to read English literature for pleasure

Sean Chidlow
Oita University, Faculty of Medicine

As a project within the field of the medical humanities, and funded by a national grant, I am constructing a Medical Humanities Database designed specifically for Japan (MHDJ). The goal of the database is to be a resource for authentic English literature for medical students and professionals. This paper focuses on the search for the literature to be included in the database which, to be effective, must motivate users to read autonomously. Three genres of literature (poetry, short stories and graphic novels) were evaluated and compared for their potential to motivate Japanese medical students and professionals to read authentic English literature. Of these three genres, the graphic novel showed the most potential. To study this genre further, I selected 30 books to evaluate. To determine whether they could be classified as literature, I judged the books by their content and use of literary techniques and devices. To research the motivational impact of the books, I introduced them to 48 fourth-year medical students, observed the students' reading behavior, and collected data on surveys. I found that graphic novels have much in common with classic literature in terms of both content and technique. In the classroom, students read the graphic novels enthusiastically, demonstrated the ability to focus on the readings for long periods of time and engaged in animated conversations with their partners. Due to the fact that graphic novels are literary and they do show excellent potential as motivational reading materials, I will proceed in my search for graphic novels that will make suitable content for MHDJ.

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Keywords Medical Humanities Database, Graphic Novels, Authentic Materials, Reader Motivation

1. Introduction to the Medical Humanities Database

The medical humanities, as a field of research and education, started to establish itself in North America as a result of changes in medical school curricula. The perception was that an exam-based medical school curriculum was producing doctors who were deficient in a somewhat intangible ability, which is often defined as "empathy." Empathy can be generally understood as a physician's ability to communicate with patients, to understand their feelings and health concerns on an intimate level. In a bygone era of medical education, "small and diverse schools meant variety of education and example, and plenty of personal mentoring."[1] Today, however, young medical students and doctors with limited life experience may be less well-equipped, character-wise, to relate to patients. Among the first schools to make changes in response to this trend was Case Western Reserve, which introduced curriculum reforms in 1957 that were "meant to give more attention to patients."[1] Ten years later, when it was founded in 1967, the Penn State College of Medicine became the first medical school in America to have a humanities department. The perceived value of humanities courses was on the rise and in 1973 the Institute for the Medical Humanities of the University of Texas Medical Branch was founded. The ensuing research in the field spawned the journal, Literature in Medicine, in 1982 and the British Medical Journal, Medical Humanities, in 2000.

The first effort to create a literature and film database for the medical humanities was taken at New York University School of Medicine in 1994. That database now contains more than 2,500 annotations for literature and nearly 250 for films. It was created to be a resource for anyone who has

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an interest in the medical humanities, including scholars, educators, students, and patients. Exposure to the literature and art compiled on the database is stated to "develop and nurture skills of observation, analysis, empathy, and self-reflection — skills that are essential for humane medical care."[2] The database keywords range from obvious medical connection, such as "epilepsy" and "surgery," to more tenuous connection, such as "freedom" and "nature." Inspired by the medical humanities in general and by the New York University database in particular I proposed a medical humanities database designed specifically for Japan. Fortunately, I was awarded a government grant to follow through on my proposal in April, 2012.

2. Medical Humanities Database Japan

It is the goal of MHDJ to maintain the integrity of the core concept of the NYU database, which is that the act of reading creative, artistic and intelligent literature will benefit those studying and working in the field of medicine because these literary works portray diverse ideas about illness, health, medicine and the human body. Within the medical humanities, the act of reading such literature is considered valuable also for its potential to improve skills of inference and interpretation. In this sense, authentic works of English literature are more appropriate for MHDJ than materials designed to learn the English language because authentic literature is created foremost to communicate subjective human ideas, feelings and emotions with readers. English language learning materials, graded readers for example, have an alternative raison d'être, which is to improve English as a Foreign Language (EFL) readers' fluency by advancing them through a series of reading levels. These levels are constructed by limiting the range of vocabulary used in a story, as well as by simplifying sentence structure and phrasing. This conscious selection and use of language for an alternative cause results in texts that are not fundamentally literary, and are therefore in conflict with the premise of the medical humanities database.

Further, it is the goal of MHDJ to exploit other potential benefits of reading authentic English literature, which include exposing readers to the cultural information that is inherent in literary works, and to increase their knowledge of how the language is naturally used.[3] An extended goal of the database is to provide English educators in Japan, both within and outside the field of medicine, with an alternative source for interesting, motivational and effective literary classroom materials.

MHDJ will differ from the NYU database in that it is designed for speakers of EFL. The NYU database assumes that its users speak English fluently. As such, most Japanese medical students and medical professionals would have difficulty navigating the site and understanding the literature annotations, let alone reading the works of literature. All of the annotations on MHDJ will be written in English and Japanese and a set of criteria will be defined used to rate the literary work in terms of difficulty. Such criteria will include factors such as vocabulary, word count, subjects, themes and cultural contexts.

The goal of the MHDJ is to be effective outside a classroom, without the guidance of a teacher. The success of the website depends on the Japanese medical student or professional taking time to search its contents for a work of English literature that he/she will buy (all books listed on the database are stocked by amazon.jp) and will take the time to read, completely autonomously. It cannot be assumed that the target readers of the website will be motivated to read works of English literature; they are not literature professors or university literature majors. Rather, they are professionals and students in the field of medicine, a science-laden discipline in which the most functional purpose for studying English is to read and write technical research papers. The thought of using their limited free time to read English literature may well be something that repels them. Hence the ultimate guideline in my search for the database content was defined: the literature must be entertaining.

2.1. The Criteria for MHDJ Authentic English Literature

In the search for authentic English literature that would entertain Japanese medical students and professionals I considered three genres: poetry, short stories and graphic novels. If a piece of literature in any of these genres is going to entertain the reader, it must engage the reader; it must capture the reader's interest and attention. If pleasure readers (readers who are not motivated by impending examinations) cannot understand a work of literature, it will not engage them, they will not be entertained and they will be unmotivated to continue reading it. Therefore, I considered four factors that affect the comprehensibility of the literary genres listed above for EFL readers: vocabulary, syntax, literary devices and cultural content.

Of the three genres, poetry offers some of the shortest literary works, which means that there is less vocabulary for readers to process. However, while some narrative poetry is written colloquially, much of the work in this genre employs vocabulary that is not often heard in colloquial conversation. In addition, poetry is also the most syntactically complex of

the three genres, as the conscious arrangement of language in a poem contributes to its meaning. Poems are also densely packed with challenging literary devices, such as rhyme, metaphor, symbol, alliteration, and allusion. Due to the economy of language in poetry, for example, allusions to cultural phenomena that are central to a poem's impact may be very subtly presented and require intimate knowledge of the poet's culture to comprehend.

Although the short story genre has significantly more vocabulary than poetry for readers to process, the syntax of prose is familiar to Japanese readers. The rules of English grammar that Japanese high school graduates study, and which help medical professionals understand research articles written in English, can also be applied when reading short stories. However, this grammar translation method of reading short stories will be of limited use as readers encounter many new collocations and expressions in a genre of writing that is vastly different than technical prose. Collections of short stories that I considered for inclusion on MHDJ, including works by Raymond Carver, Tobias Wolff, William Carlos Williams and Ernest Hemingway, averaged in length at about 6000 words. While high-level EFL fiction readers will be able to manage works of this length, even they will encounter difficulties with passages of detailed descriptive text and cultural content.

Graphic novels are a combination of cartoon drawings and narrative text. The "father" of the genre, Will Eisner, published the first book to be marketed as a graphic novel, "A Contract With God," in 1978. Therefore, the syntax used in graphic novels is predominantly that of contemporary English. While the vocabulary of a graphic novel is not necessarily easier than that of a short story, there is less of it for a student to process. Furthermore, the text that is omitted in a graphic novel is the descriptive text, as the graphics largely take over this job, so what is left to read is natural English dialogue. As is the case with short stories, literary devices are frequently used in graphic novels. However, the support of graphics helps the reader to understand devices such as metaphor, symbolism, time shifts and irony. This is equally true of cultural content. In text-only prose the reader must form a mental image from the words on the page, whereas the concrete depictions in graphic novels allow students to more quickly understand difficult cultural information.

Much of the authentic English literature in the poetry and short story genres that I read for consideration on MHDJ would prove challenging for high-level EFL readers. The visual information in graphic novels, though, gives them a clear advantage in terms of comprehensibility over text-only short stories and poems. As Bridges points out, for the L2-English reader who engages a graphic novel, "the experience resembles leisure reading" in a situation where the material is an "unmodified text targeted at native speakers."[4] Therefore, of the three genres evaluated, the graphic novel emerged as the most promising prospect of authentic English literature that could motivate EFL readers to read autonomously.

3. The Motivational Factor of Graphic Novels

The appeal of the graphic novel is so great that it is often championed as a gateway genre that has potential to draw readers into the literary classics. In the context of L1-English education, Schwarz states that "everyone from the reluctant reader, challenged reader to the high achieving but easily bored adolescent can find an intriguing graphic novel."[5] The appeal of graphic novels to readers of all ages and of all levels has been observed by librarians as well, and in an effort to promote literacy, they are building collections of graphic novels in schools across the United States that are in high circulation, even if they are not required reading for classes.[6] Graphic novels have broken into the L2-English publishing business as well, with Cengage Learning marketing a series of graded graphic novels they describe as a "fresh blend of contemporary storytelling and captivating artwork to entertain, educate and encourage students" to read.[7] Although the Cengage texts are graded for EFL readers, the series is limited to very traditional canonized titles by Shakespeare, Shelley, Brontë, Dickens and Wilde that have been rewritten for the purpose of language study. As stated above, the priority for MHDJ is authentic English literature, and therefore priority is given to original contemporary works. As Lazar concludes, choosing traditional works from the literary canon may be counterproductive when selecting texts intended to motivate EFL readers, as these works may not "reflect the lives and interests of our students."[3]

The obvious advantage the graphic novel has in motivating Japanese readers in particular is that Japan is already the biggest consumer of comics, known as manga, worldwide. It is a genre that is not only familiar, but also embraced, in Japan. According to Shuppan Geppo, Research Institute for Publications, manga and manga magazines account for nearly 40% of the total volume of publications sold in Japan.[8] However, returning to the idea of the medical humanities database, the goal of the website is to motivate medical students and professionals to read English literature. Of some 2500 literature entries on the NYU medical humanities database, there are only five annotations for

graphic novels. However, many of the themes and subjects of the works on that database are also represented in graphic novels that are currently not included. This may be in part due to the fact that comics are not perceived as literary works. As the graphic novel is closely aligned with the comic book, it is fair to question its literary integrity. What, then, are the differences between comic books and graphic novels, and how can these genres be compared to manga? According to Paul Gravett the Japanese drew inspiration from American comics but manga subsequently "liberated the medium's language from the confining formats and genres . . . and expanded its potential to embrace long, free-form narratives on almost every subject, for both sexes and almost every age and social group."[8] It is my contention that the graphic novel more closely resembles manga than it does the traditional American comic book.

The standard format of the traditional American comic book is 32 pages, staple-bound and printed on cheap newsprint. The market is controlled by two publishing giants, Marvel and DC, who account for 60% of comic book revenue in America. Largely, these comics are dominated by superheroes like Batman, Superman, and Green Lantern for DC, and The Incredible Hulk, The Amazing Spiderman, and Ironman for Marvel. The graphic novel, conversely, has no standard format. It can be of any number of pages, any size and shape, can have both hard and soft cover, and, like manga, it takes on any subject matter. Graphic novels are often perfect bound and have spines, as they are designed to stand on shelves in bookstores and libraries. They fall into any of the common bookstore genres, such as biography, autobiography, history, culture, science fiction, fiction, drama and memoir. The list of companies who publish graphic novels continues to expand and includes Pantheon, Penguin, Faber and Faber, W.W. Norton and Vertigo, to name only a few.

4. Graphic Novels As Literature

Those who defend the graphic novel as literary are quick to reference Art Spiegelman's Pulitzer Prize winning story about his father's life as a Polish Jew during World War II. Gravett takes exception to the perception of the graphic novel as a stepping stone toward reading the canonical texts, as it implies that graphic novels do not stand on their own as literary books.[9] In order to look more closely at the literary value of graphic novels, I selected 30 titles to read. In my selection process I was looking for characters, settings, subjects and themes that connected to medicine. As stated above, though, the spectrum of keywords listed on the New York University medical humanities database demonstrates how broad the medical humanities field is. As Pattison puts it, "Our concern and study is humanity itself. Nothing other than the broadest approach can possibly do justice to this subject, particularly in relation to health care."[10] As such, my choices of graphic novels sometimes had a direct connection to medicine, such as Brian Fies' work, "Mom's Cancer" and David Small's memoir, "Stitches." In other cases, the link to medicine was less overt, as in Will Eisner's seminal graphic novel, "A Contract With God," and Posy Simmonds' graphic novel of manners, "Gemma Bovary."

Beyond the connection to the medical humanities, I had no other criteria for selecting the graphic novels other than to choose a variety of works that would appeal to the different interests of different readers. In the end, the 30 graphic novels I collected were written by authors from 8 different countries: 10 American, 6 British, and 1 each from Canada, France, Iran, Israel, Italy, and Japan. The books touched on many fields of scholarship common to classic literature, such as culture, history, politics, gender, philosophy, psychology and sociology. Specific examples of subject and theme in the books include the Iranian Cultural Revolution, immigrant experience, coming of age, sex and drugs, self-discovery, Arab-Israeli relations, Huntington's disease, mysticism, inner fears and demons, urban anxiety and epilepsy. In terms of the common devices which help to define literary works, through the blending of words and images in graphic novels, I found stimulating examples of metaphor, simile, symbolism, time shifts, point of view, anthropomorphism, onomatopoeia and the unreliable narrator. Due to the visual element, the process of reading a graphic novel differs from that of reading a text-only work. As Eisner explains it, "The format of comics presents a montage of both word and image, and the reader is thus required to exercise both visual and verbal interpretive skills ... The reading of a graphic novel is an act of both aesthetic perception and intellectual pursuit".[11] The two genres have a strong relationship in regard to subject, theme, characterization and other literary devices, and the visual information in a graphic novel does not eliminate ambiguity or the need for inference and interpretation. As is the case with text-only literature, the process of reading a graphic novel requires a creative and critical mind. In the most general sense, graphic novels and text-only literature share a common goal which is, as Versaci describes it, to prompt the reader "to ask and answer the deeper questions that the given work suggests about art, life, and the intersection of the two."[12]

5. Graphic Novels In The Classroom

As a means of collecting introductory data on the motivational effect and entertainment factor of graphic novels on Japanese medical students, I introduced 7 graphic novels to 48 fourth-year students (**Table 1**). Due to a limitation of resources, I had two students share a single copy of each book. They were instructed to read silently in pairs. Beyond this, I gave the students no introduction to the books or directions on how to read them. The goal was to observe to what extent the graphic novels would engross the students in an activity that was meant to simulate a pleasure reading situation.

In the first reading session, each student read for a total of 90 minutes, with two 10-minute breaks. In the second session, they read for a total of 120 minutes, with three 10-minute breaks. In the end, each student read 3 or 4 graphic novels in their entirety. I was the only observer as all 48 read students read in a single classroom. I walked among their desks, listened to their verbal responses and took photographs and short videos of them as they read. Specifically, I was monitoring their ability to concentrate on the readings for long periods of time, their general moods and emotional responses while reading the books, and their willingness to engage in discussion about the stories with their partners. One further point I monitored was the students' tendency to use their dictionaries while reading.

In general, I was impressed by the students' ability to focus on the readings and complete them in the allotted time. Despite the fact that some of the readings were very challenging, no students gave up on them. In some cases I observed some frustration over the amount of text on a page or over a difficult storyline, but even in these cases, students tended to look at the pictures, turn the pages and find their way back into the story. Many times in the past I have seen students drop their heads to their desks in defeat in the middle of short story and poetry reading sessions, but with the graphic novels, all heads remained upright. During the reading sessions there were many signs of emotional connection with the stories. I observed laughter and other vocalizations I inferred to represent surprise, disbelief, sadness and disgust. The students' moods were good during the reading sessions and they showed strong willingness to communicate with their classmates as they worked through the stories. They often pointed at the pages and commented to one another as they read. Finally, I found that students referred to their dictionaries much less than when they read text-only literature. The explanation for this may be, as Bridges notes, with graphic novels, readers find that "comprehension is constantly reinforced by images that give words a context," which enables them to sustain the reading experience "without feeling compelled to constantly refer to a dictionary."[4] This point is particularly important because in the portrait of the leisure reader, in which entertainment takes priority over education, the dictionary has no prominent place on the armchair. This is not to say that reading graphic novels listed on MHDJ will not be educational, but that if the literature on the database does not entertain readers, medical students and professionals may never be motivated to read it.

6. Survey Results

At the end of both reading classes, I asked the students to complete a short survey about the graphic novels they had read (**Table 2**). Interestingly, the graphic novels that were rated to have less connection to clinical medicine were those that inspired students to read more graphic novels. This suggests that the students have a wide range of interests outside the fields of science and medicine, and the literature content on the medical humanities database should cater to that variety of interests. Ninety-five percent of the students who read the longest book, *Stitches*, at 329 pages, reported that it inspired them to read more graphic novels, and 100% of those students recommended it to their class-

Table 1. Graphic Novels Read in Class.

Title	Author	# Pages
Jamilti	Rutu Modan	21
Summer Blonde	Adrian Tomine	31
Seeds	Ross Mackintosh	88
Chicken With Plums	Marjane Satrapi	96
The Drowners	Nabiel Kanan	104
Mom's Cancer	Brian Fies	128
Stitches	David Small	329

Table 2. Survey Questions.

1.	How interesting was this graphic novel? Not Interesting 1 2 3 4 5 Very Interesting
2.	How difficult was this graphic novel to understand? Very Difficult 1 2 3 4 5 Very Easy
3.	How much connection does this graphic novel have to clinical medicine? Strong Connection 1 2 3 4 5 No Connection
4.	Did this graphic novel inspire you to read more graphic novels? Yes / No
5.	Would you recommend this graphic novel to your classmates? Yes / No

mates (**Table 3**). The students were able to read this sizable book in four consecutive 30-minute reading sessions. Although I have no data on the depth of their understanding, they were clearly able to enjoy this book as evidenced by their survey answers. Despite its 329 pages, this book was not rated by students as the one most difficult to read. In fact, students rated 4 of the other 6 books as more difficult reads, including *Summer Blonde,* at 31 pages. The difficulty factor of graphic novels, then, is not directly connected to number of pages, but rather it is likely that the text-to-graphics ratio plays a more significant role in perceived difficulty. This being said, *Stitches* is a memoir about family life in America that tells the author's story from age 6 to age 30. The book is replete with American customs and culture and delves deeply into the psychology of the main character. Again, it is unknown to what extent students understood the layers of meaning in this story, but they were able to complete the reading in a short period of time and report a positive experience while being exposed to a rich body of new ideas and cultural norms.

7. Conclusions

Following the model of the NYU medical humanities database, MHDJ will be a resource for medical students and professionals who have an interest in reading authentic English literature as a means of improving their skills in interpretation, observation and communication. The selection of literary works should be as varied as possible to account for a broad range of interests while being unified by the general themes of health, illness, body and medicine. Unlike the NYU database, careful consideration must be given to the fact that MHDJ users are EFL readers. If the literature presented on the database is too difficult for users to understand, they will not be motivated to buy it and read it. Therefore, the literature must be comprehensible and, to appeal to their interests as autonomous pleasure readers, it must entertain them.

The graphic novel is a genre of literature that Tabachnick boldly claims "will eventually become the most popular form of reading."[13] Graphic novels are already widely used in L1 English education both as motivational material for reluctant readers and as provocative literary material for motivated learners. Works in this genre are being produced by writers from around the globe on a wide range of subjects. The text is combined with a graphic element, which supports comprehension of the story, lowers the word count and exposes readers to natural, dialogue-driven English. The format of the graphic novel enables Japanese EFL readers to digest more ideas at a faster rate and experience the satisfaction of autonomously reading books in their entirety. Therefore, while the inclusion of other types of literature on MHDJ will not been ruled out, the initial phase of the literature content will be comprised solely of graphic novels. More research is required on the difficulty range of graphic novels. There is great variation in the text-to-graphics ratio among these works. To assist MHDJ users in the selection of works that are appropriate to their English level, each graphic novel will be given a difficulty rating based on information that is in part objective (text-to-graphics ratio), and in part subjective (a review of subjects, themes, and cultural content). English translations of manga will also be considered for inclusion on MHDJ. These works may be recommended for lower level readers, for example, because the cultural setting creates no obstacle to comprehension and,

Table 3. Survey Results.

Title	1. How Interesting	2. How Difficult	3. Clinical Connection	4. How Inspirational	5. How Recommendable
Chicken With Plums	4.1	2.7	3.4	4.3	75%
Stitches	4	2.9	2.7	4.8	100%
The Drowners	4	2.3	3	3.3	75%
Jamilti	3.8	3.2	2.9	3.2	61%
Seeds	3.7	3.8	1.8	4.3	90%
Mom's Cancer	3.1	2.0	1.7	2.8	50%
Summer Blonde	2.8	2.4	3.5	2.0	18%

further, the reader has the option to read the work in its original Japanese to facilitate comprehension. Further research must also be conducted on the variety of works that exist in this literary form, and the reasons why some works are preferred over others by Japanese medical students. The graphic novel shows exciting potential as a genre that will motivate Japanese medical students and professionals to read the English literature to be compiled on MHDJ.

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第16回日本医学英語教育学会学術集会
特別講演
「日本脳神経外科同時通訳団の活動と研修会の意義：医学英語教育の面から」

Activities of simultaneous interpreters' group in neurosurgery and significance of training course: from the viewpoint of medical English education

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1. はじめに

日本脳神経外科同時通訳団は，日本医学英語教育学会の名誉理事長である，植村研一先生が設立されたユニークな団体で，日本脳神経外科学会や日本脳神経外科コングレスの補佐組織として，30年以上にわたって，学会の外国人講演者に対する貢献のみならず，医学英語教育の面からも脳神経外科医の英語能力の向上に寄与してきた。演者は，2003年よりこの組織の団長を仰せつかり，約70名のメンバーとともに活動を続けてきた。毎年開催される夏期研修会は，若手脳神経外科医(若手医師，若手研究者と置き換えられる)を対象とする，英語での口演発表のスキルをいかに向上させるかの訓練の場であり，また，同時通訳を行える中堅・ベテラン脳神経外科医(中堅・ベテラン医師と置き換えられる)の，同時通訳能力をさらに磨く重要な場である。この夏期研修会の内容を紹介することは，医学英語教育に携わる本学会の参加者にとって有益なものと思われる。

本稿では，歴史的なことも含めて同時通訳団の活動を紹介し，研修会がいかに医学英語教育の面から有用であるかについて，研修会の状況をまじえて解説する。脳神経外科医以外の医師，英語教師の先生方にも今後の参考になれば幸甚である。

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本稿は，第16回日本医学英語教育学会学術集会（2013年7月20・21日，千葉県浦安市）における特別講演として口頭発表した内容を元に文章化したものである。

2. 私自身の英語の経歴

私は英語を専門に学んできたわけではない。中学校，高校と大学入試の為の受験英語を学んできたのであり，私の英語の基本は受験英語にある。ただ，英語を習い始めた時から英会話には大変興味があり，NHKのラジオ英会話を中学校1年生の時から，毎日録音して聞いてきた。これは今でも続いている。我々が若いころはnative speakerの英語を聞く機会はなかなか簡単には得られず，短波ラジオを親に買ってもらって，フィリピンから聞こえるVOA(Voice of America)の放送を毎朝聞いていた。文法よりも発音やイントネーションを大切にしてきたと思っている。

脳神経外科医になって，英語論文が医学の最先端を学ぶのにいかに重要かを感じるようになった。大学院での研究を続けるために，米国ニューヨーク州のロチェスター大学医学部に1988年から1990年の2年間留学した。帰国後，日本脳神経外科同時通訳団に加わり，2003年からは団長を務めている。

3. 日本脳神経外科同時通訳団の活動

3.1. 日本脳神経外科同時通訳団とは

日本医学英語教育学会の創設者であり，初代理事長である，植村研一先生(浜松医科大学脳神経外科名誉教授)が1980年頃に設立したものである。日本脳神経外科学会専門医で英語の得意な医師が集まり，植村先生を中心に活動を始めたのが創設期である。毎年，夏期研修会を行い，高い評価を受けたメンバーを新しく団員として加えていき，現在約70名(そのうち実際に現在もactiveに活動しているのは40名程度)が同時通訳団員である。

本組織は，他の医学関係の学会には見られないユニークな組織であり，日本脳神経外科学会総会や日本脳神経外科コングレスを中心に，脳神経外科関連学会で活動している。同時通訳団が大きな組織になり，学会から信頼されて活動を続けていけるのは，なんと言っても創設者である植村研一先生のリーダーシップによるところが大きい。

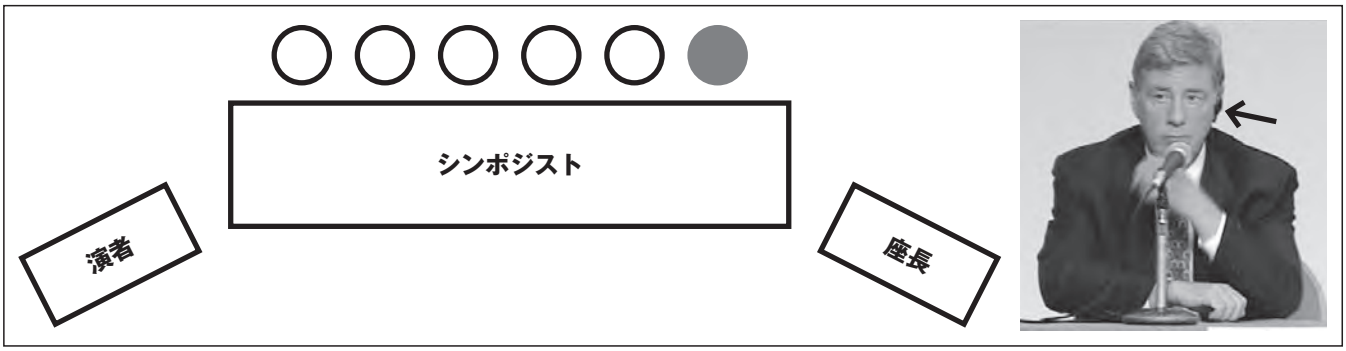

図1　シンポジウムにおいて同時通訳を聞く外国人招待講演者
シンポジストによるプレゼンテーション後，壇上で総合討論が行われる。この模式図では6名のシンポジストが壇上で討論する。
黒丸で示される外国人招待講演者は矢印で示すように，左耳に同時通訳を聞くためのレシーバをつけている。

図2　同時通訳ブース内
通常ヘッドセットとマイクロフォンが2セット準備されている。

3.2. 日本脳神経外科同時通訳団の主な活動目的

日本脳神経外科学会総会のような大きな学会では，いくつかのシンポジウムが企画され，その中に外国人招待講演者が含まれるのが一般的である。日本国内の学会であるから，通常シンポジウムを含み，日本語で学会は進行する。私たち同時通訳団の役割は，シンポジウムに加わる外国人講演者およびフロアで聴講中の他の外国人のために，日本人シンポジストの講演内容を日本語から英語へ同時通訳することにある(日→英)。このことによって，プレゼンテーション後の総合討論の際に，外国人招待講演者やフロアの他の外国人がスムースに討論に参加することができる（**図1**)。

外国人講演者の発表の後の質疑応答で，フロアからあるいは座長から日本語で質問がされる場合，同時通訳団が日→英の同時通訳を行うことによって，学会参加者が外国人講演者に遠慮なく日本語で質問ができる状況を作るのも大切な役割である。

外国人講演者の英語の講演を日本語に同時通訳(英→日)する機会は極めて稀である。

日本脳神経外科学会あるいはその関連学会に招待された外国人講演者は，自分の講演をするだけではなく，他の日本人の講演を同時通訳で聴き，コメントを求められたりするため，「寝る間がない」との愚痴も聞かれる(冗談です)。

3.3. 同時通訳ブース

同時通訳ブース内には，通常2つのヘッドセットとマイクロフォン，および音量調節などの装置が備わっている(**図2**)。2名で交代で通訳を行うが，3人目もいざというときに備えてstand-byすることが多い。同時通訳をしている間に集中するためだんだん体が前のめりになり，マイクに近づき過ぎて音が割れることがあるので，ブース内には，マイクロフォンから20cmは離れるように注意書きがある。

3.4. 各学会の同時通訳手配と同時通訳者の公表，学会への活動報告

脳神経外科学会の関連学会では，会長名で，同時通訳を依頼するe-mailを団長である私に送付される。団長である私は，同時通訳団のメンバーに学会中のどの日時の同時通訳が可能かをたずね，可能なメンバーを各学会の会長に回答する。会長が作成する学会のプログラムには，ところどころ，ヘッドセットのロゴが入っており，そのセッションは同時通訳が可能，という意味である。また，同時通訳団

図3　学会ボードに掲示された同時通訳担当者の名前
同時通訳団のモチベーションと責任感を高める効果がある。

図5　研修会会場に設定された4つの同時通訳ブース
本格的なブースを設置して，夏期研修会は行われる。

のモチベーションを高めるために，学会のボードに，同時通訳担当者の名前を掲示してもらっている(**図3**)。年間の同時通訳団の活動については，毎年日本脳神経外科学会と日本脳神経外科コングレスに報告をしている。また，同時通訳団の活動をいくつかの論文でも報告しているので，ご覧いただきたい。[1,2]

3.5. 通訳ブースあれこれ

通訳ブースはしばしば会場の高いところに設定されていて，会場全体を見渡しやすいことが多い。上から見ていると外国人講演者が会場内のあちこちでレシーバーを使って我々の同時通訳を聞いていることが認識できる。日本人の講演が終わった途端，急に立ち上がって講演者に質問する姿が上からよく見える。壇上の日本人が，日本語の発表のあと急に外国人が英語で質問し始めるのでちょっとあわてるシーンも，脳神経外科関連学会ではよく見かける光景である。

また，通訳ブースからみたスクリーンの角度がかなり斜め方向で見にくいことがある。そのような場合は，通常，ブース内に液晶モニタを設置してもらっている(**図4**)。

図4　スクリーンが斜めに見えるブースでは液晶モニタを設置
白色の囲みが液晶モニタである。これによって斜めからでは見にくいスクリーンの情報を完全に見ることができる。

4. 日本脳神経外科同時通訳団の研修会

4.1. 研修の概要

同時通訳団のレベルとモチベーションを維持するために，毎年夏季に研修会を1泊2日で行っている。これには，全国の若手脳神経外科医と同時通訳団の団員が参加するのであるが，この研修会で新たに同時通訳団に入ってもらうメンバーを決めるという重要な役割も果たす。現同時通訳団員の多くは，植村研一先生にこの夏期研修会で指導をうけ，同時通訳のスキルを磨いてきた。

4.2. 夏期研修会のスケジュールとその様子

夏期研修会では，若手脳神経外科医に英語でのプレゼンテーションの機会を提供する「日本脳神経外科国際学会フォーラム(JNEF)」が同時開催される。このJNEFを利用して，英→日の同時通訳のトレーニングも同時に行う。夏期研修会のメインイベントである日→英の同時通訳研修については，会長が日本語のプレゼンテーションを，脳神経外科関連のいろいろなサブスペシャリティーごとに準備し，それを使ってtraineeは日→英の同時通訳訓練を行う。trainerである同時通訳団のメンバーが，小休止をはさみながら，マンツーマンに近い状態で指導をする。また，同時通訳団のシニアメンバーは，ひとりひとりのtraineeに対してスコアをつけ，新たに同時通訳団に加わる者を決める。

研修会におけるブースの設定は，本番同様のものを用い，採点を行うためのレシーバーも実際の同時通訳の時に使う，本格的なものであるため，traineeの評価は極めて公正で，正確である。ブースは毎年4つ程度準備される(**図5**)。

実際の研修の様子をいくつかのパターンに分けて，2013年7月の特別講演の際は主にビデオで紹介したが，本稿では省略する。

2日間の研修でtraineeもtrainerも疲労困憊状態となるが，同時通訳団のメンバーにとっては，同時通訳に取り組む気持ちを新たにする良い機会である。

内頸動脈海綿静脈洞部の巨大動脈瘤に	Regarding IC cavernous
対しては、	giant aneurysms,
以前から	so far
頸部での	at the neck
内頸動脈あるいは総頸動脈の結紮術が	IC or CC ligation has been
主として行なわれてきた。	mainly performed.
最近になって、	Recently,
血管内手術の発達により	due to development of endovascular surgery,

図6　頭から訳すためフレーズごとにわける
文章をこの図のようにフレーズにわけ，頭から同時通訳していく。

5. 専門分野での日英同時通訳：植村研一先生に学んだそのコツとpitfall

私たち同時通訳団が行っているのは，脳神経外科医が脳神経外科医のためにおこなっている同時通訳である。よって，ことばをそのままことばに訳す，というよりは，医学的に正確な内容を伝えることに重点が置かれている。同時通訳のコツは植村研一先生が独自に作り上げられてきたものであるが，これを夏期研修会などでわれわれは教えられ，そして実際の同時通訳の場で実践し，pitfallも体験してきた。いくつかを紹介する。

5.1. 頭から訳す

一つの文章を最後まで聞き終えてから訳し始めないことが大切である。これは訳している間に次の文章が頭に入ってきて通訳できなくなってしまうからである。文章をフレーズにわけ，フレーズごとに頭から訳すのである(**図6**)。

5.2. As for は便利

スタートした文章がどう進むかわからないときに，「〜に関して」という表現(as for , regardingなど)は重宝する。「頭から訳す」という原則を守るためにも，欠かすことのできない表現である。

5.3. 完全な逐語訳は同時通訳では不可能

英→日，日→英，とも訳文は原文の1.5倍である。そのため，不要な語句はカットして，要点のみ訳すようにしないと，完全な逐語訳は同時通訳では不可能である。

5.4. 文法をあまり気にしない

日本人にbroken Japaneseが通じるように，英語のnative speakerにもbroken Englishが通じるのである。聞いてくれているのは同じ専門分野を持つ脳神経外科医なのである。キーワードさえ外さなければ，文法を気にしすぎる必要はない。

5.5. 演者の先取り

同じ専門分野を持つ脳神経外科医が同時通訳を行う最大のメリットがここにある。つまり，演者が次にどのようなスライドを出してくるかの推測がつくし，内容自体を理解した通訳が可能である。言葉だけを訳しているのではない，という長所がある。

5.6. ビデオプレゼンテーションでのポインター追い

ビデオプレゼンテーションでは，ポインターにぴったり合わせながら同時通訳することが必要である。特に解剖学的用語がでてきたら，他の訳をやめてでも同時に通訳をしなければ，意味がない。同じ脳神経外科医だからこそビデオの解剖が理解できるのであり，腕の見せ所と言える。

5.7. 無言は禁忌

通訳者が通訳に戸惑って黙ってしまうと，レシーバーが壊れたのかと思って，聞いている外国人はレシーバーのチャンネルを切り替えたりややこしいことになる。“I'm sorry, I do not understand what the speaker is saying”などのフレーズを述べて聞いている外国人に音声を流し続けることが必要である。黙ってはいけない。

5.8. ブース内にオペラグラスと換算表

通訳ブースはしばしばスクリーンから遠くにあり，スライドが見にくい。オペラグラスが役に立つことがよくある。また，「ウロキナーゼ18万単位」などの大きな数字がでてきたとき，あるいは，「A先生は昭和37年にB大学を卒業され」などが出てきたとき，18万，昭和37年をすぐに訳せない場合がある。**図7**のような換算表をブース内に持っていると便利である。

5.9. 会場には招待者以外の外国人も居る

アジアからかなりの留学生，脳神経外科医が学会に参加している。それは，脳神経外科学会が同時通訳つきであることが知られているからで，彼らはしばしば同時通訳を利

大正5	1916	昭和30	1955
大正10	1921	昭和35	1960
大正15	1926	昭和40	1965
		昭和45	1970
昭和元年	1926	昭和50	1975
昭和5	1930	昭和55	1980
昭和10	1935	昭和60	1985
昭和15	1940		
昭和20	1945	平成5	1993
昭和25	1950	平成10	1998

1万：ten thousand
10万：one hundred thousand
100万：one million
1000万：ten million
1億：one hundred million
10億：one billion
100億：ten billion
1000億：one hundred billion
1兆：one trillion

図7　年号および数字の換算表
このような換算表をブース内に持ち込んでおくと，便利である。

用して積極的に発言するので，白人が会場に見あたらないからといって手を抜いてはいけない。

6. 同時通訳団の活動と医学英語教育

医学英語教育の面から，同時通訳団の活動を振り返ると，通訳団員個人個人としての意義と，脳神経外科全体に対する意義に分けて考えることができる。

6.1. 通訳団員の個人個人に対しての意義

いい同時通訳をしなければ，という思いから，英語の能力を高めなければいけないというプレッシャーにさらされている。英語を学ぶmotivationが続く。

また，同時通訳をしている10〜15分間の集中力は，他の知的活動では経験することができないほどの集中力であり，脳を極限近く活性化させている。加えて，脳神経外科全分野に関する知識をいつも向上させなければいけないため，それだけ関心も広がる。これは，医学そのものの知識だけでなく，どの医師・研究者がどのような考えをもっているか，というpoliticalな問題にも及ぶ。

6.2. 脳神経外科全体へのインパクトとしての意義

同時通訳団の存在により，加入をめざす若手脳神経外科医が多い（毎年，同時通訳夏期研修会に新たに10〜15名の参加者がある）。同時通訳団で活躍している脳神経外科医の多くは，脳神経外科学会および関連学会でも活躍し，多くの論文を発表している。多くの教授が同時通訳団員の中から誕生してきた。また，脳神経外科医には，英語に関係する著書を書いたり，日本医学英語教育学会に加わったりする医師が多いが，これも同時通訳団の存在が影響している。同時通訳を行う人にとってわかりやすいスライド作り(つまりブースから一瞥してわかりやすいスライド)が良いスライド作りであることから，プレゼンテーション自体に興味を持つ脳神経外科医が多い。

7. まとめ

日本脳神経外科同時通訳団の存在は，学会の外国人招待講演者にとって日本人講演者とのスムースなコミュニケーションを可能にするだけでなく，学会員全体の英語に対する興味とレベルを高めることにつながる。日本医学英語教育学会の会員にとって，その活動を知ることは医学英語教育の面からも有意義であると思われる。

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第16回日本医学英語教育学会学術集会
シンポジウム1
「医療現場は医学英語教育に何を期待するか」

座長：吉岡俊正（東京女子医科大学）
Reuben M. Gerling（日本大学医学部）

The journal symposium was initiated to foster better communications between clinicians and EMP teachers. In many instances the clinicians expect certain things and the EMP teachers teach others. This is not only a matter of poor communications, it also has to do with the needs of the learners at each stage and the knowledge they possess at that stage.

To make the EMP programme more efficient it is necessary for the EMP teachers to understand what the clinicians expect of the learners when they reach the clinical stage. At the same time it is crucial for the clinicians to understand the principles of language education and the challenges faced by the EMP teachers. In this way it is hoped that both sides will be able to foster better communications and enable the learners to benefit from the EMP programme.

Short contributions from all interested parties, clinicians and EMP teachers, JASMEE members or not, are welcome. Contributions can be either in English or in Japanese. Replies to and discussions of contributions already published are particularly welcome.

- Please send your contributions by e-mail to: **jasmee@medicalview.co.jp**
- Please enter the subject of the mail as: **Journal symposium**
- Please write your name and position in the first line. Follow this with either '**new entry**' or, '**in reply to ….**'.
- Please end with a **short conclusion** of your entry. If you wish to see the galleys of your entry please write so at the end of your entry.
- Please limit your complete entry to **no more than 300 words in English** or **300 characters in Japanese**.
- You can add a photograph of yourself to the entry. Please note that if any other faces are seen in the photo, **the people in the picture have to be notified and give permission** for their photo to be published.

Opening remarks
Reuben M. Gerling（座長）

Good afternoon. I hope you enjoyed your lunches. This is a symposium, so we'd like everyone to participate.

If you want to catch a quick nap, now is the time, because later on, you have to talk.

Professor Yoshioka proposed this idea that we need to know more what clinicians expect from English teachers, and so he proposed a symposium. The idea is that of a running symposium, an ongoing symposium will start today, it will be published in the Journal, and then if you read that and send us mail, we'll publish your opinions in consecutive journals and it'll keep on rolling and hopefully develop.

So for that purpose there are forms in the reception that you can pick up later—you don't have to go now. We ask you two things: first of all, we're going to take some pictures. If you do not want your photograph to be published, please let us know. And the second thing is if you want to see the galleys of your views, all the opinions here will be published, if you want to see the galleys of your opinion before they are published, then please let us know.

The introduction today will be by Professor Yoshioka, who is the Chancellor of Tokyo Women's University and Associate Editor of the JASMEE Journal. Professor Yoshioka, please.

Introduction
吉岡俊正（座長）

皆さん，こんにちは。これよりシンポジウムを始めさせていただきたいと思います。

いま，Gerling先生からお話がありましたように，このシンポジウムを通して，本学会の学会誌である*Journal of Medical English Education*にいろいろなご意見をいただきたいと考えています。

今回のシンポジウムのテーマはEMP（English for Medical Purposes）です。本学会は医学英語をどう教えるか，あるいはどう学ぶか，そういうことを考える学会で，本学会誌もそれに向けた教育・研究成果を掲載しています。

しかし，その中でこのEMPというものが非常に幅広いものであるということ，それから本学会の大きな構成としては，もともと英語を教えているフィールドからいらしている先生と，もともと医学を教える，あるいは医療プラクティスのほうからこの会に参加されている先生方がいらっしゃって，実際，医学教育の中でもこれがなかなかうまく融合して教育されていない部分もあるかと思います。

そういうものを今後，integrationといいますか，fuseした形で，よい教育ができるようにということで，今回はさまざまなフィールドの方からディスカッションの糸口になるようなお話をいただくことになっています。その後にフロアからのいろいろな討論を期待していますので，よろしくお願いしたいと思います。

では，最初のスピーカーの方にご登壇いただきたいと思います。岡山大学の伊達先生に“What the clinical faculty expects from medical English education: the chairman of neurosurgery's viewpoint”ということでお話しいただきたいと思います。

では，よろしくお願いいたします。

1. What the clinical faculty expects from medical English education: the chairman of neurosurgery's viewpoint

伊達　勲（岡山大学医学部脳神経外科）

吉岡先生，ご紹介ありがとうございました。

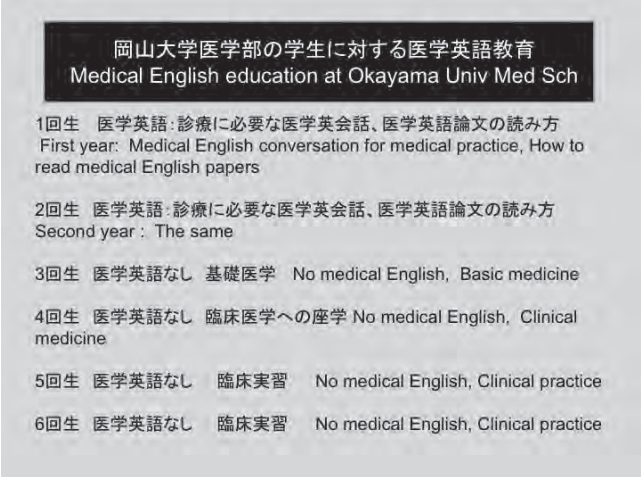
私はいま，岡山大学脳神経外科の主任教授をしています。医学英語教育に関して，いくつか感じていることがありますので，それを少しご紹介申しあげたいと思います。

私の脳神経外科教授としての役割は，大きく2つあります。1つは，将来の医師，これは医学生のことですが，この教育全体を預かっている責任者の一人であるわけです。

2つ目には，もう脳神経外科医になっている人，すなわち若手の脳神経外科医を有能なスペシャリストにするという責務があります。そのためのトレーニングをしているということです。

1つ目が，本会に関していちばん関係あることだろうと思います。2つ目については簡単に，最後のほうで述べたいと思います。

まず最初に，岡山大学医学部で学生に対してどのような医学英語教育が行われているかということを簡単に書いたのが，この**スライド1-1**です。



スライド1-1

1回生と2回生に，医学英語という授業があります。そこでは，診療に必要な医学の英会話，あるいは医学英語論文の読み方といったことを教えます。

しかしながら，3回生，4回生になりますと医学英語としての時間枠はとっていなくて，3回生では基礎医学を学びますし，4回生では臨床医学のための座学を中心に学んでいます。

5回生，6回生も医学英語という時間は特にとっているわけではなくて，5回生のときは全科を臨床実習で回り，6回生のときは選択実習としてその学生が希望する科を回るという形になっています。

1・2回生，3・4回生，5・6回生に分けて見てみますと，先ほども申しましたように，1回生，2回生では医学英語教育として基礎的な診療に必要な英会話を学びます。そして，基礎的な医学英語論文の読み方を習います。この指導方法自体については，私は全く賛成ですし，いまのやり方でよいのではないかと思っているわけですが，3回生，4回生のときに医学英語のクラスがないのが問題です。

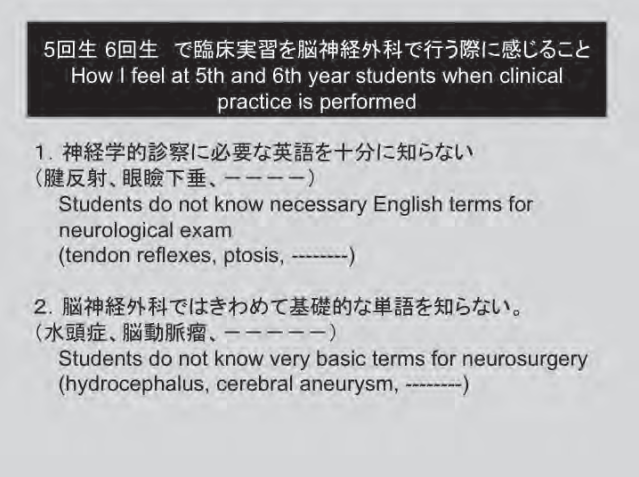
その理由は，基礎医学と臨床医学の講義でいっぱいいっぱいであるということです。どこの医学部でもそうだと思いますが，特に臨床医学のほうは次々に講座が増えて，講義を入れるので手一杯です。また，基礎医学についても新たな分野が誕生し，シラバスが手一杯で，医学英語を別個に確保して設けるのは難しい状況になっています。

理想的には，基礎医学や臨床医学を教える際に，できるだけ医学用語を，日本語だけでなく英語でも教えていただければと，常々思っているわけですが，実際は，日本語だけのケースが多いのです。

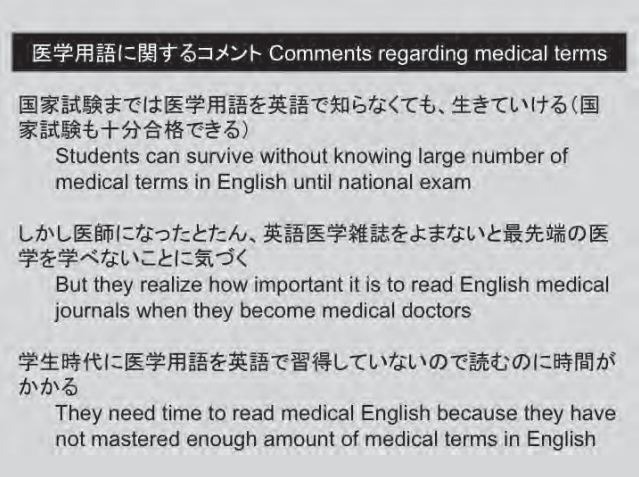
学生自らも医学英語について，日本語だけでなく，英語でこれはどう表現するのかということを常に意識して学んでほしいのですが，なかなか，実際にはそうはいきません。英語に非常に興味のある学生はそういう態度を示しますが，ほとんどの学生は日本語で満足しているという状況です。

そういう状況で，5回生，6回生で私どもの前にやって来て，臨床実習を行うわけです。全科に行きますから，私どもの脳神経外科も当然，全員が来ます。私は脳神経外科医ですので，神経学的診察というものが非常に重要なのですが，実際にはこの診察に必要な基本的な単語自体も学生は十分知りません。

例えば「腱反射」や「眼瞼下垂」，もちろん日本語では学生



スライド1-2



スライド1-3

は知っていますが，英語で言えるかというと，全然言えないのです。

脳神経外科の基礎的単語に関しては，かなり英語ができる学生でも，日本語の単語は言えるけれども英語の単語は言えません。**スライド1-2**の2にあるように，例えば，脳神経外科で「水頭症」や「脳動脈瘤」が言えないと，実習の意味がありません。Hydrocephalus，cerebral aneurysmです。昨日，学生に少し講義をしてきましたけれども，この2つの単語を全く言えませんでした。

医学生が，医学用語を英語でもっと表現できるようになってほしいというのが，臨床の教室の教授としていつも思っていることです。

特に，臨床実習というのは全科を回っているので，最も医学用語をたくさん学べるチャンスなのです。各科の医学用語を，日本語では皆言えるようになっているのですが，英語で言える，あるいは英語で言おう，英語で覚えようというようにはなかなかなっていない。そういう環境づくりがいるのではないかといつも思っています。

医学用語に関するコメントをいくつか申しあげますと（**スライド1-3**），国家試験までは医学用語を英語で言えなくても十分医学生は生きていけます。「生きていける」というのは，国家試験も十分合格できるということです。現在の国家試験では，2%だけ英語単語が出ることが認められている状況と伺っていますが，普通の学生はそういう医学用語を英語で言えなくてもよいわけです。もちろん，日本語で言えないと合格できませんけれども。

ところが，実際に医師になりますと途端に，英語の医学雑誌を読まないと最先端の医学を学べないことに皆が気づくわけです。気づいたときはもう遅いといいますか，学生時代に医学用語を英語で修得していませんから，読むのに大変時間がかかるように見ていて感じます。動詞などはすぐにわかるけれども，名詞でとまってしまう。医学用語を日本語ではわかっていても，英語でわかっていないということがあります。

この学会で医英検をやっているわけですが，医学用語が豊富に出題されていますので，5回生，6回生にとってはとてもよいモチベーションになるのではないかと思って，私の大学ではこれをぜひ受けるように，いま一所懸命指導しているところです。すでに2年ほど経ちました。

医師国家試験で，医学用語をもう少し多く英語で出題してもらうと，医学英語の教育の面からは非常に好都合だと思っていますが，いまのところ2%だけということです。

医学英語の論文の読み方の授業は，よく行われていると認識していますが，今後はしゃべるほう，あるいは医学英語のプレゼンテーションの授業を医学生に対して行っていただきたいと，いつも思っています。

実際，医師になって国際学会で発表するということは，その医師にとって非常に重要です。それによって，その発表が医学英語論文につながっていくわけだからです。

最後に，脳神経外科医になった若手に対してどんなことを英語のトレーニングとしてやっているかを，簡単に申しあげます。

*Journal of Neurosurgery*と*Neurosurgery*，私どもの分野では，この2つのジャーナルがトップジャーナルで，やはりこれを読んでいないといわゆるcutting edgeには追いついていかないということで，いつも読ませるようにしています。

具体的には，毎週火曜日に抄読会を行っていて，大体6～7人の若手に10分ずつ，その時点での重要な論文を読ませて，サマリーしてプレゼンをさせるというようなことをやっています。

若手脳神経外科医に指導していることとしては，国内学会や国際学会で発表した内容は必ず英語論文として書き上げようと言っています。そのためには，医学部のときからプレゼンテーションをできるようになってほしいと思っているわけです。

ということで，まとめますと，診療に必要な英会話や医学英語論文の読み方に加えて，医学用語をできるだけたく

さん英語で教えていただきたいと感じています。

そして，医学英語におけるプレゼンテーションの仕方を教えていただきたいと思っています。

どうもありがとうございました。

Summary

大学における臨床科の一つである脳神経外科の教授として，医学英語に関して最も医学生に求められているのは，医学用語の英語での習得ではないかと感じている。医学生の間は国家試験を含め，医学用語の習得は日本語でもほとんど問題ないが，いったん医師になって最先端の医学を実践しようとすると論文を中心とする最新の情報は英語でしか得られない。医学部在学中に医学用語を英語で理解しておくことはこの状況に対応するために極めて重要である。また，英語でのプレゼンテーションを学ぶことは，国際学会での発表などに有益であり，ひいてはそれが医学英語論文執筆という，最終ゴールに到達するための重要なステップとなる。国際学会での英語の発表は，必ず英語の論文にまとめる，という習慣を身につけることが大切である。

【吉岡(座長)】伊達先生，ありがとうございました。臨床の立場から，特に医学部での教育，あるいは医学部を出たあとの教育の中でどういうものを教え，あるいは学んでもらいたいかというお話をいただいてきました。

全体的な討論のほうは最後に行いたいと思いますが，ただいまの伊達先生のお話の中で何か内容についてclarificationのようなものがあれば，いまお受けしたいと思いますが，いかがでしょうか。

【Bukasa Kalubi(徳島大学)】1年生の人たちは，医学英語の授業を受けるのですか。

【伊達】1年生，2年生は医学英語の授業があります。

【Kalubi】うちの大学は，1年生からという話があったときは，共通教育のところでこの1年生のプログラムは文部省で決められているから，それはできない。

【伊達】We have the same thing. The general English is taught from the first year—and plus Medical English. That's my university's case.

【Kalubi】Yeah. I understand the problem you have. So in my university, we teach Medical English three years: second, third, and fourth. And then, when they move to the fifth and the sixth grade, so they almost understand the terminology of all specialties. So that's the thing.

【伊達】That's the ideal thing, but for the neurosurgeon specialists like me, the terminologies the general students know are not enough for specialists... I should say...

【Kalubi】Sorry: I understand. So what we needed to solve that problem is in the fourth year, you have what we call the Clinical Communication class. So in that class, we teach the whole year, so we have an English section, for every part (Internal Medicine, Surgery, etc.). So when the students finish at least they know already the basic terminology of all specialties, and then when they move to clinic, it is easier, but the problem we are having is the clinicians don't want to teach English.

【伊達】OK, so are they the English teachers who are teaching medical terminologies? Is that correct?

【Kalubi】No, no... the problem is just that the teacher is a medical doctor.

【伊達】Ah, OK.

【Kalubi】That's the difference.

【吉岡(座長)】Well, this is the discussion exactly to be discussed in this symposium that how we combine so-called general English and medical English, so we'd like to discuss it later. So I'd like to close this presentation. Thank you very much.

2. Medical English Education in the Dental Sector

影山幾男（日本歯科大学新潟生命歯学部解剖学第１講座）

Good afternoon. My name is Ikuo Kageyama, I am working for Nippon Dental University at Niigata, and I'm going to speak about my presentation in Japanese.

日本には80の医学部があります。しかし，日本の歯学部は現在29あるのですが，ほとんどの歯学部において一般のundergraduateの講義は日本語で行われています。

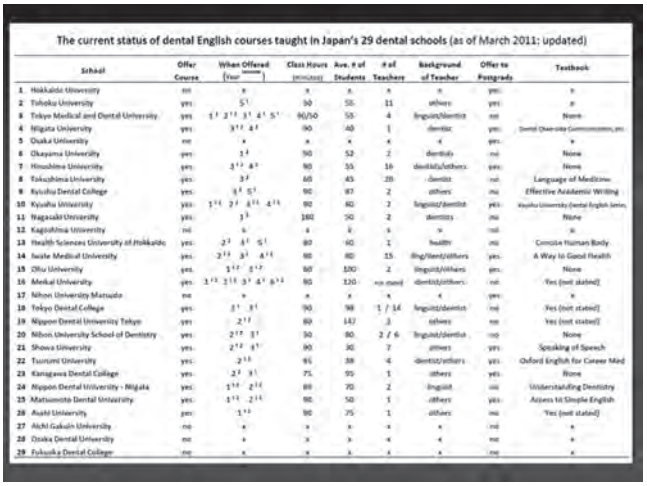
次に，アジアに目を向けますと，例えば中東，韓国，フィリピン，スリランカなどの歯学部の歯学教育ですが，ほとんど英語で行っているところが多いです。

さらにまた，英語を完全に使っていなくても，少なくともテキストは英語を使っているという国が多く拝見されています。

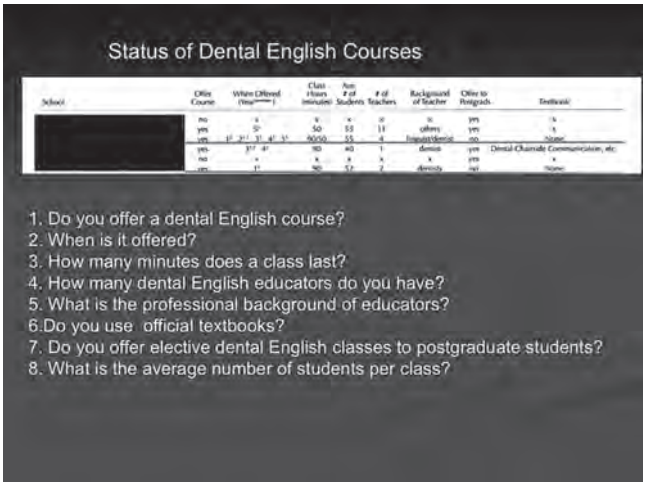
現在，29の歯学部の中に，去年の調査ですが，325名の外国のundergraduateの学生，またpostgraduateの学生，これは研究者も入るのですが，325名が歯学部でいま勉強しています。

では，その29の歯学部の中で，例えば外国から来た学生のために特別な英語教育，また英語のクラスを持っている，そういう大学はいくつあるのかというと，5校しかないのです。それは東北大学，東京医科歯科大学(TMDU)，新潟大学，徳島大学，そして九州大学の5校です。

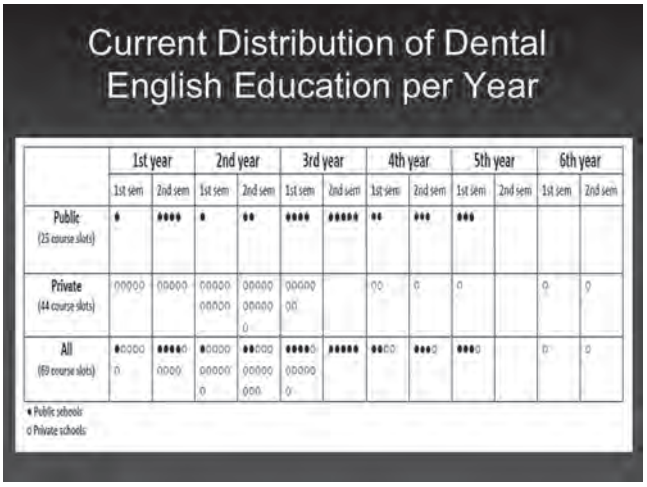
2010年4月には，日本の学術会議が「英語は非常に大切だ。グローバリゼーションのために非常に大切なので，やらなければならない」ということで，英語の必要性を非常にうたっています。しかし問題点は，特に歯学部ですが，



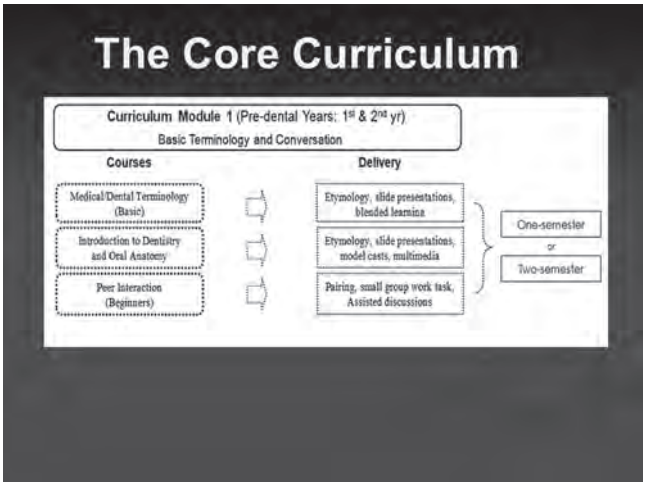
スライド2-1



スライド2-2



スライド2-3



スライド2-4

ほとんどの歯学部の学生が卒業して，医師，歯科医師になって，また研究者，発表する人が次は国際学会だ，と外国へ行くと，いま岡山大学の話もありましたが，学生時代から英語になれていません。そうすると，皆プレゼンテーションのハウトゥーもわかりませんし，練習もやったことがないので，非常に皆さん不安を感じて，それで日本人のJapanese scientists are 3S，日本人の科学者は3Sだと。1つのSはsilent，静かである。もう1つのSは，学会で寝ている人がいる，sleeping。3番目のSは，わかったような顔をするのでsmiling。そんなことを言われています。

先ほどもご紹介しましたように，29の歯学部があります。国立が11，県立が1，残りが私学で17です。この29の歯学部に，以前，岡山大学の歯学部におられましたRodis先生が調査をいたしました。この調査は余りにも細かいので，一部だけ取って，上のほうの1番から11番が国立，その次が県立，その下が全部私立です（**スライド2-1**）。

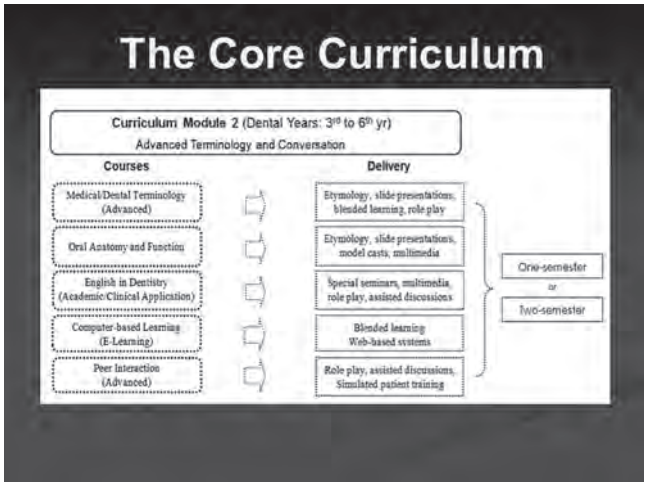
調査項目が1番から8番まで（**スライド2-2**），英語のコースがありますか，いつ導入しましたか，どのぐらいの時間がありますか，それから少し小さすぎて見えないのですが，実は3番目が東京医科歯科大学，6番目が岡山大学なのですが，国立の中でも1年から5年まで医学教育を行っているところもあるかと思えば，やはり1年だけとか，そういうところでばらつきがあるように思えました。

さらに，いつ英語を教えているかというと（**スライド2-3**），やはり1年次，2年次，3年次，●のほうが国立で，少し見えづらいですが○が私立なのですが，意外と1年次，2年次，3年次に医学教育を終えてしまって，4年，5年，6年になるとほかの臨床教育が多いのです。また，6年の最後には国家試験があるので，それどころではなくなるということで，医学教育がおろそかになってしまうわけです。

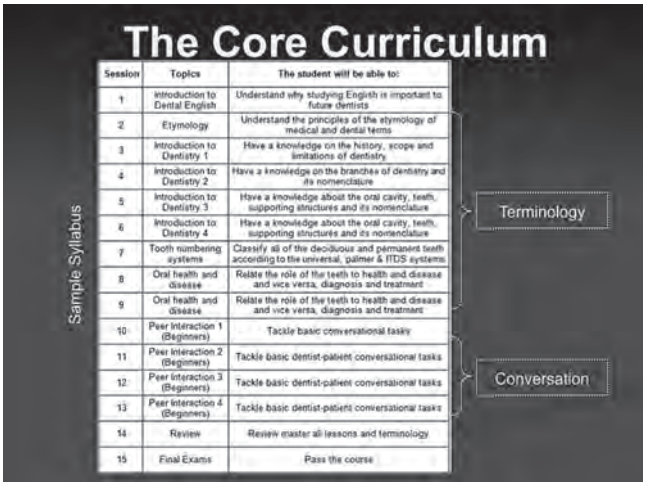
これではやはりよくない，通年，6年なら6年，医学教育での継続性というものが大切ですから，歯学部の中でも，そういうものをやったらどうだということで，dental educationのフォーラムを2011年8月に行いました。次の2回目が，2012年6月です。

これは岡山大学歯学部のRodisさんがつくったコアカリです（**スライド2-4〜6**）が，実際にはこういうコアカリがない。ない上に，歯学の中で医学教育をやっているのが現実です。Terminologyの部分，conversationの部分。

最後になりますが，現在29の歯学部の中で，コアカリの



スライド2-5



スライド2-6

作成とか，あとはスタッフも含めまして，歯学部における医学教育は非常にプアーな状態ではないかと思います。

これからそれを打破するために，まず問題点を挙げ，ディスカッションのフォーラムを立ち上げて，皆さんと協力してよりよい歯科の医学教育，また医科の医学教育とも協力してやっていく必要があると思います。

ご清聴ありがとうございました。

Summary

Medical English Education in the Dental Sector

According to the Science Council of Japan, English skills are very important for globalization. The council recommends that many Japanese universities will implement courses of subjects taught in English.

Currently, there are twenty-nine dental schools in Japan; eleven are governmental, one is a local public institution, and seventeen are private. Education using medical English in dental schools has been lagging far behind Japanese medical schools. As of May 2012, there were 325 foreign undergraduate and postgraduate dental students, including researchers. However, only five dental schools, namely Tohoku, Tokyo Medical and Dental, Niigata, Tokushima and Kyusyu Universities had implemented postgraduate dental education courses in English.

However, dental schools in Asia, for examples Philippines, Korea, Sri Lanka and Middle Eastern countries, many required subjects taught in English. Although, the course of the subjects taught not in English, at least English text books used in dental schools in other Asian and Middle Eastern countries. Consequently, the Asian and Middle Eastern dental students became familiar with English.

Japanese staffs who are conducting medical English at dental universities should provide an effective core curriculum using medical English. All Japanese dental universities should be implemented courses of elective subjects taught in English. Without significant English communication skills, many young Japanese dental graduates will be unable to give proper presentations at international meetings.

【吉岡(座長)】Thank you very much for the very good overview of the dental English education.

Again, if there are some question for the clarification, please ask at this moment.

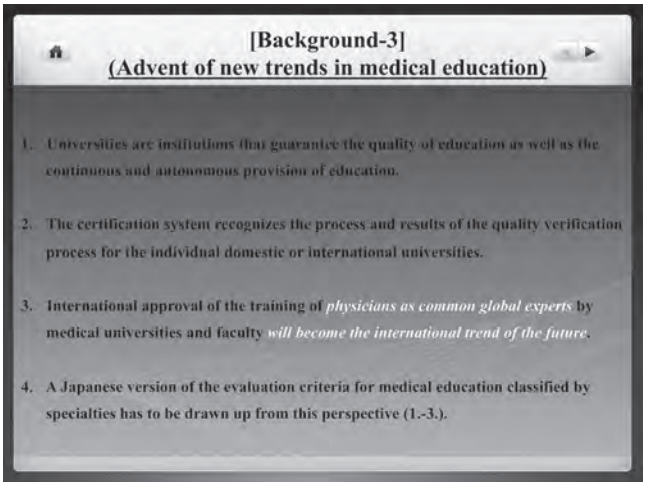
【亀岡淳一(東北大学)】歯学部で，大学院に行く方は何パーセントぐらいいらっしゃるのかということと，大学院の場合，英語の論文が必要とされているのか，教えていただけますか。

【影山】ちょっとパーセンテージまではわかりかねるのですが，私立だと大体いまは5%ぐらいなのではないかと思っています。

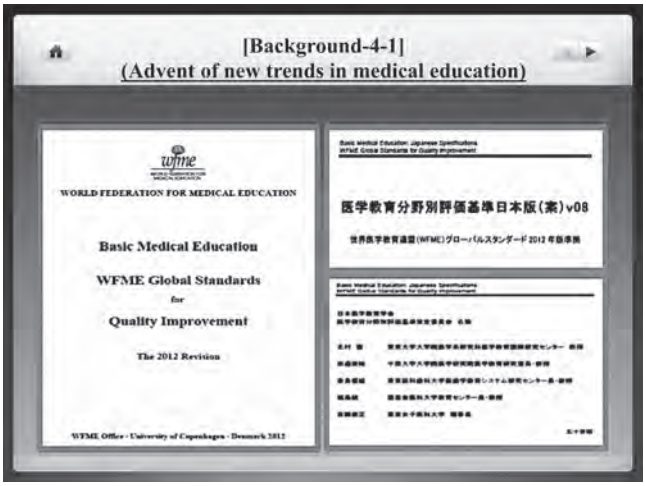
大学院の論文ですが，これも29の歯学部で1つ1つ違っています。例えばうちの大学ですと「インパクトファクターが0.8以上の国際誌に出すこと」というような規定はあるのですが，これも，では29の歯学部の中で全部同じかというと，そうではなくて，国立の歯学部でもインパクトファクターは関係ない，英語でなくて日本語でもよいというようなところがあるのが現状です。

【亀岡】ありがとうございました。

【吉岡(座長)】では影山先生，どうもありがとうございました。



スライド3-1



スライド3-2

3. What kind of physician will finally be raised through medical English education?

福沢嘉孝（愛知医科大学医学部医学教育センター）

最近の医学教育の世界に“黒船襲来”的な潮流が到来しました。そこで，その背景を簡単に説明します。

まず，2008年頃から国民（＝患者さん）のニーズが急激に変化し，特に今回のテーマにもありますphysician's professionalismに対してかなり大きな期待を抱くようになりました。

「2023年問題」を会場の皆さんがご存じかどうかわかりませんが，端的にはグローバルスタンダードに関する問題です。この中では座長の吉岡先生が最も詳しいかと思いますが，これを簡単に説明すると，2003年にWFME（World Federation of Medical Education）という世界医学教育連盟が医学教育の質の向上を目指したグローバルスタンダード基準の導入を発表しました。

また，2010年にECFMG（English Certification of Foreign Medical Graduates）が「2023年度問題」をより具体的に宣言（2023年以降，医学教育の国際認証制度を導入する，後述）しました。

さらに，WFMEが2012年に国際認証制度に関する基準の改訂版を発表し，それに呼応して日本国内でも医学教育の質の向上に関する気運が高まり，日本独自のJACME（Japan Accreditation Council for Medical Education，日本医学教育認証評価評議会）という組織が立ち上がったのです。

東京女子医科大学が日本で最初に外部評価（WFMEの評価基準に準拠）を受けたのが2012年秋頃だったと思います。本年度は，JACMEによって東京医科歯科大学，新潟大学，東京慈恵会医科大学が認証評価を受ける予定になっています。

既述の「2023年度問題」というのは，結局のところ，WFMEが認証するグローバルスタンダード評価基準に準拠した医学教育を受けている医科大学・医学部の卒業生以外には，USMLE受験資格を認めないことになります。今後，世界的に認証評価受審の動きが加速するであろうと言われています。

このスライドにも記載した通り（**スライド3-1**），結局，physicianは世界的にも，グローバルコンセプトの中で大いに期待されていますので，この流れは急加速するだろうと思われます。

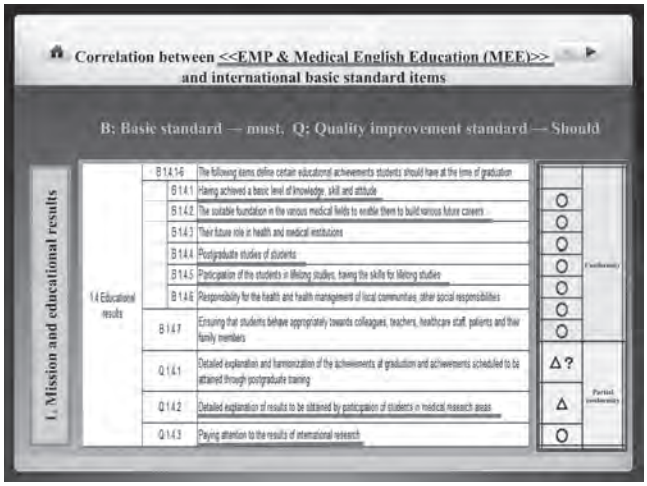
一方，日本医学教育学会の医学教育分野別評価基準策定委員会メンバーが，WFMEの日本版（Japanese specification）を，2013年5月27日に発表しています（**スライド3-2**）。向かって左側がWFMEのグローバルスタンダード（英語版）で，2012年のrevised editionです。右側が今年5月に日本医学教育学会から公開された日本版のドラフトです。ここに既述の策定メンバーが記載されています。

その基準領域には，9つのエリアがあり，さらに，36下位領域に分類されているのです。

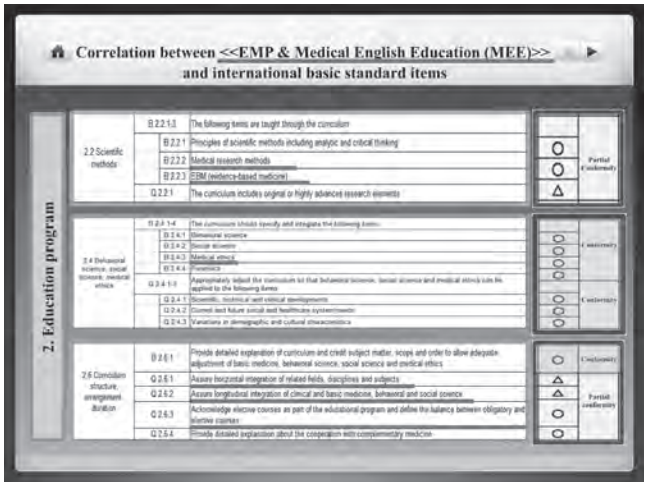
1. 使命と教育効果（Mission and Outcomes），
2. 教育プログラム（Educational Programme），
3. 学生評価（Assessment of Students），
4. 学生（Students）
5. 教員（Academic Staff/Faculty），
6. 教育資源（Educational Resources），
7. プログラム評価（Programme Evaluation），
8. 管理運営（Governance and Administration），
9. 継続的改良（Continuous Renewal）

これらの全領域について，各医科大学・医学部が自己点検・評価をして，グローバルスタンダードに合致しているか否かをチェックしなさい，ということになります。

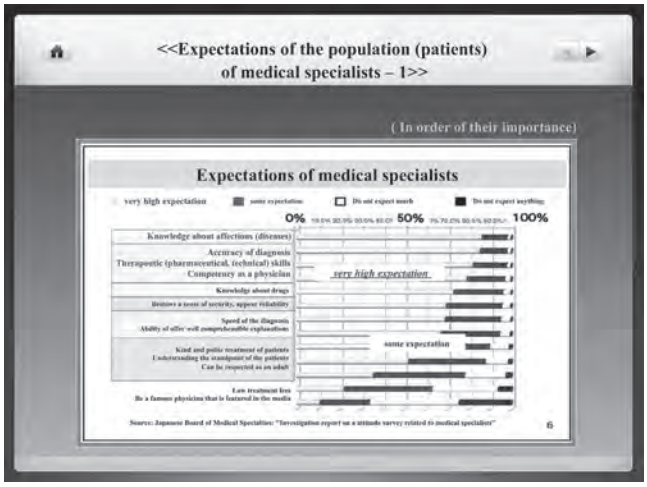
さらに問題なのは，国際認証基準の達成度を２段階の水準で提示しているのです。基本的水準に対しては“must”で表現され，これは既に達成していなくてはならない水準です。もう1つは，質的向上の為の水準で，“should”という単語で表現されています。この2つをクリアしていかなけ



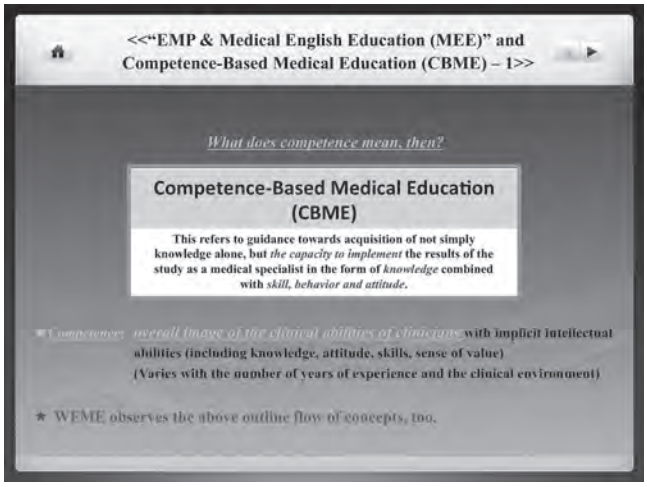
スライド3-3



スライド3-4



スライド3-5



スライド3-6

ればいけないことになります。

このスライド3-3は私が本学の医学教育を自己点検したものです。今回のシンポジウムテーマのEMPとmedical English educationとが関連するWFME基準項目をピックアップしたもので，特に関連性の深い項目には赤ラインを付してあります。

このスライドからもお分かりの通り，ベーシックレベルの知識(knowledge)，技能(skill)，態度(attitude)が必須になりますし，卒後研修及び，医学の各部門でのキャリア教育，生涯学習能力，医学研究分野(含，国際的な研究成果)といったものにやはり医学英語が密接に絡んでくるかと考えます。

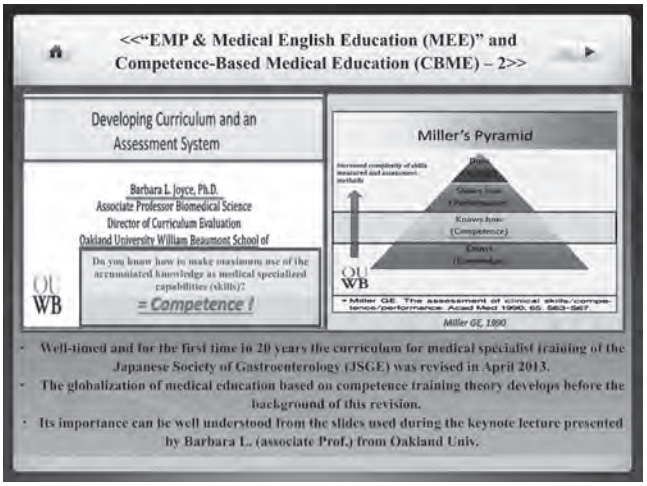
スライドサンプルなのですが(スライド3-4)，これに関しては，本学は適合(!? 自己判断)ということになります。後半の２項目は部分的適合!?といった感じで順次評価を進めて行くのです。

これは2番目の教育プログラムですが，医学英語が絡んでくるのは，医学研究手法(Medical Research Method, Scientific Method)とEBM，医療倫理(Medical Ethics)だと考えます。それ以外では，関連分野(基礎医学・臨床医学・社会科学等)でのhorizontalとlongitudinalな統合に医学英語が絡んでいくのではないかと考えています。

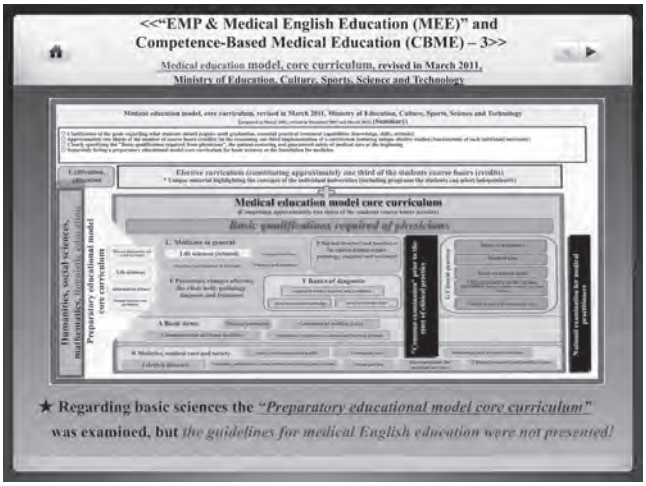
今日の午後のテーマにもありますが，情報通信技術(Information Technology)，教育の交流(Educational Exchanges)，継続的改良(Continuous Renewal)等にも医学英語とが絡んでくるのではないかと考えます。

これは日本専門医制評価・認定機構の資料の一部ですが(スライド3-5)，国民(＝患者さん)が医師(専門医)に何を期待しているかを“期待度の高い順番”に調査したものです。赤で示してあるところは，国民の期待度が大きい項目です。それは疾患(病気)の知識　診断の正確さ，治療法の能力等です。最も注目に値するのはこの医師としての能力(competency as a physician)だと思います。

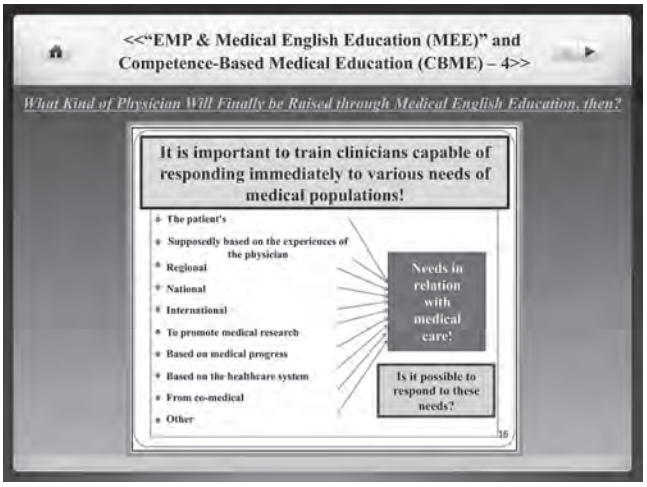
では，このcompetencyとは何かという話になってくるのですが，このスライド3-6が全てを物語っています。最も重要な問題は，competencyを最大限に高めるような世界的コンセンサスを得たカリキュラム(含，医学英語教育)は今のところないのです。従って，各医科大学・医学部において，このclinical competenceの育成を非常に大切にしなければならないのです。



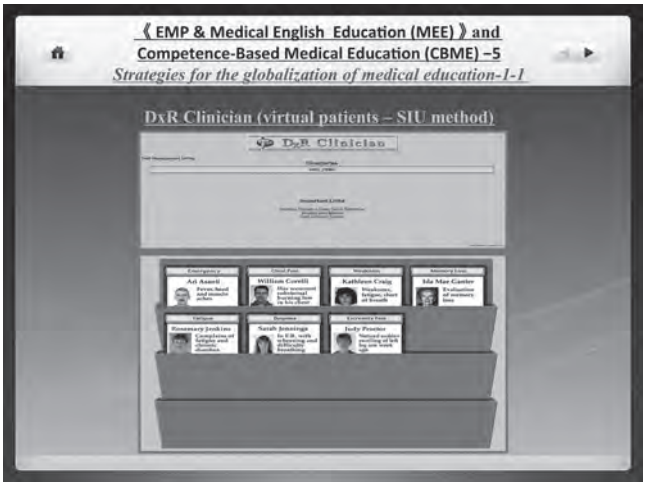
スライド3-7



スライド3-8



スライド3-9



スライド3-10

このスライドに記載されている通り，Competenceというのは，臨床医の有する臨床能力の全て(overall image)であると。やはりこの概念の流れをWFMEは踏襲しているのだと思います。

これ(**スライド3-7**)は，タイムリーにも2012年に改定した日本消化器病学会の専門医カリキュラム資料の一部を示しています。この改訂の背景にもcompetence学習理論をベースとした医学教育のグローバル化が存在しています。この改訂作業にも使用されたのが，G.E. Millerのcompetence理論でした。

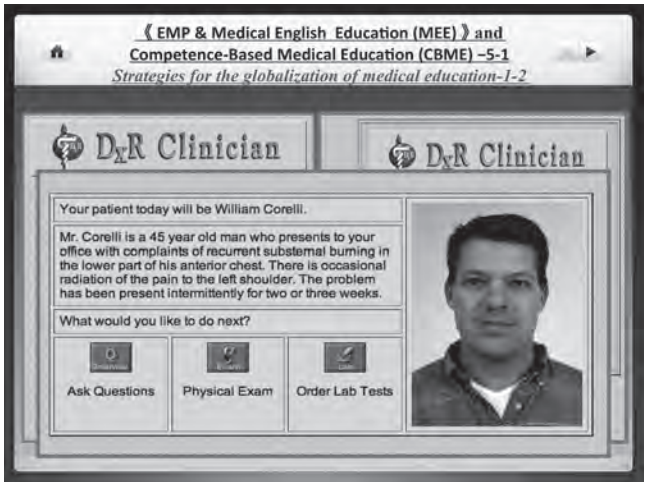
この**スライド3-8**は文科省が出している医学教育モデル・コア・カリキュラムです。この中心に医師として求められる基本的資質(basic qualification，required physician)というフレーズがあり，別冊に「準備教育モデル・コア・カリキュラム」と記載があるのですが，13年3月以降，改訂版が出ていません。更に，内容的にもMedical English Educationに関連するガイドラインすらないという現況です。

これらの話を踏まえて，もう一度，話を戻しますが，では国民(＝患者さん)のニーズは何かというと，physicianとして，国民(＝患者さん)の種々ニーズにフレキシブルに対処可能な臨床能力，これこそがcompetenceではないかと考えます。その育成には，グローバルな視点でのものの考え方が不可欠であり，その養成ツールの一つとして医学英語教育が非常に重要だと私は考えているのです。

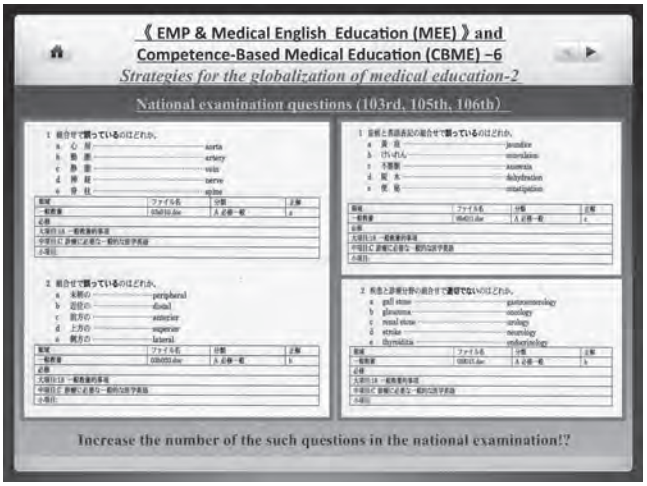
これ(**スライド3-9**)は本学医学教育のグローバル化達成のためのストラテジー(私案)です。

グローバル化に準拠した医学英語教育を強化・推進するツール活用例の一つを紹介します。SIU(Southern Illinois University)で開発された臨床推論能力育成ソフト(DxR clinician)等を利用するのも一つの手段かと思います(**スライド3-10**)。仮想模擬患者(virtual patient)が出現します。この人物が私の患者さんとします。IDとパスワードを入力し，エンターキー，スタートボタンをクリックします。

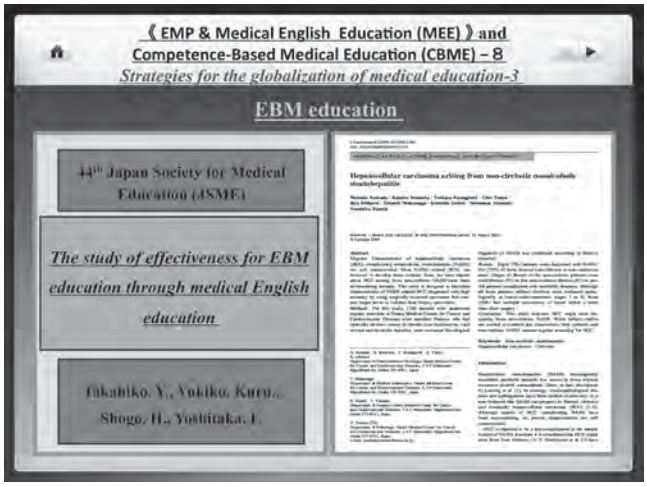
「今日の患者さんはWilliamさんです。」と表示されます(**スライド3-11**)。"What would you like to do next?"次の診断手順として，"Ask Questions"に進みたいのか"Physical Exam"に進みたいのか"Order Lab Tests"に進みたいのかで，アルゴリズム的に順次分類され，個々の進行状況も変化してくるのです。同時に個人別評価も実施されるのです。この様



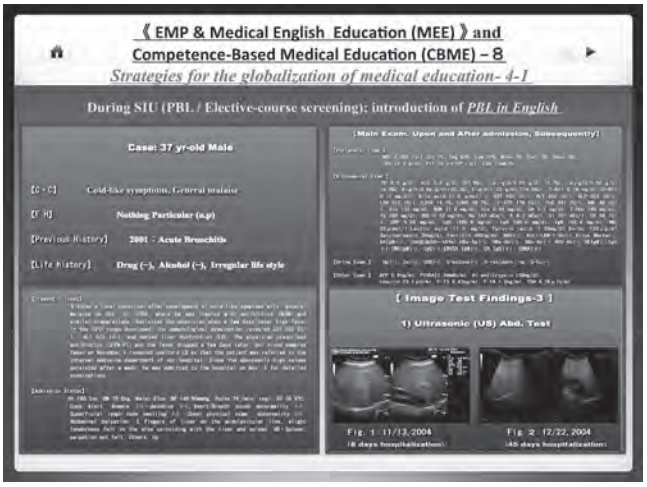
スライド3-11



スライド3-12



スライド3-13

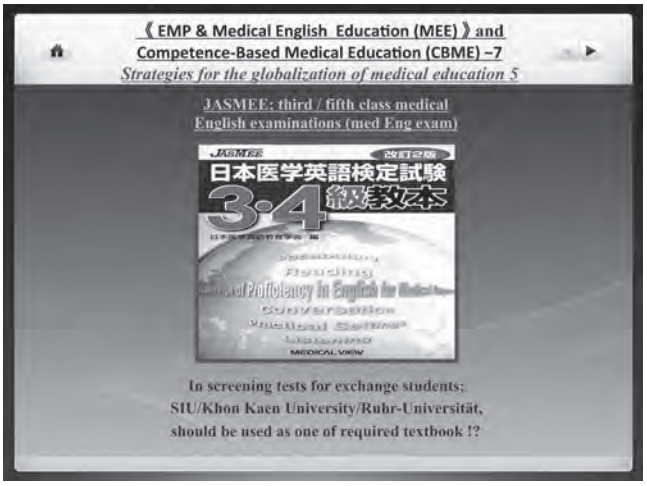


スライド3-14

なツールを積極的に活用してどんどん繰り返し学習することにより，clinical reasoningが医学英語を用いて容易にできるように工夫されています。

先ほどの伊達先生の講演にもありましたが，私も過去にどの様な問題が医学英語を活用した問題として国家試験に出題されているのかを調査しました。第103回，第105回，第106回の国家試験に出題されているものの極僅かで，2％も出ていません。このような比較的簡単な医学英語問題が国家試験には出ているのです(**スライド3-12**)。しかし，余りにも出題数が少ないのが問題点の一つでもあります。即ち，医学英語を使用した国家試験問題の出題数をもっと増やせば，医学生も興味を抱いて更に勉強するのではないかと考えています。

この**スライド3-13**は，本学の医学英語担当教官の山森先生との共同演者として第44回医学教育学会(慶應義塾大学日吉キャンパス，2012年7月28日)で報告したものです。本学は，Journal Club 1 & 2でEBM educationを数年前から実施しており，私が選定したNASH(non-alcoholic steatohepatitis, 非アルコール性脂肪性肝炎)論文を活用してそのeffectivenessを検討した結果，非常によい結果を認めてお



スライド3-15

ります。

この**スライド3-14**は私が作成したSIU派遣留学生選抜試験問題です。SIUの実習に派遣する医学生をスクリーニングする際に，試験問題を提示し，PBL形式でディスカッションをさせています。このシナリオは，実際の私のNASH患者さんの症例で，個人情報を慎重に配慮しながら作成し

ました。その最後に課題を提示し，スモールグループでディスカッションをさせ，主に知識・態度等を複数の教官で評価しています。この**スライド3-15**は，本学会で企画・作製した医英検3・4級教本の表紙写真です。特に３級教本を今後，既述の選抜者スクリーニングに是非とも活用したいと考えています。SIU以外にも本学は，コンケン大学(タイ)，ルール大学(ドイツ)とも交換留学制度を有していますが，これらの大学への派遣学生選抜時のminimum essential textbookとしての活用はどうかとも考えています。

私の講演サマリーは，下記の通りです。本学も現在，医学教育強化・推進委員会(旧，中・長期医学教育検討会議)を設置し，グローバル化のためにWFME評価基準に準拠して，医学教育の改善・改革に鋭意取り組んでいる状況ですが，医学英語教育的課題としては，1〜6年生までの全学年により実践的でグローバルな医学英語教育(含，WFME評価基準準拠)を如何にして取り入れるかが非常に重要であると考えております。

以上です。

Summary

Japanese medical education is far from meeting the world standard, a situation called “galapagosization”. Yet, after 2010 some new trends in the style of “the black ships” have emerged. Precisely this represents the so-called “2023 problem” according to which the World Federation for Medical Education (WFME) has proclaimed, through the Educational Commission for Foreign Medical Graduates (ECFMG), that it will acknowledge qualifications to take the United States Medical Licensing Examination (USMLE) only of students who underwent medical schooling at medical universities of faculties meeting the global standard evaluation criteria. Further, based on global common concepts (highly competent medical professionals who are entrusted with the lives of the patients) high and constant expectations are placed on physicians also regarding their role on a global level.

Thus, within these new currents the Japanese medical education too has to undergo globalization and its current situation must change. The contents of the WFME evaluation criteria include many items that are closely related to medical English education. The individual medical universities / faculties should urgently perform self-checks and relevant evaluations and examine whether their respective original medical English education methods meet the relevant requirements and, if necessary, must endeavor to improve the quality of the education and implement reforms.

It is considered to be of great importance to urgently present guidelines for the medical English education that meet the WFME evaluation criteria requirements by JASMEE.

【Gerling(座長)】Thank you very much. We’ll leave the questions for later, for the discussion.

4. EMP in the Undergraduate Curriculum: An English teacher’s perspective

James Hobbs（岩手医科大学）

OK, thank you very much. I’m James Hobbs from Iwate Medical University and I have no PowerPoint so please listen carefully. I hope you’ve all looked at the program and I hope you realize that although I’m the only English teacher among the speakers, I’m not speaking on behalf of all the English teachers here, I’m just giving my own opinion, but I hope that will serve as a springboard for some useful discussion.

First of all, as EMP teachers I think we’re in a very fortunate position. I think we’re very fortunate because we already know what career path our students are destined for, and we know it’s a career path in which English ability will be a very useful and a very necessary skill.

I remember when I first started teaching English in Japan, some twenty years ago, I met a lot of English teachers who complained that in this world of TOIEC, of TOEFL, what they were teaching could best be described as TENOR (T-E-N-O-R—you may not be familiar with that...): it stands for Teaching English for No Obvious Reason.

With our students, with students who want to be doctors, dentists, nurses, pharmacists, obviously that’s not the case. We know they need English. And if we want to know exactly what we should be teaching our students, it seems very sensible to start by going out and asking actual medical practitioners what they need English for and what they think we should be teaching our students.

On the other hand, I think we need to recognize that that’s only a starting point. It’s not simply a case of saying to medical professionals: “OK, so what do you think you need English for? OK, I’ll teach my students that.” Our students’ brains are not hard disks; we can’t just imprint on them knowledge as and when we choose, and expect it to stay there.

For example: What? You need to write research papers in English. OK, I’ll teach my students to write research papers

in English. It's not as simple as that for various reasons, some of which I think the other speakers have already mentioned.

First, I think we need to look at who we're teaching: are we teaching first-year students? fourth-year students? graduate students? or actual doctors?

Now, for example, I think most of us would agree that English presentation skills are very useful, very useful to medical professionals, but how we go about teaching that is going to vary depending on who we're teaching. Now I don't actually teach graduate students at the moment, but if I did, I can well imagine getting them to do actual model conference presentations to match the requirements of a particular conference. And I can imagine getting into very detailed training about specific phrases, specific rhetorical devices, effective use of PowerPoint slides, and so on.

On the other hand, what I actually do with my first-year students is I still have them give presentations, but the focus is much wider, the topics are much more general, and my main interest is in just giving them an early taste of what it feels like to stand in front of an audience and speak in English to a time limit and to drill into them that any opinions that they present have to be supported by evidence.
In first year, I think that's enough. I don't think it would be beneficial to go much further with that, much further with that with students for whom an actual conference presentation is still just a vague concept, it's still just something which may or may not happen some time in the very distant future.

Now second, we need to think about motivation. If I am working with an actual doctor who just had her English research paper rejected because of poor writing style, then I don't need to worry about her motivation for improving her writing skills, and I don't need to worry about getting her interested in my lessons. On the other hand, if I'm working with second-year undergraduates, then I do need to worry about their motivation, because for them the need for English is still a theoretical concept, it's still something that they keep hearing about but they haven't really experienced it firsthand. So with my second-year students, I'm not just going to be thinking about what their ultimate needs are, I'm also going to be thinking about how to make my lessons interesting and engaging and how to foster positive attitudes toward studying English. In my university's medical school, English classes only run until the end of the third year, and what I absolutely don't want, what I don't want is students getting to the end of their third year and saying "Phew! I'm glad that's finished! I'm really glad we don't have any more English next year." I don't want that kind of reaction.

Ideally, I want them to look back and say, "Wow! I've learned so much English in these classes, I've really improved as an English user, and I want to learn more and I can't wait for a chance to get out there and actually use what I've learned."

OK, so first, who are you teaching? What year are they in? And will they be able to build on what you've taught them? Or are they likely to just forget it all before they get a chance to actually use it?

And second, do you need to motivate your students? Or can you take motivation as a given?

Third, I think the issue of class size is important. One reason I do oral presentations in first year rather than in second or third year is because there are thirty students in a class in first year and that's the smallest class size I teach in our medical school. And with thirty students, two 90-minute sessions is enough for every student to give a four-minute presentation, in front of the whole class, and it sets up a nice situation where each time one-half of the class is giving a presentation and the other half of the class are listening and giving questions and feedback. So it's very efficient.

In second and third year, I have 60 to 65 students in a group and personally, I think that's too many to teach speaking effectively, so in those classes, I focus more on terminology, on reading, and on listening.

Fourth, it matters whether you have students at a similar English level or whether you have a wide range of abilities all thrown in together. Now I'll be talking tomorrow about a voluntary class that I teach with a colleague in which we train students to demonstrate and explain practical medical procedures—for example, measuring blood pressure—entirely in English. And the reason that class works is because it's a small group of selected students who are very confident in English.

Now, for example, I could imagine teaching those students advanced skills for dealing with questions and answers at a conference presentation. I couldn't imagine teaching that to my whole third-year class of 65 students, not only because the class is much bigger, but also because I think that would be far beyond the abilities of many of my students.

Right. And fifth and finally, I think there's the issue of the limits of the English teachers' abilities. I know when I started out there were many things I didn't teach simply because I didn't know them well enough myself. So I think in many cases it's not going to be enough to just say to the English teacher: "OK, this is what the students need. Please go and teach them this." It's going to be much, much better if you can get English teachers and medical professionals working

together—at least to make the course materials and perhaps even to do teaching together. I know from my own experience quite often we get situations where the medical English class is left entirely to a teacher who doesn't really have any specialist knowledge of medical English. Or in other cases, you get a medical specialist who happens to be a good English speaker who is suddenly forced to teach English classes even though they have no training in how to teach English. In both cases, the result is not likely to be very successful, and that's a great pity, because those same two teachers working together could probably do a wonderful job.

Right, so to summarize: the more feedback we can get from medical professionals on what English they actually need and use, the better. But the order / priority of their needs and the order / priority in the EMP curriculum are not necessarily going to be the same. (I have another twenty seconds or so...)

At the end of the day, I see English teaching as not just about satisfying needs, but about opening doors. For me, it's about making the best use of the time and resources you have available to achieve what you can, and hopefully in doing so to maximize the opportunities that will be available to your students in the future.

Thank you very much.

Summary

What do Japanese doctors need English for? Most English teachers working in medical schools identify areas such as technical vocabulary, skills for reading and writing specialistmedical texts, skills for interacting with English-speaking patients and other medical professionals, and conference presentation skills. However, each of these is a wide area that can only be explored to a limited degree at the undergraduate level. In other words, identifying doctors' English needs is just the first step: Once we go about actually creating an EMP programme, deciding specific syllabus content, and choosing or devising a context- appropriate teaching methodology, many choices must be made, and most likely many obstacles will be encountered. Space for English in the medical school curriculum is often limited, and teachers often have little or no control over class size, the range of students' English ability within a group, or the distribution of English classes across the 6-year curriculum. Factors such as these are often overlooked, but can place significant constraints on what is possible. Moreover, we may have a clear idea of what we want to teach, but find ourselves unable to teach it effectively without the direct support and involvement of medical professionals, or unable to find other like-minded and suitably-qualified language teachers to share the teaching burden. For the English teacher, then, the issue is not just what doctors need, but also what is possible: What can be taught effectively to your students, in your teaching context, considering the time and resources available, and the constraints in place?

【Gerling(座長)】Thank you very much, Mr Hobbs. Again, we'll do questions and discussion later. Before we have a short recess, I'd like to say a few words to sum up the discussion.

We learned that some places do not have any formal EMP program, and we also learned that we're still missing official guidelines.

We understand that it is crucial to consider the students' ability before we set out an EMP program. Communication between the clinicians and the EMP teachers is crucial and at the same time, as we just heard, it is cooperation between the two that's even better. So this mutual understanding—I understand your job as an English teacher, I understand your job as a clinician. I understand what you need, I understand what you can do—is very important.

We heard that the medical student is very busy, that it's very difficult to start an English EMP program, so building the useful, practical, helpful curriculum is very important.

Just putting in another lecture that has no meaning is a waste of time.

Motivation is crucial (I think it's the most difficult part) and I'd like to add another thing that I think is quite important: I think that clinicians who are interested in EMP need to know a little bit about language education and how it works, because it's very easy to say "I want the students to know this, I want the students to know that," but as James Hobbs just said, it's not as simple as all that.

We're going to have a five-minute recess and then we hope that you will mob us with questions and comments.

Thank you very much.

総合討論 Summing up

【吉岡(座長)】それでは総合討論に移りたいと思いますので，よろしくお願いいたします。

総合討論は，フロアの先生方から自由にご質問いただき，演者間，あるいは各演者にご討論いただくという形で進めたいと思います。必ずしも答えがあるものでなくても，今後の課題として残すようなものでもよろしいと思います。

初めに，本学会の名誉理事長でいらっしゃいます植村先生に口火を切っていただければと思いますので，お願いいたします。

【植村研一(名誉理事長)】今日は素晴らしいシンポジウム，どうもありがとうございます。

私がこの学会をつくったきっかけが，医学教育学会で，「日本の英語教育がどうなっているのか，特に医学部における英語はどうやって教育したらよいのか」ということが問題になって，私は全国の医学部の先生方にアンケートをとったことがあるのですが，医学部の先生方，学生，あるいは学者が国際学会でどんどん発表し，論文を出版できるように，英語を使いこなせるようになってほしいという基本があるわけです。

片方で，どうやってそれを教えるかという，そこにギャップがあったので，その専門の学会をつくるというので，この学会をつくったわけです。

今日もいろいろな議論がありましたけれども，ニーズの問題があって，どういう必要性があるか，ただ，大事なことは，中学校・高校でやってきた英語のままでは，日本人は使いこなせる英語にはならない。私は脳の研究をしていますけれども，脳の中には言語中枢があるのですが，バイリンガルとバイリンガルでない違いというのは，例えばバイリンガルの人は中枢が独立して2つあるのです。私の場合には，日本語の中枢が後ろのほうにあって，前のほうに英語の中枢があるのです。

バイリンガルでない人は，要するに中枢ができない人で，例えば何十年も文法をやって，英語を日本語に翻訳し，文法に従って作文しようと，中枢はできないのです。言語中枢の中に中枢を独立させるには，聴いて覚えるしかないのです。赤ちゃんは，言葉を聴いて中枢ができているのです。ですから，文法や翻訳をいくらやっても，何十年やっても独立した英語の中枢はできないということを，私は証明しているわけです。

ですから大事なことは，学生の素性はどうであろうと，とにかく聴かせて，わかるような訓練をまず先にやって，言語中枢を独立させればどんどん伸びていくということです。

ですから，日本のドクターは外国へ行ってなぜ通じないのか。要するに，中枢がないから聴いていてもわからないのです。それから，英語の論文を書いても日本語を翻訳しただけで，日本語と英語は言語体系が全然違うのです。直訳しても，外人には通じないのです。comfortable Englishにならない。

ですから，中学校・高校で6年間英語を勉強した人が，例えば私はこの間，某大学で授業をやったのですが，オバマ大統領の演説のnewscastをだれもわからないのです。何の話かわからない。なぜそうなっているのか。聴いていないのです。そういう人に，いくら論文を読ませてもだめなのです。

ですから，そこからスタートして，英語は聴いてわかるようになったら楽しいです。

学生にリスニングを練習させると，よくテキストを見ながら覚えてしまうのです。これはだめなのです。テキストを見るということは，逆に文字を見なくては理解できない脳をつくってしまうから，ますますできなくなります。ですから，言葉は聴いて生でわからなくてはだめだということで，徹底的に勉強の仕方を変えるのです。

そして，卒業して何十年経っても論文は読めるようになります。それから，直訳はできます。しかし，外人にはわからない論文しか書けないことになります。ですから，それは医学部4年間で勉強の仕方を徹底的に変えなかったら，私は将来も伸びないと思っています。

専門用語などは，卒業してもいくらでも伸びます。ほうっておけばよいのです。それから，英語を読む能力はほうっておけばよいのです。わかるようになります。ところが，日本語から英語にどんどん転換するには，言語が違うわけですから，そこの能力を教育していかなくてはいけないと私は思っています。

ですから，教育の方法を変えなくてはいけないと思っていますが，その辺のところのディスカッションをしていただければと思います。4年間がもったいないですから，どうやってこの間にするかということです。要するに，どうやって英語を使える人間にたたき上げていくか。そこが大事ではないかと思っています。

【吉岡(座長)】どうもありがとうございました。そういう学生たち，そういう私たちをどう教育するかということでありますが，いまの植村先生のコメントについて何か……伊達先生どうぞ。

【伊達】植村先生のおっしゃることは，全くごもっともなのですが，私はちょっと違うというか，植村先生がおっしゃるように，本当に英語が使える人たちをたくさんつくろうとすると，なかなか大変かな，というのが正直なところで，脳神経外科の教授としては，やはり日本の脳神経外科医が世界に出られる論文，学会発表ができるのが，私たちとしてはいちばん望ましい状況であって，それはしゃべるところまで完全に行けるというのはなかなか，やはり人数が限られるのではないかという気がするのです。

特に，使いこなせるレベルになれる人というのは，た

ぶん中学校・高校のレベルでかなりそういう能力がすでに発揮されている人で，そこから培うのは難しいのではないかと思います。

私がいちばん申しあげたかったのは，全体のレベルアップにつながるのはやはりterminologyをしっかりマスターして，そしてどういう論文の書き方をするかをマスターしてくれること，そのために医学部や，医学部を卒業したあとに指導できたらと思っています。

それは私の考えです。植村先生のお考えは理想だと思うし，私自身はそのようになりたいと思ってやってきたけれども，ではいまいる岡山大学医学部の学生の100人の中に，そこまで高められる人がどれぐらいいるか。でも，論文を書いたり，学会発表をしたりするレベルまで行けるのは，80人レベルで行けるのではないか。そういう感覚を持っています。

【吉岡(座長)】いまのディスカッションは，たぶん卒前教育，undergraduateのレベルで何を目指すかというところであります。では，Hobbs先生。

【Hobbs】Ah yes, on the question of getting your students to effectively process English in English without constantly translating, I completely agree with you and I think two simple points I would mention there will be, one, to make sure that English teaching is done in English. I still think a problem in Japan is that even at the university level I think there are too many English classes where teachers are teaching about English in Japanese. I think that at the university level English should be taught in English. That's one thing.

And the second point: I think to get the students engaged, interested, and wanting to listen to English is to make sure that the material that you're using in class is intrinsically interesting. I make a point in my classes of never using something just because it's in English, never using something just because it contains a particular grammar point or particular vocabulary, but I always try to find material which would be interesting even if it was in Japanese, and if it would be boring in Japanese I wouldn't teach it in English.

【吉岡(座長)】Thank you very much. Maybe I'll still ask question in Japanese.

いま，何を教えるかというところでディスカッションを進めていますが，福沢先生のほうからはいわゆるグローバルスタンダードの中で，というお話がありました。グローバルスタンダードそのものが，医学英語の教育についての直接の目標を持っているわけではありませんが，その中で先生が自己点検をしていただいた，大学の教育を考えていただいた中で，どういうことが求められるかということを先ほど少しお話しになったと思いますが，その点を少しお話しいただければと思います。

【福沢】グローバル化に即した自己点検項目として，本学会との整合性を考慮すると，①EBM教育，②ICTが挙げられます。本日午後からのテーマでもありますが，information communication technologyを自学自習のために自由自在に使いこなせる知識・態度・技能を育成することです，また，③関連分野・学科・科目(臨床医学・基礎医学・行動科学・社会科学)横断的・縦断的な統合を図ること，例えば，社会行動科学(social behavior)とも医学英語教育面でクロストークすることも重要です。④さらに，国内・国際交流，特に国外の教育機関との交流です。先程のスライドにも提示しましたが，国際交流もグローバルスタンダードのcertificationの1つになっています。

したがって，国際的な交流ができない，あるは不十分であれば，その評価は不適合(含，部分的不適合)という判断になり，quality improvementすべき(“should”)と回答されてしまいます。やはり，スライドの如く，赤線を引いたところは少なくとも医学英語的な教育をしないと，私自身はだめだと考えています。

先ほど植村先生が言ったニーズのことも勿論重要ですが，もう1つ大きな社会的な問題があると思うのです。それは，診療中のカルテ開示を日本では容易に行っていますね。最近，本学も電子カルテ診療体制を導入しておりますが，患者さんは医師の間近に座り，医師の電子カルテ入力を見守っている状況をよく目の当たりにします。ディスプレイで開示させる際には，英語・ドイツ語は患者さんにとって不要で，ほとんどが日本語記載で十分なのです。例えば，電子カルテに関わる研修医，医学生に尋ねると「電子カルテ記載で患者さんにもわかりやすい医療を追求すると逆に，どんどん医学英語表記(医学単語・医学英語的記載)を忘れてしまう」との回答も多くみられるのです。そこに大きな二律背反的な問題が潜んでいるのではないかとも思っています。電子カルテこそ，英語で記載する，むしろそれを意識付けるようにしないと，せっかく１～6年生まで，先ほどのような妥当な医学英語教育的カリキュラムを組み入れても入れても，研修医時代に忘れてしまう可能性も危惧されるのです。医学英語を使用するのはせいぜい国際学会発表のとき，医学英語論文を記載するときだけになってしまう。そうなると，グローバル化とは程遠い危険な状態にもなりかねないのです。

【吉岡(座長)】ありがとうございます。

【Gerling(座長)】I'd like to invite comments from the floor about anything that was said today.

【西澤　茂(理事長)】いくつか質問がありますし，非常に興味があるのですが，この問題は本当に医学英語教育学会の本質にかかわるシンポジウムだと思っています。

まず，伊達先生もおっしゃいましたけれども，1年生，2年生で英語のクラスがある。私たちもそうなのですが，

5年生，6年生はないですね。いかにしてmedical Englishを教えるかというときに，いちばん大事なことというかいちばんメインになるのはボキャブラリーだと思うのですね，terminology。英語を使ってディスカッションする，これが非常に重要なことになると思うのですが，それで私のストラテジーとしては，私は脳外科の卒業試験というのは全部英語で出しているのです。英語の文章は書かないで，その中に全部いろいろなボキャブラリーを入れながら，最後の答えのときに全部それを英語で書くと。そして選ばせる。そのような試験問題をつくって，もう5年ぐらいになるのです。前の大学にいたときからそれをやっていたのですが，先生としては，そういう5年生，6年生が本当にこれから卒業して使わなければいけないようなときのストラテジーというのはどのような感じでしょうか。

【伊達】いちばん手っ取り早いのは，試験問題で勉強させるというのは非常によいアイデアだと思っているのですが，国家試験がそのような方向になっていないのに，脳神経外科だけがするというのはなかなか踏み切れていなくて，西澤先生がそのようにされているのは，いま伺ってよくわかりましたが，モチベーションとしては，実際に学生が5年生，6年生で回ってきて，医師が使っているのは英語であるということは感じてくれているので，自主的に勉強させるように持っていっているのと，発表でも言いましたけれども，医英検の問題を受けるように，それを1つのモチベーションにしようと思って取り組んでいます。

ですから，試験問題というのも1つの方法だろうとは思っています。

【西澤】影山先生にお伺いしたいのですが，いわゆる私たちがやっている，医英検でつくっている3・4級試験というものをごらんになっていただいたでしょうか。

【影山】はい。

【西澤】そのときに，デンティストの先生，あるいはデンタルスクールの先生方が要求されている問題に応えているかどうかということをお伺いしたいのですが，いかがでしょうか。たぶん，terminologyやvocabularyというのは，あそこに出てくる問題はかなりデンタルスクールの先生方とは違うのではないかというのが，いま感じたことなのですが。

【影山】ご質問ありがとうございます。私はいままですべて問題は拝見させていただきました。その中で，たまにデンタルは何百問の中に入っていましたが，いわゆる歯科というのは少し特殊なtechnical termもありますので，そうすると，ではあれが全部デンティストにとって必要なことかというと，例えば先ほどのhydrocephalusなどになってくると，また完全にデンタルとは違う分野が入ってきますので，デンタルに関してはプラスアルファ，また別なことを考えていただければと思っていました。

事務局に伺うと，歯学部の学生の受けるパーセントというのはほとんどゼロに近いと。

【西澤】ええ，ですからもう少し受けていただきたいと思うのですが，実際に私たちがその要求に応えているかどうかというのは非常に不安になったところです。

【影山】“歯科狩り”をやっていただきたいと思います。

【西澤】それと，Hobbs先生にお伺いしたいのですが，日本語でお伺いしますが，やはり30人，40人という決まった人数にするには，なかなか実際問題として難しいのです。私たちがやっているのは，grand roundをやって，学生およびレジデントが終わったところで英語を交えてコミュニケーションしながらgrand roundをやるわけですけれども，それに学生を加えて，学生に問いかけて，いまやっているディスカッションは何をやっているのかわかっているのかということを問いかけて，そしてまたお互いにコミュニケーションするようにするのですが，それも1つの，いわゆるスモールクラスのティーチングスタイルかな，という感じもするのです。

そういうスモールグループのmedical English educationのクラスというわけではないのですが，それも1つの手だろうかとは，個人的には思っているのです。

【Hobbs】Yes, I mean I think especially if you want students to improve their speaking, the smaller the group, the better. If you can include an English element that's not part of an English class but is just part of their general medical education, I think that that's a wonderful thing, and I think the more of that, the better. Yet from the English teacher's perspective, large group size is a big problem. As I said, my smallest groups are groups of thirty, which is still a large class; it would be ideal to have groups of eight, nine, or ten, if you want to work on speaking. If you can't get that, you have to find ways around it. If you're an English teacher, you probably find yourself doing a lot of pair work or group work where students are speaking to each other in English all, again, in pairs or in groups.

I think what we can do in the early grades is just create a culture among the students where speaking English is something normal: it's something you do to communicate on a daily basis. It's not a special thing, it's not something to be embarrassed or worried about. So I think I can achieve some degree of success in that with students in the lower grades, and if the teachers in the later grades can pick up on that and make students actually use English during their clinical training, then it's wonderful: I think it's a great thing.

【西澤】Okay, thank you very much for your comment.

もう1つお伺いしたいのですが，すみません，私ばかり聞いて。福沢先生にもお伺いしたいのですが，電子カルテというのが本当にいま大学病院では多くて，特定機能病院には全部導入されてきています。実際に，私たち

も自分で診療しながらやると，先ほどもお話に出たのですが，それを英語に変換しながら日本語にする，英語に入れて，また日本語に移すというのは，かなり手間がかかるのです。やはり，それを全部日本語にするほうがはるかに簡単であるということが1つと，それから，カルテというのはいま，物の考え方で，やはりもともとはチャートレコードとして残しておいて，ドクターのためのものであるというような，あるいは病院のためのものであるという考え方だったのが，ペイシェントのものであるという物の考え方にいま変わりつつありますね。

特に先ほど，情報公開ということが出てきましたが，情報公開するときに，いかにそれが英語が少なくて，日本語できちんと書いてあるか，それを弁護士が読めるか，患者さんが読めるか。これが要求されているので，やはり電子カルテというのはやむを得ないことだとは思うのですが，いわゆる医学英語教育ということに関して言うならば，マイナスファクターを持っているのですが，これはなかなか難しい問題というか，国を挙げての大きな問題になってしまうのではないかという気がするのですが。

【Christopher Holmes（東京大学）】Yes, I have some comments to make about both what the panelists said and some of the questions from the audience. For example, Professor Nishizawa just talked about vocabulary, and already today several times people have talked about vocabulary as if that's one thing, but there are two categories of vocabulary: there's passive vocabulary and active vocabulary. And when you teach under normal circumstances the acquisition of all that knowledge is purely passive—unless you give students a chance to use it. So with my students (who are very good students), I put them in front of a situation from the American television show ER, for example, and they see something happening, and then I say, "OK: What did you see and hear? What did you understand? And what did you not understand? Talk about it in small groups."

(By the way, small groups is the way to handle big classrooms—so with thirty students (it can't be done very well with a hundred, but with thirty you certainly can use small groups) this is feasible; and in the small groups, the students will all talk to each other eventually, they do give each other a chance.)

But what's really remarkable is that even my students cannot express themselves. It's remarkable, but not surprising, because they have never had a chance to do this before. (And they might not even be very good at doing it in Japanese. I don't know.) But if you give them time, they all learn.

And here's another thing: if they are searching for a word which they "know" but they have never used before, it's much more difficult for them. And sometimes I'll say to them: "What are they doing in this scene?" but they totally give up. So then I say, "OK, it starts with a 'b'..." (or something like that) and I give them all kinds of hints and then they start scratching their heads and, you know, fidgeting and stuff: it's really work for the students to transform their passive vocabulary into active vocabulary. But it happens eventually.

If I give up waiting for them to come up with the word I was trying to elicit and finally tell them the word, I'll ask them: "Didn't all of you already know this word?" And they say yes. They all knew the word, but they couldn't think of it (the word was "blow up" or "explode" or something like that, a very simple word).

Well, you're going to have to do the same thing to help them with all kinds of medical terms you want them to learn, and I call this "activating their passive vocabulary". Of course, I want to teach them more passive vocabulary, words that they haven't seen or heard before, but the really important thing that you have to get them to do in the classroom (or you have to send them overseas to do) is learning how to express themselves and to react to situations in one language, not translating anything.

So that's one point, and this applies, of course, to the comment about charts. And this is also an opportunity for me to do a little bit of advertising for my talk tomorrow, but I'm going to distribute a handout (a handout or throwaway, depending on your point of view), and on one side of it is a list that I have concocted of things that medical students need to know. They need to know how to do basic things. And that list, the point of my giving them that list, is that they need to know how to do all this in English (as well as in Japanese).

If they can do it in English (I can help them to do it all in English, but not in Japanese), I assume that of course they can do it in Japanese. I don't have to teach them that, right? So they need to know how to introduce themselves and their coworkers, among other "need-to-knows". They can introduce themselves in Japanese, but they're going to do it in a different way; when you introduce yourself in English, you do it in a different way from Japanese, because there are different social expectations. Another basic thing they need to know: if you can get them to learn how to ask and respond to questions in English—not necessarily to answer the questions; that's different, right?—then of course they're going to be able to apply that in Japanese without any effort because Japanese is their native language. So something that I've

learned in another language I'll be able to do in my own. I think it goes without saying.

【吉岡(座長)】Thank you very much. Anything from the panel, re "activating"?

【Hobbs】Yes, just an extra point about passive versus active vocabulary: I think especially if you're teaching medical terminology, a very important point with that is not just to feed your students lists of words and expect them to store away hundreds and hundreds of words as distinct items, but try to develop in your students the habit of looking up words, breaking them up, and trying to extract meaning part by part. One of the words that came up during the talks today was hydrocephalus, which is not a word I have taught my students, but I think many of my students would be able to work that out, because they would remember from my classes, "Well, I've seen 'hydro' before, I know 'hydro' means water; I've seen 'cephalo' before, and I know 'cephalo' means brain." So from that, I think many of my students will be able to work out the meaning and I think it really helps if you can train your students to do that, not just look up a word and say "Do I know this word? Yes I do..." (or "No, I don't..."). But "Have I seen this word before?" "No, I haven't, but can I work out what it means?" I think perhaps less so with dental students: there tends to be—I think—a lot of terminology that doesn't relate a lot to other words in dental terminology, but in medical terminology, it's often quite simple and very possible to do that.

【吉岡(座長)】Thank you very much.

【長谷川仁志(秋田大学)】学部卒業時の教育目標設定が曖昧なため，各科教育が，ばらばらにその科の専門にやや偏って教えられているのが日本の問題と思います。すなわち学生にも研修医にも，専門教育に偏ってしまっているということです。やはり各科横断的に統合して，各科が各科の総合的な部分をもっと重視して教育することにより，医師免許を取得する医学生全員に，将来何科にすすんでも医師として当然の総合力をどの程度修得させて卒業させるか，その実践力を保証することが，いまいちばん国民が期待していることと思います。

評価についても，筆記試験も，より現場で役立つ実践的なものが必要ですし，OSCEなども含めた実践形式の評価の充実が必要です。まだ，卒業時のアドバンスOSCEも半数近くの大学で行われておりません。

医学英語教育については，モチベーションの高い一部の医学生への英語カリキュラムを充実させるのはもちろんですが，どちらかというとこの分野もそちらに偏ってしまっているのではないでしょうか。もっと，その前に，医師免許をとる医学生全員が，少なくとも英語の診療がスムーズにできるような英語総合能力のしっかりとした最低保証も必要なのではないでしょうか。英語医療面接といった必須レベルの目標の設定による英語教育の考え方も，今おかれた主要国の中で，英会話ができない国が日本のみになってしまっている状況を考えると重要と思います。秋田大では，１年生から頭痛，胸痛，腹痛などの主要徴候の鑑別診断医療面接を日本語と英語で開始しており，日本人とネーティブ英語の模擬患者さんによるOSCEを年４回行っておりますが，これはそのような思いから始めております。

それと，さきほど１年生の英語の単位が決まっている，一般教養の単位ががっちりきまっているので，調整できないというお話がありました。これは正確には間違いで，一般教養の単位は，その大学全体の各学部間のバランスの事情で決まっているだけで，一般教養の単位数や医学の教科をどれぐらいの単位が入れられるかというのは，実は各大学や各学部で自由に設定できます。その辺は，世界的にみた日本の医学科のおかれている現状を考え，是非，コーディネートしていただいてよいと思います。

【Gerling(座長)】Thank you very much. Just one second. I'm afraid our time is up. So the two gentlemen who are standing in front of the microphones will be the last to comment, I'm afraid, but please mail us your comments, because we're going to print everything that you mail to us, and I'd like the two gentlemen who are going to be talking now to be brief, please. Kalubi-sensei.

【Kalubi(徳島大学)】So, let me make my comment in Japanese.

教育の目的は，学校で学んだことはきちんと卒業してから使えるようになることですね。英語も同じです。Medical terminology，専門用語も一緒です。

その言葉の勉強の仕方というのは，私のアプローチとしては，まずは基礎。家を建てるときも基礎をしっかりしておけば，台風が来てもきちんと建っている。

だから，いま先生がおっしゃったように，僕のmedical terminology，ベーシックのときは，学生たちはディクショナリーを持ってきています。ところが，オペをするときは何もわかっていない。けれども，4クラスのあと，オペをしたら何となく，半分以上の専門用語を分析することによって意味がわかる。だから，その2回のアプローチがあって，そのあとは，勉強しているときは何を覚えたら良いか，それが大切です。

だから，5年，6年に上がっても全然苦しくない。英語で言われていることも全部わかっている。

それから，もちろん教え方はいろいろアプローチがあります。色々ありすぎて，ここの学会の役割としては，本当のガイドラインをつくりましょうと。それぞれの大学は自分でやりたいことをやってもよいけれども，ガイドラインがあれば良いと思います。

【亀岡(東北大学)】伊達先生に，2つあるのですが，時間がないので1つだけ。

先生は，まずオーラルプレゼンテーションで，ゆくゆくはライティングと。私は両方大事だと思いますけれども，1つだけであればライティングだと思います。

理由を3つ述べます。1つ目は，テクニカルライティングをきちんと身につければ，それなりのトレーニングを加えれば，オーラルプレゼンテーションはできると，私はそう思っています。

2つ目。卒業して，大学に残る人，研究を続ける人，いろいろいます。その中で，国際学会で発表する機会がない人はたくさんいます。でも，一般病院，開業医でも，珍しい症例に出会ってケースレポートを書く機会というのは，むしろ全体としては多いのではないか，従って，将来的なことを考えると，ライティングはプライオリティが高いと思います。

3つ目，これがいちばん大事なのですが，ライティングというのはきちんとした型が確立しています。パラグラフ・ライティングとか，トピック・センテンスとか。オーラルプレゼンテーションは，名人芸を含むアートです。今後，大学教育で日本を背負っていく人材を育てていく上で，「ロジックとレトリック」という重要な要素，これは医学英語や医学に限るものではありませんが，それを伝えるという意味で，型がしっかり確立しているライティングが，私は最良の教育だと思っています。

【Gerling(座長)】ありがとうございます。すみません，伊達先生の返事というか説明というのは，誌上でお答えください。*1　今日はありがとうございました。

【吉岡(座長)】では，これで終わりにさせていただきます。少し十分ディスカッションできない部分もあったかと思いますが，最初に申しあげたように，これをきっかけにジャーナルを含めて英語の教育というものをまた考えていきたいと思います。

どうもありがとうございました。

(2013年7月20日，東京ベイ舞浜ホテルクラブリゾートにて収録。English transcription by Christopher Holmes)

＊1【追記(亀岡氏の質問に対する伊達氏の回答)】

亀岡先生の最後のコメントにお答えします。

亀岡先生のご意見は，プレゼンテーションとライティングを比べると，よりライティングの方が大切である，ということに要約されるかとおもいます。

わたしの発表では，まずは国際学会などでプレゼンテーションをして，それを論文にする流れが大切，だからプレゼンテーションの技術などを医学英語でおしえていただくことが，大切，と申しました。しかし実際はゴールはライティングにあるのは申し上げるまでもありません。その前段階としての英語プレゼンテーションは，ライティングよりも取っつきやすい面も多々あるので，そちらも強調した次第です。

結局，亀岡先生のお考えも，私の考えもゴールとしてのライティングの重要性を強調している点は，同じ，と思っています。

Series editor:
Takayuki Oshimi

Tokyo Women's Medical University School of Medicine: English Education

東京女子医科大学は医学部と看護学部および大学院からなるが，医学部の英語教育は2011年度より，「国際コミュニケーション」という名称で，英語によるコミュニケーションに必要な，読む力・書く力を併せ持ち，国際的に全人的医療を行える人材を育成することを目標にした学年縦断カリキュラムを行っている。具体的には，１年次において英語の４技能の徹底定着をはかり，２年次から６年次までは医学英語を語彙学習から，症例報告，論文講読，論文の書き方，医療面接など幅広い分野で段階的に教育を行っている。また，５年生末にクリニカルクラークシップ医療研修を海外で行う交換留学生プログラムで約四分の一の学生が国外で研修しており，今後一層英語教員と医学専門教員との協働教育の発展が望まれる。

1. Introduction

Before the 2011 academic year, Tokyo Women's Medical University, School of Medicine offered a few medical English lessons for 2nd , 3rd and 4th year students, though 1st year students had 2 two general English lessons per week throughout the year. A new curriculum with the name of "International Communication" went into effect for the 2011 academic year under which English for Medical Purposes has been emphasized and Clinical Medicine English has also been incorporated into the new ongoing programs. Besides these compulsory courses for EMP, elective classes have been offered under the names of Medical English and Medical Discussion so that those who are planning to go abroad for clinical clerkship in 5th year or any time in the future can have opportunities to study more advanced English for Medical Purposes.

2. Department of English Language Faculty (as of September 2013)

2 Full-time instructors

・Mitsuyo Suzuki（Associate Professor）

・Mika Endo（Assistant Professor）

14 Part-time English instructors

・10 Lecturers: English for General Purposes（7 native speakers of English and 3 Japanese）

・4 Lecturers: English for Medical Purposes Alan Lefor（Doctor）/ Todd Stoudt（Lecturer）/ Oshimi Takayuki（Doctor）/ Daniel Salcedo（Doctor）

3. English Program

3.1. Program Objectives

In the framework of the new curriculum, English education is carried out for six years successively, starting with English for General Purposes（EGP）in the 1st year when students are supposed not only to improve their English reading, listening, speaking and writing abilities but also to get used to critical thinking and gain global perspective. Based on those acquired English communicative skills, students are expected to study English for Medical Purposes for the next 5 years. The ultimate goal of our English Education for the six years is to graduate students as those who are prepared to work in medical fields worldwide, with sophisticated overall English skills and a global perspective.

3.2. Program Structure and Contents

・3.2.1. Program Structure

<International Communication>

<table>
<tr><th></th><th>Compulsory</th><th>Elective</th><th>Extra-curricular</th></tr>
<tr><td>1st year</td><td>General English
Wednesday 1st & 2nd periods
12 classes divided by TOEIC
score. 8 to 10 students/class.
70min. × 60 sessions/year.
E-learning for self-study</td><td rowspan="5">Basic Listening
English
Literature

Medical
English
Medical
Discussion

These elective classes are 70min. × 30 sessions/year.

The number of the enrolled students vary from year to year (around 20/class)
Clinical Clerkship- abroad Program</td><td></td></tr>
<tr><td>2nd year</td><td>Medical English I
70min. × 9 sessions/year
E-learning for self-study
(Medical Vocabulary)
with vocabulary tests.</td><td>Private
Lessons
↓</td></tr>
<tr><td>3rd year</td><td>Medical English II
70min. × 6 sessions/year.
E-learning for self-study
(Medical Vocabulary)
with vocabulary tests.</td><td>Study-abroad
Programs</td></tr>
<tr><td>4th year</td><td>Medical English III
70min. × 8 sessions/year.
E-learning for self-study
(Medical Vocabulary)
with vocabulary tests.
Sessions for Medical
Interview (in preparation).</td><td></td></tr>
<tr><td>5th year</td><td>(in preparation)</td><td></td></tr>
<tr><td>6th year</td><td>(in preparation)</td><td></td></tr>
</table>

・3.2.2. Program Contents

In the 1st year general English program, students are trained to improve their overall English skills such as reading, listening, writing, speaking and at the end of the course each of them is required to make 3 minutes English presentation in front of all the 1st year students as well as English teachers and also some other teachers concerned with 1st year education. Together with those regular sessions, the students are expected to continue self-study of English through e-learning.

Under the new curriculum, Medical English education start for the 2nd year students and continues until their graduation. For the 2nd year classes, basic Medical English is taught step by step, from the word formations of the medical terminology to reading of short articles related to medicine such as those from *News in Health*. The students are also required to take English lectures covering some of the same medical topics they have learned in Japanese. Furthermore, the self-study program, e-learning for English medical vocabulary, is utilized effectively with occasional monitoring and achievement testing.

The 3rd year and 4th year programs offer the students more opportunities to use Medical English by themselves. For the 3rd year students, case study and case presentation is incorporated into the programs, and the 4th year students are expected to carry out Medical Interviews individually (4th year program is now being made for the 2014 academic year). In addition to these clinical medicine English programs, lectures and reading and writing research papers are also incorporated into the new curriculum. In the meantime, e-learning is continuously going on, and the students are expected to acquire about 3,000 English medical terms by the end of their 4th year.

Besides these compulsory courses, elective

courses for EMP are being offered. In Medical Discussion sessions, students join a native English teacher in discussions after reading articles related to various medical and public health topics. In Medical English, sessions were renewed under the new curriculum and focus on Clinical Medicine English such as history taking and physical examination. For those involved in the international exchange program, more practical Clinical Medicine English is taught as an elective.

As extracurricular programs, the English Department offers private lessons such as research paper reading with 2 or 3 students and encourages the students to participate in study-abroad programs (especially Stanford Medical Programs).

3.3. Evaluation

In the 1st year, students are evaluated by class grades (including their performance in class activities) and end-of-semester written exams as well as speech presentation. From the 2nd and 3rd year, students are graded based on their positive participation in each class and their worksheets, together with the results of vocabulary tests. 4th year students, in the 2013 school year (still under the old curriculum), are graded by their positive participation in each class and the end-of-semester written exam, but from the 2014 academic year, the new curriculum will incorporate new evaluation guidelines which will be more student performance based.

4. The Future

Since the new curriculum was implemented in 2011, ESP is drawing more attentions from doctors in various departments at Tokyo Women's Medical University. The Department of English, therefore, is now planning to work in collaboration with those doctors. In fact, in January 2012, two successive English sessions were held in cooperation with the teachers of medical fields. After the sessions, feedback from students for this trial was positive and they seemed to be very encouraged and motivated to study Medical English even harder. In medical schools, generally there are fewer English classes for 3rd year and 4th year students. If ESP is carried out in collaboration with teachers in the classes of medicine, the students will get both medical knowledge and English language competence at the same time, which will be beneficial for both teachers and students.

Finally, the ESP programs for 4th, 5th and 6th years are now still in preparation and so we would like to plan more collaborative sessions like those mentioned above and make systematic arrangements of the programs.

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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*) in the March of last year. Alistair gave us permission to publish all 9 articles, for which we thank him and the editors decided to do this in two installments. In this edition our readers will find three articles following the first four ones in our February issue.

Myths about English (2)

Alistair Reeves

5 [Reprinted with permission from *The Write Stuff*, Vol. 16, No. 3 (2007) pp. 118–120.]

Another 10 myths about English to follow Myths 1–20 in previous issues [1–4]. Apart from some that are new to me, some old chestnuts have been thrown at me over the past 6 months at training events (see Myths 26–30), which, although fallacies, are claimed by participants be 'rules', usually backed up by an elusive 'native speaker' somewhere in my questioner's immediate vicinity or past. These old chestnuts enjoy astonishing robustness—but then old chestnuts wouldn't be old if they didn't, would they?

Myth 21 : You have to say 'those patients' in the following situations

You have a sample of patients who have undergone hysterectomy. The aim was to perform laparoscopic hysterectomy, but some patients had complications and were converted to laparotomy. Your author writes: *223 patients were enrolled. 201 underwent laparoscopic hysterectomy and 22 had to be converted to laparotomy. In* ***those*** *patients who had to be converted to laparotomy, the duration of surgery....* OR You have 24/194 patients with grade 3 or 4 leukopenia under chemotherapy for cancer. 22 had grade 3 leukopenia and 2 grade 4 leukopenia. Your author writes: *In* ***those*** *patients with grade 4 leukopenia ....* OR Your author writes: *Major deviations are defined as* ***those*** *deviations which lead to the exclusion of the subject from the PP set.*

I was recently told that a 'native speaker' had said you had to use *those* 'because you are talking about specific groups'. Unfortunately I had to take all the vicarious 'native-speaker' wind out of this participant's sails. How on earth can you make a rule out of this, and why do you need the demonstrative pronoun (those) and not just 'the', no article, or no subsequent noun? I am increasingly seeing this, but I cannot understand why authors think it is better. Can anyone tell me? This is certainly not a rule.

In all above instances, you can delete the noun after *those* (e.g. *In those who had to be converted to laparotomy*) and this sounds much more sensible. In the third instance, you can substitute simple *are* for *defined* as, and you can actually get rid of *of the subject* too, take out a superfluous the, and 'hey presto', you have a much better and simpler sentence: *Major deviations are those which lead to exclusion from the PP set,* even though I would probably never write this, depending on the context.

Myth 22 : 'Irregardless' is US English

Another claim by an elusive 'native speaker'. There certainly will be people in the USA and UK, and indeed elsewhere, who would have no objection to *irregardless* in the following sentence: *Irregardless of the diameter of the erythematous lesion, 0.5 cm ointment was applied.* I hope they are in a minority in both countries! Always read *regardless* for *irregardless*, and give *despite* and *regardless* preference over *irrespective. Irregardless* does not exist, and *irrespective* very quickly leads to multiple-negative problems: *Irrespective of the absence of X, we did not...* looks very innocent, but I bet most readers backtrack to make sure that they have understood this correctly. You are pretty much lost here as soon as you read *we did not.*

Myth 23 : 'Whilst' and 'amongst' are pompous

Neither is pompous. British English still uses *whilst* and *while,* and *amongst* and *among* interchangeably. US English prefers *while* and *among,* and US readers will assume that *whilst* and *amongst* are evidence that an author is more familiar with British English. The Oxford English Reference Dictionary confirms this for *whilst* but not *amongst* [5].

Some like to differentiate between the meaning of *whilst* and *while,* preferring *while* as an indicator of time, and

whilst to mean although: *While the patients are receiving the infusion, vital signs must be monitored every 10 minutes; Whilst the first potential investigator objected to the inclusion of subjects with perennial allergic rhinitis, subsequent investigators did not.* In our context, *although* is always better if you mean *although,* but the latter example is a perfectly legitimate use of *whilst,* as is: *Whilst the chest X-ray is being taken, please try not to breathe.*

Myth 24 : 'Administrate' has now come into common usage

'A native speaker told me this is now in common usage': the words of another participant. I suspect this is a lost cause, but even if *administrate* has come into common usage (whatever that means), I am still quite happy to take a stance against it and quote the EnglishPlus website [6]: "*Administer* is the verb form for *administration* or *administrator.* The word administrate is an incorrect form of the verb created by some who drop the *-ion* suffix of administration. Be careful when forming verbs from nouns that end in *-ation,* as the correct verb form may not end in *–ate*". Hence—incorrect: *400 mg/m² were administrated by infusion pump.* Correct: *400 mg/m² were administered by infusion pump.*

Myth 25 : Don't you have to say and write 'an unique' or 'an hotel'?

(Almost) perfectly answered by AskOxford [7]: "The form *an* for the indefinite article is used before a spoken vowel sound, regardless of how the written word is spelt. If you say *an otel* when speaking (which is now often regarded as distinctly old-fashioned [in my mind, completely so, or affected—AR]), then it may be appropriate for you to write *an hotel*; but most people say *hotel* with a sounded h, and should [therefore] write *a hotel*". The fact that some don't, and still say and write *an hotel* is evidence of linguistic insecurity: *an hotel* is supposed to sound educated. It doesn't. It is also not necessary to say *an historic occasion...* (although I have seen a 'rule' in a USA grammar book that you say *an historic occasion* because the stress is on the second syllable in the word historic, whereas you say *a history book* because the stress is on the first syllable in the word history—bit too complicated for me!). AskOxford again: "By contrast, words such as '*honour*', '*heir*' or '*hour*' in which the '*h*' sound is dropped are written with '*an*'. Because 'European' is said with an initial 'y' sound, which counts as a consonantal sound in English speech, it is said (and written) with 'a' not 'an'". This therefore also applies to 'unique' because it sounds as of it starts with a 'y', so it is 'a unique' and not 'an unique'.

The experts on this website also cover a further question I am frequently asked: "An abbreviation such as MP (Member of Parliament), which is pronounced *em pea,* begins with a spoken vowel, and so it is '*an MP*.' Translated into our context, this means that you say ***and write*** '***a*** follicle-stimulating hormone level of XX', but '***an*** FSH level of XX', and this applies to any abbreviation that sounds if it starts with a vowel—and there are plenty.

Myth 26 : There is a rule that says you cannot start a sentence with 'However'

There are a lot of old chestnuts around, and this one looks as though it will never crumble. I wish someone could hit this one with a great big 'conker'[1] and blast it out of existence. There is no rule. However, if you do start a sentence with 'however', and it does not mean 'by what method', it should be followed by a comma.

Myth 27 : There is a rule that says you cannot end a sentence with 'however'

Another very old chestnut, and again: no rule. If you do, it should be preceded by a comma. Ending sentences with 'however' is more of a spoken device; it is a perfectly legitimate written device, however.

Myth 28 : And while we are dealing with old chestnuts: Isn't there a rule that says you cannot start a sentence with 'because'?

The same participant as in Myth 21 hurled this old chestnut at me with a triumphant glance, and again I had to apologise for taking the wind out of his sails, because the answer is: yes, you can. Because respectable writers have been

[1] Conker is British English slang for horse chestnut. I don't know if it still happens, but when I was at grammar school in England, you eagerly awaited the ripening of the horse chestnut, gathered as many as you could, decided which might be particularly resistant, threaded some string through one of these conkers and tried to break another person's conker on a string by hitting it hard. For some strange reason, only boys played 'conkers'—but this was more than 40 years ago. There were all sorts of recipes for creating the 'superconker'—various combinations of baking, boiling and soaking them in vinegar. They were named incrementally after the number of conkers they had conquered plus the number the last conker conquered had conquered plus 1 (note the crazy difference in English spelling here), i.e. if your conker had smashed 22 conkers, it was a 'twenty-twoer'; then it smashed another that had smashed 25 and it suddenly became a 'forty-eighter' (22 + 25 + 1). Not a conker was to be seen lying on the streets in Northern England, and I remember being amazed during my first visit to Germany in 1961 that the streets were strewn with conkers, nobody picked them up, and all the cars and buses were actually driving over them with no regard whatsoever!

doing it for many years, even if they were taught not to at school. It would be unusual to do this in the results section of a study report (but what's wrong with doing something unusual now and again?). It is probably more suited to your introduction or methods sections, or discussion. For example, if you had intended to determine a particular variable in a study, but decided post hoc not to because there were too many major protocol deviations or too many missing samples, why shouldn't you say *Because too many samples were missing, the analysis of … was abandoned?* I appreciate you could say *The analysis of … was abandoned because too many samples were missing,* but this may not be what you want to say and you may ***want*** to stress that it was 'because' there were too many samples. One thing to bear in mind, however, is that when starting sentences with 'because' in English you are deviating from expected word order (subject, verb, object, interspersed with adverbials, usually after the verb). This device should therefore be used infrequently when writing, usually when you want to create emphasis.

Myth 29 : And here's another … Splitting the infinitive is bad style and a sign of ignorance

This time it was a quiet participant at the back who put up her hand and said 'My boss says that splitting infinitives is bad style and a sign of ignorance. What's your opinion?' My opinion is that this boss has no idea what he or she is talking about. And that's what I actually said to this lady. Ignorance of what? If splitting the infinitive shows ignorance, then I and many others who seem to have been doing a pretty good job for quite a few years have obviously been ignorant for most of our lives. Try to avoid using the split infinitives 'to more than double' or 'to almost halve' without making it obvious to your reader that you have tried to avoid them—it's just not worth the effort. Despite my saying this, AskOxford [7] says: "It is probably good practice to avoid split infinitives in formal writing". I'd like to ask them to define what they mean by 'probably' here and why they say this, because they add the following cautionary note: "Clumsy attempts to avoid them simply by shuffling adverbs about can create far worse sentences", and in my experience they usually do.

Myth 30 : Isn't there a rule that says that 'e.g.' and 'i.e.' must be italicised?

No. But it appears that this (spurious) convention is again being propagated as a rule by those illustrious 'native speakers' because I have been asked this recently at several training events, and it has also reached old chestnut status. It may, of course, be house style or journal style—then you obviously follow it. This is linked to Myth 10 [2], where I dealt with the supposed rule that in vivo and in vitro must be italicised. If you want to italicise Latin terms, noone can stop you. But you must remain consistent to be kind to your reader, and it is easier to remain consistent if you don't do it. But the best reason is that it is not necessary.

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.
3. Reeves A. 2006. More Myths about English (3). *TWS* **15** (4): 139-40.
4. Reeves A. 2007. 5 More Myths about English (4). *TWS* **16** (2): 85-86.
5. *Oxford English Reference Dictionary.* OUP. 1996
6. http://englishplus.com/grammar/00000172.htm (accessed 10 August 2007)
7. http://www.askoxford.com/asktheexperts/faq/aboutgrammar/hotel?view=uk (accessed 10 August 2007)

6 [Reprinted with permission from *The Write Stuff*, Vol. 16, No. 4 (2007) pp. 168–169.]

Myths about correct English abound. Myths 31 and 32 here were completely new to me—I checked them out with a few other colleagues, and they were also new to them. So, just in case you hear these too, you now know that they are not rules, like all the other myths I have looked at so far! [1–5] Again, for your enlightenment, I have collected a few more claims made by people who attend my training events on writing medical English or for whom I correct and rewrite texts. There are always a few surprises.

Myth 31 : You cannot use a colon after a verb when introducing a running or bulleted list

This one is so complex that I can hardly imagine anyone going to the trouble to invent it, but there we are—it is being propagated by a 'native speaker' somewhere in Germany. Specifically, you cannot write: (as I have just done, by the way, and it looks OK, doesn't it?)

The most frequent symptoms of acute pyelonephritis

were:

- Fever.
- Rigors.
- Nausea.
- Vomiting.
- Diarrhoea.

The 'offence' here is the use of a colon immediately after a verb (I can hear you saying: 'What!?'). The apparent rule is that 'you have to write the *following* between were and the colon'.

This is rubbish. 'Our QA department always corrects this in reports, and two of them are native speakers', added the participant. Oh dear—those native speakers again! Native speakers or not, if this is all the company's QA department has to correct in reports, the company is either producing flawless reports, the QA department is trying to justify its existence, or they have no idea what they are talking about.

You might prefer to write the above as a running list without a colon: *The most frequent symptoms of acute pyelonephritis were fever, rigors, nausea, vomiting, and diarrhoea* [1]. I prefer this for a list with short elements, but for long elements, I prefer a bulleted list, and would definitely have no qualms about putting a colon immediately after the verb in the 'platform sentence' (the sentence that introduces the bulleted list).

Myth 32 : Hyphenation of a prefix depends on whether the addition of the prefix changes the pronunciation of the subsequent word

I cannot think of an example for a *prefix* where this might be the case, whether you hyphenate or not, and the person who told me that she learned this from an English colleague could not remember one either. Maybe I have just not thought hard enough. There are words where the pronunciation of the prefix itself varies, such as the 're' in *recreation*. The 're' rhymes with 'wreck' when it means leisure, and 'pea' when it means to create again (some might prefer to write *re-creation* for the latter, but this does not change the pronunciation of 'creation'). But this is also a special case because, in the sense of leisure, the *re* has been absorbed so far into the word that it is no longer evidently a prefix (as with *recollect, record* and many other words). *Prejudicial* and *prejudge* are other examples where the pronunciation of a prefix with the same original meaning changes.

As you will have noticed during your work, the hyphenation of prefixes in English is a completely unregulated 'rule-free' zone (and not the only one, as we know). You have choices: it is up to you whether you run prefixes and words together, and this is not governed by rules of pronunciation (if it were, the whole question might be easier). The only area where there is a widely observed convention is to use a hyphen between two vowels together (as in reinvent, but *antiarrhythmics, intraarterial* and others are rapidly gaining ground). As usual, be consistent in one text, and don't bother to argue for or against a hyphen.

There are some instances with *suffixes* where a hyphen is expedient, such as *tunnel-like,* where the presence of the hyphen stops you reading *tunNELlike,* so stops you feeling as if you ought to stress the second syllable because of the doubling of the of letter 'L', but I don't think there are many instances like this. Hyphens used in such situations will probably never disappear. But in my experience, prefixes and words generally slide together (less so suffixes) at some time without this changing the pronunciation of the root word. If you can think of any examples, please let me know.

Myth 33 : Efficacious and effective mean different things

I am going to zoom out onto the thinnest part of the linguistic ice and say that *effective* and *efficacious* mean exactly the same for our purposes, at least when we are talking about the success of a treatment against an illness in a single subject or group of subjects. And guess which one I prefer in this context: yes, you got it—*effective. Efficacious* is used because people still think a longer word sounds more impressive, but I think readers these days are starting to ask the question: why didn't this author just say *effective*? The same goes for *efficacy* and *efficacity* and *efficaciousness.* Take the shortest option, *efficacy,* and ditch the other two. Some people come with arguments that should make me crash through that ice and die a very rapid, cold, wet death, but I seem to have remained above water with *effective* and *efficacy* so far. *Effectivity* does not exist; *effectiveness* does; but why bother with *effectiveness* when *efficacy* is just as good?[1]

Myth 34 : You are not allowed to use abbreviations in the plural

Yes, you are. So do it! Observe a couple of things, though:

- The plurals of *TIA* (transient ischaemic attack) and *pat.*

[1] I am aware that health economists and virologists distinguish between the meaning of *efficacy* and *effectiveness*—or is it *efficacity*?—but when talking outside these special areas about whether a drug works, to try to differentiate between the three is only for those who like to split very thin hairs indeed.

(patient) are *TIAs* (**not** TIA's) and *pats* (**not** pat's.). Follow this pattern for all capital-letter abbreviations and full-stop-at-the-end abbreviations.

- If you define an abbreviation at first mention in the plural, you do not need to redefine it if it occurs in the same text later in the singular.
- SI units are never used in the plural (maybe this is where this myth came from).

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.
3. Reeves A. 2006. More myths about English (3). *TWS* **15** (4): 139-40.
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5. Reeves A. 2007. Still more myths about English (5). *TWS* **16** (3): 118-120.

7 [Reprinted with permission from *The Write Stuff*, Vol. 17, No. 1 (2008) pp. 33–36.]

Again, I present my personal view on some of the purported 'rules' in English I am told by writer colleagues and others who attend my training events. Myths 1–34 appeared in previous issues [1–6]. These are my last 5 myths—for the time being at least! I have a feeling that I will be back with more, as I am about to start some training events in countries I haven't trained in before. Thanks to all those who have written to me over the past 2 years with questions, encouragement and criticism. I am sure there are many more myths out there gnawing at the conscience of concerned—if not sometimes perplexed—writers, so if you come across any, please do let me know.

Myth 35 : You must never use inverted commas in a title or heading

I prefer not to use inverted commas in a title or heading in a study-report-type document or a formal journal article reporting on a clinical study, but it is sometimes unavoidable. Regular readers will note that I have often used inverted commas to highlight words in the titles of these myths, but this is a journal, and the type of document makes a difference. There is no 'must' about this. Inverted commas are often used indiscriminately in general. I used them around the 'must' in the sentence before last to achieve two things: (i) to highlight the word, which is further underlined by the word no before it; (ii) because using the word this way is often a spoken device, and I chose here to use it in writing, which is a little unusual, so I am calling its use in this way into question.

You usually use inverted commas when you wish to:

- Quote something.
- Stress or highlight something.
- Call something into question.
- Indicate that you are doing something unusual, such as creating a nonce word or term.
- Use something figuratively.

They are also used for newly coined terms that have not yet established themselves (but are more established than nonce terms), or terms that are regarded as casualisms (this is usually context-dependent).

You should always ask yourself why you feel you need to put inverted commas around a term, especially in a heading or title, unless you are quoting direct speech, and whether it might not be better to stress it or call it into question in a different way. This device should therefore generally be reserved for journals, marketing documents, or less formal documents, and is generally not such stuff as headings in study protocols or your Common Technical Document are made of.

The last few editions of the *BMJ* included the following titles with inverted commas:

- *Doctor takes "march of shame" to atone for drug company payments.* (*figurative use*)
- *Charity highlights "forgotten crises".* (*highlighting: not really forgotten, or deliberately forgotten*)
- *Diabetes expert accuses drug company of "intimidation".* (*quoting, calling into question*)
- *Scientists "reprogramme" skin cells to create embryonic stem cells.* (*unusual, new use*)
- *FDA may allow drug and device companies to promote "off-label" uses.* (*casualism*)

The nature of these headings shows that they were used for more news-type articles and not in titles for standard journal articles formally reporting on the results of investigations, where the use of inverted commas is much rarer. The last one surprises me: I would have thought that in our context, 'off-label' was well established enough to dispense with inverted commas, but the *BMJ* obviously still regards it

as too casual. They also obviously prefer double inverted commas. It doesn't matter which ones you choose— same as ever: be consistent. Most people go for double inverted commas when quoting what someone actually said and use single in other cases. There is no rule.

You might feel the use of inverted commas in a heading in a study protocol, report or summary document is appropriate if you have groups that require fairly complex explanation, such as 'Treated stroke-belt childhood residers', 'Treated stroke-belt non-childhood residers', 'Untreated stroke-belt childhood residers', and 'Untreated stroke-belt non-childhood residers', which I recently came across in a report I edited. This resulted in headings such as *Efficacy in 'treated stroke-belt childhood residers'.* I understood why the author had used the inverted commas: *stroke belt* needs explanation anyway, non-childhood is an unusual term and needed definition, and *resider* is a nonce word for 'person living in ...'. The groups were all defined well in the text, and I would definitely have resorted to simpler terminology in the headings (also defined in the text, of course) such as *Efficacy in Group A.*

By the way: it is not necessary to use inverted commas around terms preceded by *so-called* in English. Careful use should be made of *so-called* in English anyway, because it is often used negatively and emphatically calls into question whatever you are calling *so-called.* Because inverted commas themselves are used to reflect the idea of *so-called,* adding them afterwards makes the element of doubt even stronger.

Myth 36 : It is bad style to use 'we' when reporting on and discussing results

Not usually seen in study reports or summary documentation, this is perfectly legitimate in journal articles, and nothing can be said against it, except that it should not be done to excess—but that applies to almost everything. The use of the first person plural makes it very much easier to fulfil a requirement that you find in many styles guides, namely to write as much as possible in the active voice (this should also not be overdone either, by the way). Such widespread use of the first person plural is made in this way that I am surprised 'rules' are still circulating that this should not be done, but this has been mentioned twice to me in the past two months. You can also quite happily talk about 'our results', 'our approach', or 'our patients'. The first person singular can also, of course be used—but you should first think very carefully about whether you—and only you—really did all the planning, all the research, all the evaluation, and, of course, all the writing.

Another 'by-the-way': if you belong to a language group that traditionally forbids the use of 'I' or 'We' as the first word in a letter after the initial greeting, you can forget this in English. It is quite normal to start with either, and is not impolite or bad style. In letters and emails written by those with English as a second language, you can often see how the author has wrangled with a sentence just to avoid starting with 'I' or 'We'. Starting with yourself as the subject is expedient in English, because it enables you to stick to expected word order, and doesn't sound strange to the recipient. Don't start every sentence in the letter with 'We' or 'I', though!

Myth 37 : Clauses that begin with which are preceded by a comma

This is indeed what it says in black and white in the American Medical Association Manual of Style [7], and was no doubt the reason why, some years ago, a French colleague emphatically put commas before every 'which' in a report I had written (this was the only change he made!), which unfortunately wreaked havoc with the meaning of most of the text, and had to be reversed.

I should actually have entitled this myth *Clauses which begin with which are preceded by a comma* (note the absence of the comma before which). This is because, like many speakers and writers of British English, I often do not observe the distinction *between non-restrictive* and *restrictive* clauses by using *which* preceded by a comma for the former and *that* not preceded by a comma for the latter; instead, I often use which *without* a comma for the latter. My empirical observation is that this is increasing, that we do this more when we write than when we speak, and that it is becoming so widespread, even in good writing, that it is now unstoppable. The distinction achieved by *which* preceded by a comma and *that* not preceded by a comma seems to have retained a firmer place in US English amongst writers, at least, but there are signs that it is crumbling [8]. Preserving the distinction avoids ambiguity, but does the absence of a comma before *which* always lead to ambiguity? Here is an example of where it does:

A. The human antichimeric antibody levels, which were determined 6 weeks after the end-of-study visit, will be reported on separately.

No ambiguity: the levels were determined only after 6 weeks and will be reported on separately, i.e. all levels determined will be reported on.

B. The human antichimeric antibody levels which were determined 6 weeks after the end-of-study visit will be reported on separately.

Ambiguous: it means either same as sentence A, or that levels were determined more than once, but that only those determined after 6 weeks will be reported on separately.

If I alter the wording in the title of this myth, you see that the absence of a comma does not always lead to ambiguity:

Clauses which begin with because are only rarely preceded by a comma.

Nobody would understand from this claim that ***all*** clauses begin with *because,* even though *which begin with because* here is a restrictive clause, and according to the 'rule', should actually begin with *that.* If the meaning is clear, I no longer rigorously correct *which* to *that* for restrictive clauses.

This is also illustrated by the following example:

These small particles target the blood vessels which supply the tumour with nutrients and enable it to grow.

Again, nobody would understand from this that ***all*** blood vessels supply the tumour with nutrients, only those which actually lead into the tumour. According to the 'rule', *that* should again have been used here, but the meaning is clear, and the restrictive nature of the *which* is heralded by the use of the word *target,* which tells the reader that only selected blood vessels are involved, and not all.

So, the essence of this myth is that you will often come across (and probably write yourself) clauses that begin with *which* that are restrictive and where *that* 'should have been used', but where the meaning from the context is unambiguous. The message is that this is changing and that you have to pay attention to this when writing and editing: if there is any suspicion that the clause with *which* and no comma might lead to ambiguity, change it; if not, you can leave it, but expect to be 'corrected' by some!

Valerie Elliston explains restrictive (also called defining) and non-restrictive (also called non-defining) clauses in *TWS,* Volume 15, No. 1 [9]; commas with *which* are also discussed in *TWS,* Volume 16, No. 2 [10, 11].

Myth 38 : 'Due to' should only be used when 'due' is an adjective that modifies a previous noun

A resolute participant faced me with this. She remained immovable, and indeed her opinion does have its basis in style guides and grammar books. Let's see what you think.

This is complex because the 'due' in the following (acceptable) sentence is actually an adjective forming part of an adverbial phrase, but most people will not recognise it as such:

The failure of the assay was due to inadequate saponification of the samples (*I appreciate that The assay failed because the samples were not adequately saponified* is better [see below]).

Why is 'due' an adjective here? Because it follows the verb 'to be' as the predicate and modifies the compound term 'failure of the assay' which is the subject of the verb. Like most people—including me now—you are probably all thinking that this is getting a bit too complicated.

An easier lexical approach is to apply the 'acid test' to show whether you may use 'due to', which is: can 'due to' be sensibly replaced by 'caused by'? This shows that 'due to' is acceptable in the above sentence: *The failure of the assay was caused by inadequate saponification of the samples.* This means that *The assay failed due to inadequate saponification of the samples* would not be acceptable, because you cannot say *The assay failed caused by inadequate saponification of the samples,* but you could say *The failure of the assay was caused by inadequate saponification of the samples.*

A further complication is the existence of *owing to.* If you can say *caused by,* you can say *owing to.* This means that you could say *The assay failed owing to inadequate saponification of the samples* but not *The assay failed due to inadequate saponification of the samples.* Isn't this just splitting hairs? Is anyone going to misunderstand this sentence because you used *due to* and not *owing to* or *caused by*?

All this, of course, means that you are not supposed to start a sentence with 'due to' either because you would never start a sentence with 'caused by', but I find I cannot object to *Due to unforeseen problems, the assay was abandoned after the first two runs,* and many others agree with me.

Some still have that lingering unrest often associated with these myths, and waste time and energy grappling with which one to use. Isn't it time we recognised *due to* as interchangeable with *owing to* to spare these authors this soul searching and discussion? If you cannot bring yourself to do this, you can always just rewrite the sentence with *because* or *because of*:

The assay failed because the samples were not adequately saponified or The assay failed because of inadequate saponification of the samples.

If you do this, I prefer the first version because both clauses are verb-based, which is always better in English. And I actually prefer the solution with *because* (*of*) to the solutions with *due to, owing to* or *caused by.*

So I have already made the transition as far as 'due to' is concerned—and as with the jettisoning of many of these

deeply ingrained mechanisms to avoid what is actually a rather unimportant issue, it took quite some time. I used to apply the acid test rigorously whenever I came across or used 'due to' and act accordingly. Now I am pleased that I don't. Another thing that makes life simpler!

Myth 39 : You should always say 'for him and I' or similar

Finally, I need to get something off my chest, even though it isn't concerned with writing in our context, and it is generally not a problem for non-native speakers of English because they have a higher awareness of the accusative, dative and indirect object. Curiously enough, this problem seems to be less widespread amongst North Americans. After claiming above that the difference between 'due to', 'owing to' and 'caused by' is not worth worrying about, you may wonder how I can get worked up about this one, but there we are: we all have a bête noire (or several).

Three things in this regard were drummed into us in English lessons years ago in England:

- It is impolite to put yourself first when speaking, so you always say 'John and I went into town'.
- You never say 'John and me went into town', because you and he are the subjects of this sentence; the worst transgression was to say 'Me and him went ...'. You never got into trouble if you said 'I'.
- You retain the order in the first bullet point here when "John and I" are objects, indirect objects or follow prepositions, but in this case you say 'John and me', because 'me' is the objective/accusative or dative personal pronoun of 'I'.

This looks very straightforward, but our teachers obviously did a great job with being emphatic about the 'I', because countless people up and down the UK, also in the media, clearly have their wires crossed on this one and regularly say 'John and I' or 'you and I' when they should be saying 'John and me' or 'you and me'. Consequently, this even creeps into writing, especially emails. You have to be sure that 'I' comes second, and the rule that you shouldn't say 'me' is so entrenched that out comes an 'I' so you sound right. Interesting is that this doesn't apply to other personal pronouns: *for you and we* or *after he and they* could only be jocular and do not even form part of regional dialect.

I had to do some retraining on myself, as the inappropriate 'I' was also creeping in with me. After considerable effort to correct this, a colleague then corrected ***me***. I said: "You can come ***with him and me*** in my car, if you like". This resulted in a look of horror, a hand placed on my arm to break the news gently, and a whispered: "I hate to correct you, but you should always say *him and I*". I did not deign to respond or remind the colleague concerned that if I had just said "You can come with me in my car, if you like" she would never have dreamt of correcting me. Listen out for them! *She never gets the minutes ready on time—but that just between you and I, of course or They arrived after Susan and I.*

I recently did a training event in England. A couple of copies were missing. One of the participants went off to get copies and came back into the room, commenting: "It's all right, I asked X to make copies for you and me ...". OK. But then there was a moment's pause for a quick grammatical retake, and after a frantic glance at me as the 'medical-writing-teacher-who-knows-everything', the participant added: "...err ... em ... I mean for you and I, of course". No comment.

The way to get it right is to consider what you would say if you were on your own. And you would never say: *You can come with I* or *They arrived after I*—I am certain of that.

Of course, this throws up the whole question of whether it is correct to say 'It's me' or 'It was her', but that's one can of linguistic worms that I do not intend to open at this point.

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Letter

Quantifiers and subject-verb agreement

To the editor:

Thank you for reprinting Alistair Reeves' *Myths about English* in Vol. 12 No. 1. It was a valuable addition to the journal and was, I'm sure, greatly appreciated by the readers. However, I would like to take slight issue with the comments Alistair makes under Myth 7, which deals with subject-verb agreement in connection with *a number of + noun* and *the number of + noun*. Alistair says this topic leads to endless heated discussions, but I don't think there's any reason why it should: the case is shut and closed.

Alistair notes that *A number of variables were studied* is much more likely to occur than *A number of variables was studied*, which he explains by saying that the use of a plural verb after *a number of + noun* is "a well-established convention." Actually, it's more than just a convention, and I'm afraid he is not correct to add that "there is no rule here" or that "nobody can tell you that you are wrong" if you insist on using a singular verb after *a number of + noun*. If he were correct, *A lot of variables was studied* and *Lots of information were considered* would also be acceptable, and I can't imagine he or anyone else would care to argue that they are!

Generally speaking, the verb after a noun phrase containing two nouns linked with *of* or another preposition agrees with the first of the two nouns (the "head noun"): *the cause of the disaster was, one result of the discussions was, the conclusions of the committee were, the reasons for this are*, etc. *The number of variables was* is a typical example of this pattern, so, as Alistair says, *the number of variables were* is wrong. In my experience, native speakers of English are much more likely to mess up subject-verb agreement in such examples than well-educated speakers of other languages!

Within this *noun of noun* category, however, there is a significant subtype in which the second of the two nouns acts as the head noun (the one with which the verb agrees). This happens in noun phrases starting with expressions that share an important characteristic with *a number of*. Here are a few that spring quickly to mind: *a couple of, a bit of, a few of, a lot of, lots of, plenty of, a small/large number of, a (small/large) percentage of, any number of, a load of, loads of, heaps of, thousands of, the majority of, a small/large amount of, a great deal of, a small/large quantity of.* Some of these can be followed only by singular nouns (e.g. *a great deal of*), some only by plural nouns (e.g. *a number of*), and some by either (e.g. *a lot of*), but in each case, the subject-verb agreement is dictated by the noun that follows.

The characteristic these expressions share is that they play the syntactic role of quantifiers, as can be seen from the fact that they can all be replaced by straight quantifiers. *A couple* of, for example, can be replaced by *two* (*or three*), a *lot of* by *many* or *much*, *a small amount of* by *a little*, *a number of* by *some* or *several* (Japanese readers, please note that *a number of* does *not* mean「多くの」[*many*] – this is just one of the many mistranslations your dictionaries kindly provide you with!), and *a large number of* by *many*.

Whether these expressions are grammatically classified as quantifiers or as part of a special type of noun phrase consisting of a noun denoting quantity and a second noun functioning as the head noun depends on which grammar book you consult, but whichever classification is used, there is no dispute about which noun the verb agrees with! Personally, I think they should all be classified as quantifiers in their own right, because talking about "special types" of this, that and the other simply confuses people and confirms them in the erroneous belief that the English language has an uncommonly large number of exceptions. Such classification would also allow us to say that *A number of variables was studied* is grammatically incorrect for exactly the same reason that *Several variables was studied* is. This is actually the case, I believe.

It is worth noting that most of these expressions are considerably less formal than their straight quantifier equivalents, so there's a question as to whether they should be used in academic writing at all. The danger of misunderstanding inherent in some of them makes this question even more compelling. Take *the majority of*, for example, which

Alistair also mentions under Myth 7. He says that *The majority of patients was enrolled before Amendment 1* "sounds wrong," but again, this is simply because the first part of the noun clause (*the majority of*) functions as a quantifier and the verb therefore agrees with *patients*. The question I want to ask, though, is what does *the majority of* mean, or in other words, which quantifier can it be replaced by? A dictionary will tell you that *the majority* means *the greater number*, i.e. *over 50%*. But if you carried out a survey of native speakers of English, I would be prepared to bet quite a lot of money that almost all of them would understand *the majority of* to mean *most* (and, of course, to understand *most* to represent a much higher percentage than 51%). This discrepancy between the popularly perceived meaning and the dictionary definition is surely a good reason for never using *the majority of* in scientific papers.

Another thing worth bringing up is noun phrase components like *a set of*, *a group of* and *a collection of*. These may appear similar to *a number of*, etc., but actually they aren't, because they can't be replaced by quantifiers: *a group of patients* in itself doesn't give us any indication of *how many* patients we are talking about, whereas *a number of patients* does (*several*). Therefore, in expressions like *a set/group/collection of + noun*, we return to the normal pattern of subject-verb agreement as determined by the first noun. In spite of this, it's not unusual to see things like *a group of patients were*, but the reason for this is that collective nouns (singular nouns that refer to multiple objects or people) like *group, team* and *family* can, by recognized convention, be followed by plural verbs, especially in British English. Alistair mentions this phenomenon in connection with *government* under Myth 7. Thus, both *a group of patients were* and *a group of patients was* are considered correct. Like Alistair, I tend to prefer the singular verb agreement, so both of us are obviously rather un-British!

T.D. Minton
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Author's response

The case with a number of + noun and the number of + noun is unfortunately not shut and closed – even though I would like it to be! I report on my experience of 35 years of observing the use of British English and American English in the pharmaceutical industry, and was referring specifically to the use of a number of + noun and the number of + noun. The fact remains that I have been pulled up on this one by users of American English, so I empirically deduced that a body of American English users feel (or should it be feels?) that the singular sounds correct or at least are following some 'rule' they have been told. I have never heard anyone insist on using a singular verb after a lot of + noun and agree with this correspondent's comments on (a) lot (s) of + noun. Indeed, I have learnt from all of his or her illuminating points and agree with them, especially that the English language has an uncommonly large number of exceptions that we have to live with. Maybe a number of + noun + singular or plural should be regarded as one of these.

The correspondent also comments: "In my experience, native speakers of English are much more likely to mess up subject-verb agreement in such examples than well-educated speakers of other languages!" I am not sure that I would choose the term 'mess up' for what might be linguistic trends (but I am no scholar of these). I do agree, however, that well-educated speakers of other languages pay greater attention to such issues (among many others) than native speakers of English. At least, they certainly ask me more questions about these sorts of issues. At my courses, I regularly ask about subject-verb agreement with a number of + noun, the number of + noun, none of the + noun, one of the + noun, and subject-verb agreement in neither-nor clauses. Speakers of languages with much less flexible subject-verb agreement structures than in English (those that I am familiar with are German, Dutch and the Scandinavian languages) often want to see was after a number of + noun and the number of + noun, unless they have a language background or have spent time in an English-speaking environment. They also feel happier with was after nouns such as majority, because this is what they have to say in their native language. I occasionally come across native English speakers who still insist on constructing the majority with was, but as the correspondent quite rightly says, it is inadvisable to use the majority in scientific and medical texts anyway, so I rarely leave the majority untouched when editing texts. An estimated quantity or most (if this is the case) is always better.

Alistair Reeves

Writing Tips

Fluency

Reuben M. Gerling

Some papers, even including some in our journal, make one wonder whether the writer was interested in reaching the reader or in ensuring that no one will ever come near the published masterpiece.

The problem lies not with content, whatever merit that may have, but with style. Well-written pieces, even lightweight ones lacking gravitas, will be a pleasure to read and attract an audience, whereas heavy, unyieldingly repetitious or obtuse tracts will keep the readers at a safe distance even if the message hidden under the layers of verbiage are of importance.

Editors, being human, tend to fall for the well-written article as much as the next person, and submitting something readable may prove a factor in the acceptance game. Once submitted, work sent back for revision may contain comments that relate to style as well as content, so a writer who has done the necessary work and edited the paper before submission will have to endure less criticism and is more likely to receive a speedy stamp of approval.

Fluency means that the article flows from paragraph to paragraph; that what you write in the second paragraph leads to the third, the third to the fourth and so on down to the conclusion. The thought pattern is that of the reader, not the writer! Pl introduces something that makes the reader anticipate the content of P2.

Writers may find this idea complex and perplexing. Why write something in a direct line when you can yoyo your way up and down, repeating the same thought and kicking dust to mask the longed-for end. Authors seem to feel more at home when starting with the end and ending with the middle, with the introduction buried somewhere in between. That tendency resulted in the strict structural guidelines of IMRAD and the proliferation of writing manuals, including the AMA Manual. Here are some tips that may possibly help authors achieve some fluency.

Sentences

1. Start with the known, move to the unknown.

(Original) *Atrial septal aneurysm (ASA) is a risk factor for arterial embolism because it frequently coexists with an atrial septal defect or patent foramen ovale and mitral valve prolapse.*

The part starting with *because* is known. As the readers of this material are all initiates, they know what the second part of this sentence means. Thus,

(Better) *Atrial septal aneurysm (ASA) frequently coexists with an atrial septal defect or patent foramen ovale and mitral valve prolapse making it a risk factor for arterial embolism.*

2. Vary the length of your sentences. Making all sentences the same length, especially if that means short, results in lists and not articles.

3. As well as each paragraph leading to the next, **each sentence in the paragraph should lead to the following one.** Read your work and verify that each sentence leads to the next one.

4. Avoid meaningless sentences as well as expressions.

Example:*The clinical course of pulmonary embolism is so diverse that the evaluation of the presence, severity, or duration of the disease is often not possible without additional invasive examination.*

This is too general and doesn't say very much.

5. Try to use positive rather than negative statements (do not use negative statements!).

If the authors feel they need the example sentence above, the words *often not possible, being negative* should be changed to a positive statement (*unlikely, rare*).

Another example:*AA is a common cause of death, with less than 20% of people suffering a ruptured*

aortic aneurysm surviving.

Common cause of death is meaningless, especially as we are dealing with people in the profession. [It isn't meaningless! It may be unnecessary to point it out to experts in the field, but that is a different matter. If you insist that it shouldn't be stated because experts don't need to be told, however, you are assuming that only people who are experts in the field will read the paper. This is, I think, an erroneous assumption.] *With less than* is a negative statement. It is also inaccurate. If important, the reader will have to look it up and find what the exact percentage is; 2% is totally different from 18%. [No one would write fewer than 20% if the actual figure were 2%!] If needed, give the exact figure. So, for example, (better) *Only 17% of patients suffering a ruptured aortic abdominal aneurysm survive.* [The fact that the survival rate is low doesn't necessarily mean that the condition itself is a common cause of death – the survival rate could be 0%, but if the condition affects only 0.001% of the population, it is not a common cause of death! Therefore, from the point of view of the lay reader, being told that AAA is a common cause of death could indeed be seen as useful information.]

6. Avoid repetition of the same term within the same sentence.

In sentences such as *when the operation was conducted it was felt that the operation had to be rapid as it was an operation on a patient with severe breathing complications,* the word operation should appear only once.

(Better) *It was felt that due to the patient's breathing complications the operation had to be conducted rapidly.*

7. Avoid wordy sentences featuring unnecessary words or expressions:

Typical clinical manifestations have been previously reported in HIV-infected patients.

Have been previously reported is a cumbersome expression. All things reported are previous and the rule in medical writing is that if it is relevant, use the present simple. Thus, *typical clinical manifestations in HIV-infected patients are reported,* is clearer and less wordy.

Other points to watch for:

Paragraphs:

Structure your paragraphs so that each one aims towards the point you wish to make. Revise to assure that the paragraph leads to this point and that the point is stated clearly at the end of the paragraph.

Write a list of points at the start so that the order of paragraphs will follow from one point to the next.

Watch out for complex compound terms that can be difficult to follow or interpreted in more than one way. The term, *Normal Fc receptor medicated marrow mononuclear phagocyte system function* is ideal if your aim is to confuse your readers (cf. Huth, p. 179).

If at all possible, avoid the term *respectively*. Throwing a bunch of statistics at the reader with this word at the end means, *I am too lazy to write my results in order; you sort it out.*

It is of paramount importance to re-read your work a number of times. The first reading should deal with the point you are trying to make: *did I make it*? The second should be to go over your data and facts: did *I* present all the data and facts, and are all the data and facts presented relevant to my argument? The keywords for the third (not necessarily the final!) reading should be fluency, order, repetition, and clarity.

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