Journal of Medical English Education

JME

Journal of Medical English Education

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

第19回 日本医学英語教育学会 学術集会 開催案内

　日本医学英語教育学会は1998年に第1回医学英語教育研究会が開催され，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28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19回医学英語教育学会学術集会

日　時：平成28年7月16日（土）〜17日（日）

会　長：Timothy Minton（慶應義塾大学医学部 英語教室）

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

演題募集：平成28年2月1日正午〜3月31日 午前12時

　　（医学英語教育の目標・教育方法・評価，学生評価，語学教育と専門教育の統合，実践力教育，グローバル人材育成，医学・看護学・医療系教育における医学英語教育，英語教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，医学英語論文指導・校閲・編集，医学論文作成における倫理，国際学会でのスライド作成と発表法，USMLE受験指導，医療通訳，医学英語検定試験，その他の医学英語教育に関連する演題）

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

＊詳細は学会ホームページをご参照ください。

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

問合せ先：日本医学英語教育学会・事務局

　　　　〒162–0845　東京都新宿区市谷本村町2–30　メジカルビュー社内（担当：江口）

　　　　TEL 03–5228–2274　　FAX 03–5228–2062　　E-MAIL jasmee@medicalview.co.jp

<div align="center">

Second Announcement

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

</div>

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

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

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

Dates: Saturday July 16 and Sunday July 17, 2016

Venue: Keio University Hiyoshi Campus

4-1-1 Hiyoshi, Kohoku-ku, Yokohama

President: Timothy D. Minton

(English Department, Keio University School of Medicine)

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

・goals, methods, and assessment of medical English education

・student evaluation

・integration of language education and specialized education

・global human resource development

・medical English for nursing and other healthcare-related fields

・the use of technology in EMP education

・faculty development

・teaching of medical writing

・medical English editing

・the art of presenting at international meetings

・USMLE preparation

・medical interpreting

・EPEMP

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

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

TEL 03–5228–2274   FAX 03–5228–2062

E-MAIL jasmee@medicalview.co.jp

Journal of Medical English Education

The official journal of the Japan Society for Medical English Education

jasmee@medicalview.co.jp

Editor's perspectives

Into 2016

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

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

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

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

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

Timothy D. Minton

Editor-in-Chief

Journal of Medical English Education

An extracurricular clinical English program for Asian medical undergraduates

Takayuki Oshimi,* Eric H. Jego,* and James C. Thomas**

*Division of Medical Education Planning and Development, Nihon University School of Medicine
** Medical Education Center, Keio University School of Medicine

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

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

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

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

J Med Eng Educ (2016) 15(1): 7–13

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

1. Introduction

English is widely recognized as the lingua franca in medicine,[1] and acquiring a high level of English proficiency is assumed to be a prerequisite for a successful career in this profession. Many medical schools in non-English speaking countries provide English for medical purposes (EMP) education, which addresses academic and medical knowledge acquisition in English. Currently, not many medical schools in Japan have curricula that adequately address clinical proficiency in English. A recent survey revealed that Japanese medical students wanted more opportunities to develop their clinical communicative English competencies, including patient encounter skills, clinical case presentation skills, and clinical research article discussion skills.[2] These three skill sets are also essential for clinical clerkships in the United States.[3]

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

2. Methods

2.1. Description of the program

The authors are collaborating with a non-profit organization that offers a cross-cultural exchange program in the San Francisco Bay Area aimed at medical undergraduates of Asian extraction. This program is known as "Medical

● **Corresponding author:**
Takayuki Oshimi, MD
Division of Medical Education Planning and Development,
Nihon University School of Medicine
30-1 Oyaguchi Kamicho, Itabashi-ku, Tokyo, 173-8610 JAPAN
Tel: +81-3-3972-8111 (ext 2350)
Email: oshimi.takayuki@nihon-u.ac.jp

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

The organizer of the program, formerly known as *Volunteers in Asia* (*VIA*), is a non-profit organization founded in 1963 to send Stanford University student volunteers to Asian countries. *VIA* has been organizing short-term educational programs for Asian students at Stanford University since 1977.[5] The MED program is modeled on their Exploring Health Care (EHC) program, which initially started with two Japanese private medical universities (Tokyo Women's Medical University and Tokyo Medical University) in 1996, and has since expanded to include other Japanese medical schools.[6] Observing the positive post-program feedback from participants in this all-Japanese spring program, *VIA* started the MED program in 2012 by accepting 21 medical undergraduates. Application to the MED program is currently open to any medical undergraduates from three Asian countries, and the number of participants increased from 28 in 2013 to 34 in 2014 and 41 in 2015.

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

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

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

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

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

2.2. Subjects

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

2.3. Assessment

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

3. Results

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

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

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

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

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

Table 2. Can-do statements

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

*patient (problem), intervention, comparison, and outcome
**patient (problem), exposure, comparison, and outcome

program responses did the same. The hypothesis based on these two assumptions was that differences in pre- and post-program responses would indicate how much the participants felt they had improved on completing the program, and in which skills.

To test this hypothesis, 30 separate 2x2 McNemar tests for paired proportions were used to compare the pre- and post-program responses to individual statements (**Table 4**). Results were considered significant at an a priori alpha level of 0.05. On the basis of these criteria, participant responses to the following eight can-do statements showed no significant difference: PE-2 (*"I can use comprehensible pronunciation."*), PE-4 (*"I can summarize information provided by a patient."*), PE-6 (*"I can identify appropriate differential diagnoses."*), PE-7 (*"I can form an appropriate plan and management strategy."*), CP-4 (*"I can narrow the differential diagnoses to 2 or 3 relevant possibilities."*), CP-5 (*"I can distinguish between relevant and irrelevant information for a case presen-*

tation."), CP-7 (*"I can analyze the differential diagnoses by justifying and contrasting the other possibilities."*), and JC-1 (*"I can guess the type of medical article from its title."*).

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

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

Table 3. Can-do statements responses (yes)

Code	Pre-program: Japan (n=18)	Post-program Japan (n=17)	Pre-program: Taiwan (n=13)	Post-program Taiwan (n=13)	Pre-program: China (n=3)	Post-program China (n=3)
PE-1	2 (11.1%)	10 (58.8%)	7 (53.8%)	13 (100%)	2 (66.7%)	2 (66.7%)
PE-2	6 (33.3%)	10 (58.8%)	10 (76.9%)	12 (92.3%)	3 (100%)	3 (100%)
PE-3	3 (16.7%)	9 (52.9%)	4 (30.8%)	12 (92.3%)	0 (0%)	2 (66.7%)
PE-4	5 (27.8%)	9 (52.9%)	11 (84.6%)	12 (92.3%)	2 (66.7%)	3 (100%)
PE-5	2 (11.1%)	9 (52.9%)	3 (23.1%)	13 (100%)	1 (33.3%)	2 (66.7%)
PE-6	1 (5.6%)	2 (11.8%)	3 (23.1%)	5 (38.5%)	1 (33.3%)	1 (33.3%)
PE-7	1 (5.6%)	1 (5.9%)	2 (15.4%)	2 (15.4%)	1 (33.3%)	1 (33.3%)
PE-8	3 (16.7%)	7 (41.2%)	2 (15.4%)	10 (76.9%)	1 (33.3%)	0 (0%)
PE-9	5 (27.8%)	14 (82.4%)	6 (46.2%)	9 (69.2%)	1 (33.3%)	2 (66.7%)
PE-10	1 (5.6%)	7 (41.2%)	6 (46.2%)	10 (76.9%)	0 (0%)	0 (0%)
PE Average	**2.9 (16.1%)**	**7.8 (45.9%)**	**5.4 (41.5%)**	**9.8 (75.4%)**	**1.2 (40.0%)**	**1.6 (53.3%)**
Code	Pre-program: Japan (n=18)	Post-program Japan (n=17)	Pre-program: Taiwan (n=13)	Post-program Taiwan (n=13)	Pre-program: China (n=3)	Post-program China (n=3)
CP-1	6 (35.3%)	15 (83.3%)	8 (61.5%)	10 (76.9%)	1 (33.3%)	2 (66.7%)
CP-2	7 (41.2%)	14 (77.8%)	6 (46.2%)	13 (100%)	1 (33.3%)	3 (100%)
CP-3	6 (35.3%)	10 (55.6%)	9 (69.2%)	12 (92.3%)	2 (66.7%)	3 (100%)
CP-4	1 (5.9%)	7 (38.9%)	2 (15.4%)	5 (38.5%)	2 (66.7%)	0 (0%)
CP-5	0 (0%)	4 (22.2%)	5 (38.5%)	7 (53.8%)	2 (66.7%)	2 (66.7%)
CP-6	1 (5.9%)	5 (27.8%)	6 (46.2%)	10 (76.9%)	0 (0%)	2 (66.7%)
CP-7	0 (0%)	3 (16.7%)	2 (15.4%)	3 (23.1%)	0 (0%)	1 (33.3%)
CP-8	0 (0%)	6 (33.3%)	3 (23.1%)	9 (69.2%)	0 (0%)	3 (100%)
CP-9	1 (5.9%)	4 (22.2%)	0 (0%)	2 (15.4%)	0 (0%)	1 (33.3%)
CP-10	1 (5.9%)	4 (22.2%)	7 (53.8%)	12 (92.3%)	1 (33.3%)	2 (66.7%)
CP Average	**2.3 (13.5%)**	**7.2 (40.0%)**	**4.8 (36.9%)**	**8.3 (63.8%)**	**0.9 (30.0%)**	**1.9 (63.3%)**
Code	Pre-program: Japan (n=18)	Post-program Japan (n=17)	Pre-program: Taiwan (n=13)	Post-program Taiwan (n=13)	Pre-program: China (n=3)	Post-program China (n=3)
JC-1	13 (76.5%)	16 (88.9%)	11 (84.6%)	13 (100%)	3 (100%)	3 (100%)
JC-2	8 (47.1%)	17 (94.4%)	6 (46.2%)	11 (84.6%)	3 (100%)	3 (100%)
JC-3	3 (17.6%)	15 (83.3%)	3 (23.1%)	13 (100%)	0 (0%)	3 (100%)
JC-4	3 (17.6%)	16 (88.9%)	7 (53.8%)	13 (100%)	1 (33.3%)	2 (66.7%)
JC-5	3 (17.6%)	15 (83.3%)	1 (7.7%)	13 (100%)	0 (0%)	3 (100%)
JC-6	4 (23.5%)	11 (61.1%)	11 (84.6%)	13 (100%)	1 (33.3%)	3 (100%)
JC-7	2 (11.8%)	14 (77.8%)	4 (30.8%)	13 (100%)	0 (0%)	3 (100%)
JC-8	1 (5.9%)	15 (83.3%)	4 (30.8%)	13 (100%)	0 (0%)	3 (100%)
JC-9	2 (11.8%)	7 (38.9%)	3 (23.1%)	12 (92.3%)	0 (0%)	3 (100%)
JC-10	1 (5.9%)	8 (44.4%)	3 (23.1%)	12 (92.3%)	0 (0%)	3 (100%)
JC Avarage	**4.0 (23.5%)**	**13.4 (74.4%)**	**5.3 (40.8%)**	**12.6 (96.9%)**	**0.8 (26.7%)**	**2.9 (96.7%)**

possibilities."), and CP-9 ("*I can plan management for a patient's medical issues.*").

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

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

3.4. Can-do statement responses: Japan vs Taiwan

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

4. Discussion

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

Although the clinical English program was designed to improve the skills identified in the 30 can-do statements, the statistical survey results presented in **Table 4** shed some light on the skills that participants found particularly difficult to acquire through this short-term clinical English program. Both PE-2, which requires comprehensible pronunciation, and JC-1, which demands skills for predicting the type of medical article from its title, were not interpreted to be challenging by the participants prior to the program. On the other hand, responses to six other can-do statements showed no significant skill acquisition by the end of the clinical English program (PE-4, PE-6, PE-7, CP-4, CP-5, and CP-7). These were regarded as being particularly challenging at the beginning of the program as well as at the end. Why PE-4 (summarizing a patient story) was regarded as challenging may be

Table 4. McNemar test results

Code	Odds ratio	Probability value
PE-1	1.56	**0.001**
PE-2	0.78	0.077
PE-3	1.64	**0.001**
PE-4	0.8	0.114
PE-5	1.9	**0.000**
PE-6	0.15	0.371
PE-7	0.03	0.480
PE-8	0.71	**0.006**
PE-9	1.44	**0.001**
PE-10	0.65	**0.009**
CP-1	1.71	**0.001**
CP-2	4.50	**0.001**
CP-3	1.11	**0.043**
CP-4	0.41	0.070
CP-5	0.38	0.114
CP-6	0.59	**0.004**
CP-7	0.19	0.074
CP-8	0.94	**0.000**
CP-9	0.22	**0.041**
CP-10	0.63	**0.016**
JC-1	3.50	0.182
JC-2	4.67	**0.001**
JC-3	8.33	**< 0.001**
JC-4	6.67	**< 0.001**
JC-5	9.00	**< 0.001**
JC-6	1.71	**0.006**
JC-7	6.00	**< 0.001**
JC-8	9.00	**< 0.001**
JC-9	1.50	**< 0.001**
JC-10	1.82	**< 0.001**

understood as follows: (1) summary requires multifold skills, such as listening comprehension, memory retention, identifying key issues, and delivering in a patient-centered manner, which are difficult to master in a short period of time; (2) this result is due to lower self-assessment score among the Japanese participants. Tendencies unique to Japanese participants will be discussed in section **4.4**.

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

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

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

4.3. Comparing Japanese participant responses with those from Taiwanese and Chinese participants

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

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

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

Throughout the program, the Taiwanese participants were generally more proactive than the Japanese in engaging with the guest speakers and tutors, which may have undermined confidence in the latter group, causing them to answer in the negative to many of the statements where they might not have done so under other conditions. We also have to take into consideration the fact that five of the Japanese participants were first-year students, and that the survey was only in English, which may have affected the results in unexpected and possibly disproportionate ways. Most medical subjects are taught via materials written in English at Taiwanese medical schools, which may go a long way to explaining the higher scores observed in this group.

4.5. Generalizability and implementation

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

4.6. Conclusions

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

Disclosure

Acknowledgements

References

1. Maher J. 1987. English as an international language of medicine. *Med Educ* **21**: 283–284.
2. Noda C and Watanabe A. 2014. Future directions for curriculum development in English for medical purposes: a closer look at student needs. *J Med Eng Educ* **13**(3): 65–74.
3. Moody S, Deshpande G and Levine J. 2013. Panel Discussion 4: Medical English Requirements at Western-Style Residency/Internship Programs in Japan. 医学教育 **44**（補冊）第45回日本医学教育学会大会予稿集: 34–35.
4. VIA. 2014. Medical Exchange and Discovery Program Homepage. Stanford, the United States of America. <http://viaprograms.org/exchange> (Accessed March, 2015).
5. VIA. 2014. History of VIA Homepage. Stanford, the United States of America. <http://viaprograms.org/history> (Accessed March, 2015).
6. Louise Azuma A. 2011. Short-term medical exchange: A proposal for VIA in Stanford, California. *Capstone Collection*. <http://digitalcollections.sit.edu/capstones/2407/> (Accessed March, 2015).
7. The Federation of State Medical Boards of the United States, Inc., and the National Board of Medical Examiners. 2015. Step 2 Clinical Skills (CS) Content Description and General Information. <http://www.usmle.org/pdfs/step-2-cs/cs-info-manual.pdf> (Accessed March, 2015).
8. Wolpaw T, Wolpaw D and Papp K. 2003. SNAPPS: A Learner-centered Model for Outpatient Education. *Acad Med* **78**(9): 893–898.
9. Huang X, Lin J and Demner-Fushman D. 2006. Evaluation of PICO as a Knowledge Representation for Clinical Questions. *AMIA Annu Symp*

Proc 359–363. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1839740/> (Accessed March, 2015).

10. NCSSFL-ACTFL Can-Do Statements. 2013. American Council on the Teaching of Foreign Languages. <http://www.actfl.org/sites/default/files/pdfs/Can-Do_Statements_2015.pdf> (Accessed March, 2015).

Appendix 1. Patient Encounter Skills

Medical Exchange & Discovery 2015: Clinical English Lessons

Patient Encounter Skills

☑ Can-Do Statements

☐ China	( )-year medical student
☐ Japan	
☐ Taiwan	Name

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

Appendix 2. Case Presentation Skills

Medical Exchange & Discovery 2014: Clinical English Lessons

Case Presentation Skills

☑ Can-Do Statements

☐ China	( )-year medical student
☐ Japan	
☐ Taiwan	Name

I can understand case presentations at a clinical setting.	☐ Yes
I can identify what is a good case presentation.	☐ Yes
I can summarize a medical history.	☐ Yes
I can narrow the differential diagnoses to 2 or 3 relevant possibilities.	☐ Yes
I can distinguish between relevant and irrelevant information for a case presentation.	☐ Yes
I can use appropriate expressions in my case presentation.	☐ Yes
I can analyse the differential diagnoses by justifying and contrasting the other possibilities.	☐ Yes
I can ask questions to an attending doctor about uncertainties, difficulties, or alternative approaches.	☐ Yes
I can plan management for a patient's medical issues.	☐ Yes
I can select a case-related issue for self-directed learning.	☐ Yes

Appendix 3. Journal Club Presentation Skills

Medical Exchange & Discovery 2014: Clinical English Lessons

Journal Club Presentation Skills

☑ Can-Do Statements

☐ China	( )-year medical student
☐ Japan	
☐ Taiwan	Name

I can guess the type of medical article from its title.	☐ Yes
I can guess the conclusion of an original article from its title.	☐ Yes
I can determine if an original article is global or local research by examining its authors' affiliations.	☐ Yes
I can determine what is new about an original article by examining its Background section.	☐ Yes
I can identify the type of research and the clinical question of an original article by evaluating the "PICO" or "PECO".	☐ Yes
I can evaluate the results of an original article by examining its ratios, confidence intervals, and p values.	☐ Yes
I can identify the interpretation of the results and generalisability of an original article by examining its Discussion section.	☐ Yes
I can determine the value of an original article by examining its Editorial article.	☐ Yes
I can evaluate articles that are similar to an original article by examining its Correspondence article.	☐ Yes
I can evaluate the impact of an article on the community by examining its Conference Report.	☐ Yes

The use of vocabulary learning strategies and technology among Japanese medical school students

Kaoru Kobayashi and Andrea Little

The School of Life Sciences, Tokyo University of Pharmacy and Life Sciences

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

J Med Eng Educ (2016) 15(1): 14–21

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

1. Introduction

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

● **Corresponding author:**
Kaoru Kobayashi, Ph.D.
Part-time lecturer, The School of Life Sciences, Tokyo University of Pharmacy and Life Sciences
5-6-3 Miyazaki, Miyamae-ku, Kawasaki, 216-0033
(〒216-0033　川崎市宮前区宮崎5-6-3)
Phone: 044-872-8299
Email: mq7k-kbys@asahi-net.or.jp

In addition, the students' use of technology when learning English vocabulary was investigated.

We asked the following research questions.

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

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

Neither research question sought to distinguish between general vocabulary and medical vocabulary. Instead our focus was on which VLSs and technology the students are using to learn any vocabulary. Students are exposed to and learn both types of vocabulary, even in classes where English

medical terminology textbooks are used, since they have not yet mastered all general vocabulary (e.g., "be associated with," "range," "variables"). In addition, some vocabulary terms overlap, so it is difficult to tell which vocabulary category a term belongs to, general or medical. For example, while "aorta" is a medical term, "blood" belongs to both medical and general vocabulary categories. Finally, we recognize that vocabulary terms in either group may cover a range of terms, including, but not limited to, single words, phrases, and figurative expressions.

2. Literature review

2.1. The need for learning strategies

After conducting an action research project aimed at making students active participants in their own language learning processes by introducing learning strategies, one researcher concluded "language classrooms should have a dual focus — not only on teaching language content, but also on developing learning processes."[3(p143)] Japanese medical school students face an increasingly globalized work environment due to factors such as the government's desire to promote medical tourism[4] and international pressure to present and publish research in English. To this end, explicitly teaching language learning strategies, especially VLSs, will assist medical school students in becoming more effective, self-regulating learners. Thus, as a first step, it is necessary to understand which VLSs are familiar to and used by medical school students so that their current strategy repertoire can be fully utilized and built upon to provide them with the tools for continuous, successful vocabulary acquisition.

2.2. Benefits of VLSs

It is well-known that vocabulary learning is both incremental in nature and multifaceted, involving many kinds of word knowledge.[5] In addition to receiving guidance on which vocabulary terms to learn, learners can also benefit from help in developing effective strategies for learning these terms.[6] Among other things, VLS studies have shown significant positive correlations between VLS use, EFL proficiency, and vocabulary size.[7,8] They have also shown VLSs are effective tools for helping learners decide what vocabulary to learn and how to learn it.[9] Studies on teaching VLSs explicitly suggest it may increase intrinsic motivation and enhance learners' self-efficacy, a key factor for self-regulating learning.[10] Explicit instruction also raises learners' awareness of strategy use and lessens the learning burden for those vocabulary terms perceived as difficult.[11]

2.3. Classifying VLSs and VLS scales

Over the years, various researchers have identified and created learning strategy taxonomies. From these, scales for measuring various VLSs have been developed. Schmitt's inventory,[2] developed in the 1990s, is particularly relevant for Japanese EFL learners as it was based on survey results showing how Japanese intermediate students studied vocabulary. The 58 strategies identified were categorized into two major classes and six groups: *discovery strategies*, comprised of determination and social strategies, and *consolidation strategies*, comprised of social, memory, cognitive, and metacognitive strategies*.*

As the name implies, the first class of strategies is used for discovering a new word's meaning and usage. Learners use determination strategies to decipher an unknown word's meaning when they have no one to ask. These strategies involve guessing (from context, from L1 cognates, and from their existing structural knowledge of the language) or using a dictionary.[2,5] In contrast, social strategies involve interacting with other people to discover a new vocabulary term's meaning. This may entail asking someone for the meaning or translation.[5] In short, determination strategies help learners make the initial form-meaning link, the first step in acquiring word knowledge.[6]

The second class of strategies is for consolidating a word in memory so it can be used later. This class, too, includes social strategies. Examples are group work to practice vocabulary, and interacting with native speakers.[5] Another group within this class is memory strategies. Generally, these strategies entail some type of elaborate mental processing which facilitates recall.[2,5] For example, linking the term to be retained with some previously learned knowledge using pictures/imagery or grouping (e.g., the keyword technique, semantic maps, Loci method).[2] These strategies involve deeper processing, which has been found to lead to better long-term retention.[5] In particular, the keyword technique results in faster, more secure learning for both receptive and productive recall.[12] This group also includes studying affixes and roots, using cognates, using new words in sentences, connecting words to a personal experience, and using physical action, to name just a few.[2]

Cognitive strategies are also included within the class of consolidation strategies. These resemble memory strategies, but involve less manipulation and are thus cognitively shallower as they entail less semantic processing.[2] Examples include word lists, word cards, written and verbal repetition, labeling, and keeping vocabulary notebooks. Though not deep, these strategies are effective for acquiring various kinds of word knowledge (e.g., form and pronunciation), con-

solidating the form-meaning connection, and as a first step toward deeper processing.[12] Word cards are especially efficient for quickly increasing vocabulary size.[12] Moreover, research shows using L1–L2 word pairs leads to better retrieval and recall for foreign language learners of both high and low proficiency.[6]

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

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

These 47 items were reduced to 25 after piloting, with overused and rarely used items eliminated. The resulting scale measures six subscales of strategic vocabulary learning behaviors: self-management, input-seeking, imagery, writing rehearsal, oral rehearsal, and association. Using Schmitt's taxonomy, these six subscales can also be categorized as metacognitive, involving conscious decision-making about the learning process (self-management) and maximizing exposure to the L2 (input-seeking); cognitive (writing rehearsal and oral rehearsal), involving shallower processing; and memory strategies (imagery and association), involving deeper, more elaborative processing thereby facilitating long-term retention.[2,5] As this scale was developed specifically for Japanese university EFL students, we adopted it for this study.

2.4. Technology and language learning

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

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

3. Data collection and analysis

To answer the research questions, we conducted a survey in June 2014. The survey (see **Appendix** for the English translation) was the aforementioned one created by Mizumoto and Takeuchi.[13] However, for this study, items related to technology use were added.

The survey contained 34 items, including one requesting the students' consent and guaranteeing anonymity. The other 33 items were classified into seven categories: self-management (7 items), input-seeking (4 items), imagery (5 items), writing rehearsal (3 items), oral rehearsal (3 items), association (3 items) and the use of technology (8 items). All student responses, except for Item 34 in the technology category, were measured on a 5-point Likert scale (1 = never or almost never true of me, 2 = not true of me, 3 = undecided, 4 = true of me, 5 = always or almost always true of me). Item 34 asked the students to select as many choices as they liked regarding which technologies they used to learn vocabulary. The lowerclassmen took the survey online using SurveyMonkey, a commercial online survey tool, and the upperclassmen completed a printed version of the same survey during English classes. The questionnaire items using the Likert scale (N = 32) all had high reliability (Cronbach's α = .92).

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

Bonferroni correction was applied for multiple comparisons of means (0.05/7 = 0.007).

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

4. Results

4.1. Student VLS preferences

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

exceeded the mid-point, but among upperclassmen was lower with a significant difference between the groups. As for memory strategies, the mean scores per item among lowerclassmen exceeded the mid-point but were lower among upperclassmen, indicating lowerclassmen use memory strategies more than upperclassmen.

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

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

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

Table 1. VLS preferences of the students

VLS Category	Lowerclassmen (n=104)		Upperclassmen (n=189)		Difference (%)	p
	Mean (SD)	Mean/Item	Mean (SD)	Mean/Item		
Metacognitive Strategies						
Self-management (7 items: Total Scores 7–35)	18.2 (6.0)	2.6	12.7 (4.8)	1.8	5.5 (16%)	< 0.001 *
Input-seeking (4 items: Total scores 4–20)	12.0 (4.2)	3.0	10.1 (4.4)	2.5	1.9 (10%)	< 0.001 *
Cognitive Strategies						
Writing Rehearsal (3 items: Total scores 3–15)	10.3 (3.1)	3.4	10.7 (3.5)	3.6	N/A	0.353
Oral Rehearsal (3 items: Total scores 3–15)	9.7 (3.3)	3.2	8.5 (3.3)	2.8	1.2 (8%)	0.003 *
Memory Strategies						
Imagery (5 items: Total scores 5–25)	16.7 (4.1)	3.3	14.7 (4.8)	2.9	2 (8%)	< 0.001 *
Association (3 items: Total scores 3–15)	9.9 (3.2)	3.3	8.2 (3.2)	2.7	1.7 (11%)	< 0.001 *

*: p < 0.007 (Student's *t*-test)

Table 2. Technology use of the students

Category	Lowerclassmen (n=104)		Upperclassmen (n=189)		Difference (%)	p
	Mean (SD)	Mean/Item	Mean (SD)	Mean/Item		
Technology Use (7 items: Total scores 7–35)	14.2 (5.9)	2.0	12.2 (5.7)	1.7	2 (6%)	0.005 *

*: p < 0.007 (Student's *t*-test)

Table 3. Technology use of the students in detail

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

*: $p < 0.007$ (Fisher's exact test)

5. Discussion and recommendations

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

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

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

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

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

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

3. Explicitly teach metacognitive strategies for effective long-term language learning.

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

students even after graduation.

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

The objective of the second research question was to identify the use of technology among medical school students when learning vocabulary. The results revealed that medical school students do not appear to particularly favor using technology when learning vocabulary, including medical terminology. Again, this did not match our expectations given the growing number of studies showing learners are favorably disposed toward technology for language learning.[16,17,20,21,25] However, since technology use has been proved effective in many ways, including the use of SNS, where through usage the students can develop their productive knowledge of vocabulary terms,[26,27] we believe that investigating methods that best fit medical school students' needs would be worthwhile.

5. Teach how to use online dictionaries effectively.

Interestingly, the use of online dictionaries for learning medical terminology was higher among upperclassmen (26.5%) than for lowerclassmen (3.8%). Dictionary lookup is a useful coping strategy when learners initially encounter unknown vocabulary terms. A learner may notice the term, and after looking it up, utilize other strategies, such as writing the term on a word card or on a vocabulary list. Even though Mizumoto and Takeuchi's VLS scale excluded dictionary lookup and guessing the meaning of a term from context,[13] research shows both are essential in the initial process leading to vocabulary acquisition and retention.[28]

Despite the effectiveness of using online L1-L2 dictionaries in vocabulary retention,[29] there are also some demerits. Electronic dictionary use is often so quick and convenient that there is a danger that users will be less motivated to find the meaning that best fits the context in which the term appears.[30] While medical school students should be encouraged to use online dictionaries, potential pitfalls must be explained.

6. Limitations

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

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

Additionally, since VLS use changes as learners mature,[2] a qualitative methodology could have uncovered the reasons why upperclassmen and lowerclassmen preferred different strategies. This would have been particularly noteworthy, as the VLS results gathered from the two groups in this study were actually the opposite of those found in Schmitt's study, in which memory strategies tended to replace cognitive strategies as learners matured.[2]

Furthermore, a qualitative approach using study logs of VLS use or observing learners as they used VLSs may have revealed what they actually do. As Rose notes, successful learning is not dependent on the frequency of VLSs but on the way in which they are used.[31]

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

References

1. Sakata N, Tanaka E, Fujieda M, et al. 2015. Assessing English needs of medical students using Can-Do Statements: Responses of teachers. *J Med Eng Educ* **14**(1): 15–24. [In Japanese]

2. Schmitt N. 1997. Vocabulary learning strategies. In: *Vocabulary: Description, acquisition and pedagogy* (Schmitt N, McCarthy M, eds). Cambridge: Cambridge University Press: pp 199–227.

3. Nunan D. 2002. Learner strategy training in the classroom: an action research study. In: *Methodology in language teaching: an anthology of current practice* (Richards JC, Renandya WA, eds). Cambridge: Cambridge University Press: pp 133–143.

4. Japan: slow growth for Japanese medical tourism. *International Medical Travel Journal* [Internet]. 2013 Dec. 18. <http://www.imtj.com/news/?entryid82=432709> [Accessed 2015 Aug 10]

5. Schmitt N. 2000. *Vocabulary in language teaching.* Cambridge: Cambridge University Press.

6. Schmitt, N. 2008. Review article: Instructed second language vocabulary learning. *Language Teaching Research* **12**(3): 329–363.

7. Gu Y and Johnson RK. 1996. Vocabulary learning strategies and language learning outcomes. *Language Learning* **46**(4): 643–679

8. Mizumoto A and Takeuchi O. 2009. Examining the effectiveness of explicit instruction of vocabulary learning strategies with Japanese EFL university students. *Language Teaching Research* **13**(4): 425–449.

9. Gu Y. 2010. Learning strategies for vocabulary development. *Reflections on English Language Teaching* **9**(2): 105–118.

10. Mizumoto A. 2012. Exploring the effects of self-efficacy on vocabulary learning strategies. *Studies in Self-Access Learning Journal* **3**(4): 423–437.

11. Little A and Kobayashi K. 2015. Vocabulary learning strategies of Japanese life science students. *TESOL Journal* **6**(1): 81–111.

12. Nation, ISP. 2001. *Learning vocabulary in another language.* Cambridge: Cambridge University Press.

13. Mizumoto A and Takeuchi O. 2008. Exploring the driving forces behind TOEIC scores: focusing on vocabulary learning strategies, motivation, and study time. *JACET Journal* **46**: 17–32.

14. Mizumoto A and Takeuchi O. 2008. A closer look at the relationship between vocabulary learning strategies and the TOEIC scores. *TOEIC Research Report* **4**:1–34. Tokyo: IIBC.

15. Chen C-M and Chung C-J. 2008. Personalized mobile English vocabulary learning system based on item response theory and learning memory cycle. *Computers & Education* **51**(2): 624–625.

16. Thornton P and Houser C. 2005. Using mobile phones in English education in Japan. *Journal of Computer Assisted Language Learning* **21**(3): 217–228.

17. Alavinia P and Qoitassi K. 2013. On the viability of vocabulary learning enhancement through the implementation of MALL: the case of Iranian EFL learners. *Journal of Language Teaching and Research* **4**(2): 412–426.

18. Stockwell G. 2010. Using mobile phones for vocabulary activities: examining the effect of the platform. *Language Learning & Technology* **14**(2): 95–110.

19. Browne C and Culligan B. 2008. Combining technology and IRT testing to build student knowledge of high frequency vocabulary. *JALT CALL Journal* **4**(2): 3–16.

20. Kennedy C and Levy M. 2008. L'italiano al telefonino: using SMS to support beginners' language learning. *ReCALL* **20**(3): 315–330.

21. Motiwalla LF. 2007. Mobile learning: a framework and evaluation. *Computers & Education* **49**(3): 581–596.

22. Naka M and Noi H. 1995. The effect of repeated writing on memory. *Memory and Cognition* **23**(1): 201–212.

23. Aizawa K and Mochizuki, M. 2010. *Eigo goi shidou no jissen aid-eashuu* [Practical ideas on English vocabulary teaching.] Tokyo: Taishukan Shoten.

24. Brown T and Perry F. 1991. A comparison of three learning strategies for ESL vocabulary acquisition. *TESOL Quarterly* **25**(4): 655–670.

25. Watson K and Agawa G. 2013. Integrated language skills CALL course design. *JALT CALL Journal* **9**(3): 297–306.

26. Kabilan MK, Ahmad N and Abidin MJZ. 2010. Facebook: An online environment for learning of English in institutions of higher education? *The Internet and Higher Education* **13**(4): 179–187.

27. Wang B-T, Shen T-W and Nagai M. 2011. Evaluating the English-learning of engineering students using the Grey S-P chart: a Facebook case study in Taiwan. *Global Journal of Engineering Education* **13**(2): 51–56.

28. Knight S. 1994. Dictionary use while reading: The effects on comprehension and vocabulary acquisition for students of different verbal abilities. *The Modern Language Journal* **78**(3): 285–299.

29. Laufer B and Hill M. 2000. What lexical information do L2 learners select in a CALL dictionary and how does it affect word retention? *Language Learning & Technology* **3**(2): 58–76.

30. Nesi H. 2000. Electronic dictionaries in second language vocabulary comprehension and acquisition: the state of the art. *Proceedings of the Ninth EURALEX International Congress* 2000 Aug 8–12; pp. 839–847.

31. Rose H. 2012. Language learning strategy research: Where do we go from here? *Studies in Self-Access Learning Journal* **3**(2): 137–148.

Appendix

1	I have read the information about the study and agree to take part in it.

Vocabulary Learning Strategies

Self-management

2 I regularly review the vocabulary I learned to check if I remember it.

3 I keep a vocabulary book or word list to check the vocabulary anytime I wish.

4 I try to make it a rule to memorize a certain number of words in a specific time period (e.g. '10 words a day').

5 I try to learn extra vocabulary in addition to what I am taught in class.

6 I try to take time for vocabulary learning.

7 I consciously set aside time to study vocabulary to prepare for tests such as TOEIC, TOEFL, or other.

8 I use my own methods for remembering, checking, or reviewing vocabulary.

Input-seeking

9 I try to expose myself to English vocabulary by reading or listening a lot.

10 I try to manage the learning environment so as to expose myself to English vocabulary.

11 I try to make use of the media (TV, radio, Internet, mobile phone, or movies) to learn vocabulary.

12 I study vocabulary with the intention of using it.

Imagery   *When I try to remember vocabulary,…*

13 I make a mental picture of what can be associated with a word's meaning.

14 I link my personal experiences to it.

15 I create an image of the spellings or orthographic forms.

16 I use the keyword method (keyword mnemonic technique).

17 I imagine whether the meaning of the word is negative or positive.

Writing rehearsal   *When I try to remember vocabulary,…*

18 I write it repeatedly.

19 I write it on a note or a card.

20 I remember not only the meaning but also the spelling of the word by writing it.

Oral rehearsal   *When I try to remember vocabulary,…*

21 I say it aloud repeatedly.

22 I vocalize it to remember not only its meaning but also the pronunciation.

23 I say the sample sentence aloud.

Association   *When I try to remember vocabulary,…*

24 I associate it with the synonyms or antonyms I already know.

25 I also memorize the synonyms or antonyms of the word.

26 I memorize words similar to it in meaning, sound, or shape, or the related words.

Use of technology

27 I use vocabulary-learning websites such as Quizlet, Anki or Flash Card Exchange to learn, review, and test myself.

28 I watch English language videos online (with or without subtitles) to learn or practice new vocabulary.

29 I listen to English language audio recordings or broadcasts to learn or practice new vocabulary.

30 I read English language websites, blogs, or news articles to learn or practice new vocabulary.

31 I utilize Social Networking Services (SNS), such as Twitter or Facebook, to learn or practice new vocabulary.

32 I use mobile apps or online English language learning games to learn or practice new vocabulary.

33 I use online or apps dictionaries that have vocabulary learning functions like list-saving or flash card

34 Which of the above technology do you use for learning medical terminology? Choose as many as you use.

Japanese doctors in discussion sessions at international medical conferences

Michael Guest

Faculty of Medicine, University of Miyazaki

Question/answer and discussion sessions (DSs) are by far the most anxiety-inducing aspect of performing English-language presentations at international medical conferences for Japanese doctors. In contrast to the body of the presentation itself, which will usually be scripted and thus under direct control of the speaker, post-presentation DSs are often unpredictable, spontaneous, and sometimes, adversarial. Managing them successfully requires the ability to think on the fly, to read between the lines, to negotiate and respond in real time, all in an appropriate and/or accurate manner. This certainly presents, as Hyland[7] states, "an interactional challenge to all but the most accomplished speakers" (p.84). For non-native English speakers (NNESs) in particular, the immediate application of such metacognitive and metadiscourse skills under the pressure of an expectant live audience of peers can make the sessions particularly daunting. However, DS comments and questions are not entirely unpredictable and speakers can expect that certain discourse patterns will emerge in the sessions. Thus, in order to master DSs, speakers need to develop strategies for both identifying and managing these dynamic interactions. In this paper, I will outline both successful and unsuccessful strategies used in DSs by 110 non-native English speakers at 5 international medical conferences I attended in various Asian locations in 2013-2014. First, I will introduce some of the most typical question/comment gambits used by DS commenters, and will follow this with a discussion regarding which response strategies used by presenters were effective, why they were effective, and which strategies were not.

J Med Eng Educ (2016) 15(1): 22–28

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

1. Background and Introduction

A number of researchers have described the main body of oral conference presentations (CPs) as being dialogic in nature,[1,2] or as a co-constructed, interactive forum involving the establishment of a rapport with the speaker's professional discourse community,[3] necessitating a greater focus upon the interpersonal dimension of speech.[4] However the fact that presentations are largely scripted and controlled by the presenter distinguishes the main body of the presentation markedly from the discussion sessions (DSs) which typically follow. Although some researchers[5] have treated DSs as a mere continuation or extension of the more monologic main body of the presentation, for many non-native English speakers (NNESs) presenters in particular, DSs represent a great psychological and performance leap from prepared, scripted content into the dynamic and unpredictable.[6]

DSs not only epitomize the specialized discourse indicative of the professional or academic discourse community but add interactional challenges that can make negotiating the sessions particularly difficult.[7] This is partially because, since DSs are often viewed as evaluative, they demand a very different set of skills from the main body of the presentation, particularly interpersonal management skills revolving around politeness strategies and face-saving.[8,9] Since DSs are inherently unpredictable and demand spontaneous responses in real time, combined with the added possibility of having

● **Corresponding author:**

Michael Guest

Associate Professor of English, Faculty of Medicine,

University of Miyazaki

Email: mikeguest59@yahoo.ca

Tel/Fax 0985-85-0998

Home Address: 744-43 Imaizumi-hei, Kiyotake-cho, Miyazaki Pref. 889-1602

* This research was funded by a scientific grant-in-aid from the government of Japan.

** This paper is partially based upon the presentation performed July 19, 2014 at the 2014 JASMEE Conference held in Ochano-mizu, Tokyo entitled: *'Strategic competence; Managing dynamic interactions in the medical discourse community.'*

to deal with adversative or challenging comments, DSs can be a stressful event for any presenter, but is particularly so when one is engaging the audience using English as a second language. Not surprisingly, Japanese doctors cite DSs as the most anxiety-inducing aspect of a CP precisely because it is perceived to be difficult to manage and control due to its dynamic, open-ended nature.[10] Moreover, most presentation skills textbooks do not target the NNES, operating under the apparent assumption that English proficiency skills will never be an issue.[11,12]

Some researchers have thus taken a multi-modal approach to analyzing DS interactions, focusing heavily upon both speaker and commenter paralanguage, noting that such skills are rarely taught to NNESs,[9] while others have performed analyses of DSs through intonation and related prosodic patterns.[13] Very few researchers, however, appear to have focused upon pragmatic strategies employed by the speakers in response to questions and comments in the DS despite the fact that strategic competence has been considered a pillar of overall communicative competence for over thirty years.

2. Methods

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

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

of DS skills.

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

- What types of questions or comments were typically asked or made?
- What strategies did presenters use to manage lengthy, adversative, difficult, or awkward questions or comments?
- What caused communicative breakdowns and how did the NNES presenters manage (or mismanage) them? Answering this question was also informed by subsequent interviews with 8 Japanese presenters.

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

3. Results and Observations

3.1. Patterns of discourse in questions and comments

Five typical pragmatic functions in DS comments and questions have been noted by Webber,[14] expressed as follows:

Type 1a: information eliciting (facts)

Type 1b: information eliciting (opinions)

Type 2: criticism or attack

Type 3: suggestions

Type 4: comments

Type 5: more than one of the above pragmatic functions

Utilizing this typology, in a study of post-presentation DS interactions at a conference in Hong Kong,[13] it was noted that by far the common responses (total n=61) were those of type 1a (information eliciting: facts; n=38) and type 5 (a combination of the other 4 pragmatic functions; n=20), the latter most commonly made up of combinations of types 1a and 4 (eliciting facts plus comments; n=8) and types 2 and 4 (criticism plus comments; n=9), followed by type 1b (information eliciting: opinions; n=10), with the other types being noted only very rarely (n=2 or less).

In my own observations, although I was not strictly following Webber's typology, types 3 and 4 (suggestions and com-

ments respectively) were also widely deployed as stand-alone items (n=15 each), as well as in combination with the other pragmatic function types (which may indicate additional cultural or English proficiency factors, since Webber's subjects were all NESs) indicating a degree of balance across all response categories. Although Webber's categories are fluid, and thus estimates may be a bit approximate, I identified the following frequencies of Webber's first 4 types as follows (the total include types used in combinations, thus the number exceeds 110):

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

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

3.2. Effective DS response strategies

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

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

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

Thanking the commenter for a critical or adversative comment is widely recognized as a face-saving measure for both the speaker and the audience.[3,4] As an indirect means of addressing criticism,[8] which in Webber's study made up a significant 52 of the 130 comments observed,[14] this also has the effect of potentially mollifying and/or deflecting further criticism and is thus an effective strategy when responding to adversative comments.

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

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

2. **Asking for brief rephrasing:**

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

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

A request for clarification might also be perceived as a challenge by the presenter, especially if the question is difficult to answer.[14] Head-nodding from the presenter during the commenter's speech is a common indicator as a signal of cognitive assent.[15] A lack of such prosody, or an adversative one such as a visual expression of confusion, should help indicate to the commenter that his/her is not being fully comprehended. Many will take this as a cue to reformulate or summarize without any explicit request to do so from the presenter.

3. **Asking for a stylistic adjustment:**

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

At a truly international conference the onus is upon every participant to adjust their English expectations to the reality that a wide variety of international Englishes will be employed and that many participants will not be native English speakers (NESs). NNESs, particularly Japanese presenters, are inclined to think that breakdowns and misunderstandings represent a failure on their part.[1] However, ques-

tions and comments from the floor are not always articulate or well-formed. Often, the obvious limitations of the presenter's English skills are ignored. However, this can, and perhaps should, be recognized as a communicative failure on the part of the insensitive commenter, not the confounded listener.

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

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

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

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

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

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

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

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

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

Initially, evasion may seem to be a deceptive tactic. However, hedging *("I think...")*, is widely used as a strategy in situations where the presenter does not feel qualified to offer a conclusive response in DS settings.[5] Evasion tactics are readily used when questions asked fall outside the scope of the presentation.[14]

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

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

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

Often, it appeared that the commenter simply wanted the opportunity to present their own view or explain their own practices, without having a specific question per se. In some cases, returning a question to a commenter who clearly wanted a turn to indulge their views was effective. Rather than focusing upon the presenter's possible errors or short-

comings and concocting a defense thereof, a legitimate and effective strategy was to simply allow the questioner to offer their approach or opinion. Giving the commenter the floor, the right to take a turn, often had an appeasing effect upon the critical commenter. They should be thanked and no further discussion may be needed.

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

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

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

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

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

3.3. Ineffective responses and managing breakdown

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

1. *Saying "I agree with you" or some variation thereof, to appease the critic, even when it was apparent that the speaker and commenter do not agree with each other.*

The speaker may have been using this as a stock response as a face-saving measure, but conversely, this immediate capitulation had the effect of devaluing the speaker's research presentation efforts, making the speaker appear wavering and indecisive, by immediately seceding academic ground to critics.

2. *"..." (no response for several, agonizing, seconds).*

On these occasions (n=5, all Japanese speakers), it was apparent that the speaker had not grasped the question/comment adequately and, further, could not retrieve an English strategy to address this breakdown. Post-presentation interviews with two Japanese speakers who suffered such breakdowns revealed that they were ashamed of not being able to comprehend the comment, and, because they felt personally responsible for the breakdown, did not feel it was incumbent upon them to force the speaker to repeat or rephrase the question, and that it would be impolite to imply that the breakdown was the questioner's fault.

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

3. *Responding without clearly understanding the question or comment.*

This was noted on an estimated 9-13 occasions (this number being an estimate because it is possible that even though the speakers may fully have understood a question, they may have digressed or offered opaque responses for other reasons). It was noted that this occurred more frequently with other NNES Asian presenters than with Japanese. In the vast majority of these cases (with only one exception) no attempt was made by the speaker to check the suitability or efficacy of their response, which had the upshot of making the presenter seem evasive or otherwise ignoring the commenter's point. As this can leave an audience perplexed or destroy rapport with the audience, once again the importance of using clarification strategies is paramount.

4. Discussion

Japanese-language guides to presenting in English tend to offer up DS advice in the form of numerous set phrases to be memorized but lacking value in real-world settings.[12] However, I would contend that given the pivotal role that formulating situationally-appropriate responses plays in CPs,[3] a focus

upon pragmatic strategies, rather than the memorization of set phrases, would have more beneficial applications for Japanese and other NNES presenters managing DSs.

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

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

It has also been observed that many questions and comments followed a frame-issue-question sequence,[14] meaning that the framing of an issue, followed by a reference to a slide or part of the presentation content or theme would precede the actual question. This held true for my observations as well and thus provides presenters in DSs with a type of rhetorical scaffold.

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

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

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

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

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

In order to overcome this problem, presenters should be trained to avoid viewing DSs primarily as a form of evaluation (or, more precisely, of being evaluated) and more fundamentally regard them as opportunities negotiate, clarify, and

expand. Teacher/trainers would do well to remind NNES presenters that many in the audience will also likely be NNESs who are sympathetic to the speaker's lack of English proficiency. Furthermore, teacher/trainers should imprint upon novice presenters that the onus of formulating a comprehensible comment or question is upon the speaker and consequently, that the fault in misunderstandings and miscommunication may in fact lie more with the commenter. Presenters should not be made to feel that they are to be blamed for every breakdown, but, most importantly, if they do, should have the tools to negotiate repair.

5. Summary and Conclusions

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

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

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

References

1. Ventola E. 2002. Why and what kind of focus on conference presentations? In *The language of conferencing* (Ventola E, Shalom C and Thompson S, eds), Frankfurt: Peter Lang, pp 15–50.

2. Webber P. 2005. Interactive features in medical conference monologue. *English for Specific Purposes Journal* **24**(2): 157–181. [http://dx.doi.org/10.1016/j.esp.2004.02.003]

3. Shalom C. 2002. The academic conference: A forum for enacting genre knowledge. In *The language of conferencing* (Ventola E, Shalom C and Thompson S, eds), Frankfurt: Peter Lang, pp 51–68.

4. Rowley–Jolivet E and Carter–Thomas S. 2005. The rhetoric of conference presentation introductions: context, argument and interaction; context, argument and interaction. *International Journal of Applied Linguistics* **15**(1): 45–47.

5. Wulff S, Swales J and Keller K. 2009. "We have about seven minutes for questions": The discussion sessions from a specialized conference. *English for Specific Purposes* **28**(2): 79 – 92. [DOI: 10.1016/j]

6. Anthony L. 2008. Improving the Q&A Experience: A Collaborative Effort. *IEEE PCS Newsletter* Vol. 52, No. 11.

7. Hyland K. 2009. *Academic Discourse English in a Global Context.* London: Continuum.

8. Querol–Julián M and Fortanet–Gómez I. 2012. Multimodal evaluation in academic discussion sessions: How do presenters act and react? *English for Specific Purposes Journal* **31**(4): 271–283.

9. Heino A, Tervonen E and Tommola J. 2002. Metadiscourse in academic conference presentations. In *The language of conferencing* (Ventola E, Shalom C and Thompson S, eds), Frankfurt: Peter Lang, pp 127–146.

10. Guest M. 2013. Japanese Doctors at International Medical Conferences: Why the Worry? *J Med Eng Educ* **12**(3): 47–55.

11. Anthony L, Turk DC, Yamazaki AK and Orr T. 2006. Q&A: Published advice vs. real-world difficulties. In *IEEE International Professional Communication Conference,* pp 11–21. [4114144] 10.1109/IPCC.2006.320371

12. Orr T, Gupta R, Yamazaki A and Anthony L. 2008. Presenting in English to international audiences: A critical survey of published advice and actual practice. In *Connecting people with technology: Issues in professional communication* (Hayhoe G and Grady H, eds), Amityville, NY: Baywood, pp 97–108.

13. Cheng W. 2004. 'Well thank you David for that question': The intonation, pragmatics and structure of Q&A sessions in public discourses. *The Journal of Asia TEFL* 1/2: 109–133.

14. Webber P. 2002. The paper is now open for discussion. In *The language of conferencing* (Ventola E, Shalom C and Thompson S, eds), Frankfurt: Peter Lang, pp 227-253.

15. Jurado JV. 2015. A multi-modal approach to persuasion in conference presentations. In *Multimodal Analysis in Academic Settings: From Research to Teaching* (Crawford–Cammiciottoli B and Fortanet–Gomez I, eds), Routledge: London. pp 108–122.

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

Chieri Noda

Department of Applied Linguistics and Communication, Birkbeck, University of London

Using needs assessment for reevaluating and refining existing courses is an important undertaking in English for Specific Purposes (ESP) course development. In response to the findings of earlier student surveys which showed that students wanted opportunities to engage their medical knowledge in more challenging ways, trial lesson materials were devised for use in four 4th-year English for Medical Purposes (EMP) lessons. The materials centered around case presentations on topics which had been taught in concurrent clinical lectures given in Japanese. Handouts included the following: 1) preparation using an English-Japanese terminology list, 2) introduction to the structure of case presentations, 3) short discussion on accompanying images/photos, 4) comprehension/fill-in-the-blanks listening activity, and 5) language-focused activities. Student feedback was obtained using a Likert scale questionnaire consisting of three questions together with an open-ended question asking for comments and suggestions for improvement. The survey revealed that the majority of students were confident in dealing with the medical content, and many found the EMP lessons to be of value as a revision of content learned in their Japanese clinical lectures. The majority of students found the trial lessons to be beneficial as EMP lessons.

J Med Eng Educ (2016) 15(1): 29–36

Keywords English for medical purposes, English for specific purposes, needs analysis, case presentation

1. Introduction

Ongoing needs assessment is an integral component of ESP course development.[1-4] Particularly important is taking learner perspectives (e.g. self-perception, awareness of target situations, expectations for the lesson) into account when reevaluating and refining existing courses.[4,5] For those involved in curriculum development in the field of EMP, designing courses that are motivating and relevant for students is of vital importance given the increased importance placed on acquiring proficiency in English to meet global standards of medical education.[6]

The findings of student surveys conducted at Tokyo Medical University in the academic year 2012–2013[7] showed that while many students rated highly the fact that the university's EMP course at the time ran in parallel to clinical lectures in Japanese, some felt the course could be improved if the materials compelled them to engage their medical knowledge in more challenging ways. Students who had returned from the university's newly launched one-month clinical clerkship program abroad also pointed out in interviews and questionnaires conducted in 2012 and 2013[8, 9] that while the terminology learned as part of the EMP course provided a sound basis for interacting with their peers abroad, the university's EMP course could be improved by incorporating the teaching of more functional phrases for communicating in clinical settings.

To respond to such student expectations, a new set of trial materials using case presentations was developed for use in the summer term of 2013. Case presentations were a natural choice, as they are a genre that filled the gap between doctor-patient consultations and journal articles, both of which were already part of the EMP course. It was hoped that case presentations would offer stimulating and relevant content

● **Corresponding author:**

Chieri Noda

Doctoral Research Student, MA in Communication

Department of Applied Linguistics and Communication

Birkbeck, University of London

26 Russell Square, London WC1B 5DQ

Email: cnoda01@mail.bbk.ac.uk

The trial lessons and surveys described in this paper were undertaken as part of the EMP program at Tokyo Medical University, where Chieri Noda was a faculty member until August 2013. The observations in this paper only concern the program at the time and in no way extend to the current program. Chieri is now completing her doctoral research at Birkbeck, University of London.

for the students while at the same time offering opportunities for reinforcing medical phraseology. The decision to use case presentations as the core text was also prompted by the successful use of case presentations in EMP courses at other institutions.[10, 11]

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

2. Methods

2.1. Participants

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

2.2. Teaching Materials and Lessons

2.2.1. Selection of case presentations

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

2.2.2. Terminology list

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

would help students activate the medical knowledge they had recently acquired in Japanese.

2.2.3. Worksheet

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

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

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

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

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

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

2.2.4. Listening activity

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

2.2.5. Assessment

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

2.2.6. Lesson plans and pre-lesson meetings

To ensure consistency of what was taught in the six groups, a lesson plan for each lesson was sent to the instructors and

pre-lesson meetings were held. As there was some concern over whether the material could be taught by a language instructor alone, it was emphasized that the instructor's role was to engage the students' medical knowledge and elicit output in English by asking pertinent questions.[15]

2.3. Questionnaire Survey

2.3.1. Student Feedback Sheet

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

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

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

2.3.2. Instructor Feedback Sheet

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

3. Results

3.1. Students' feedback

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

3.1.1. Responses to Statement 1: I had difficulty following the lesson because the English was too difficult
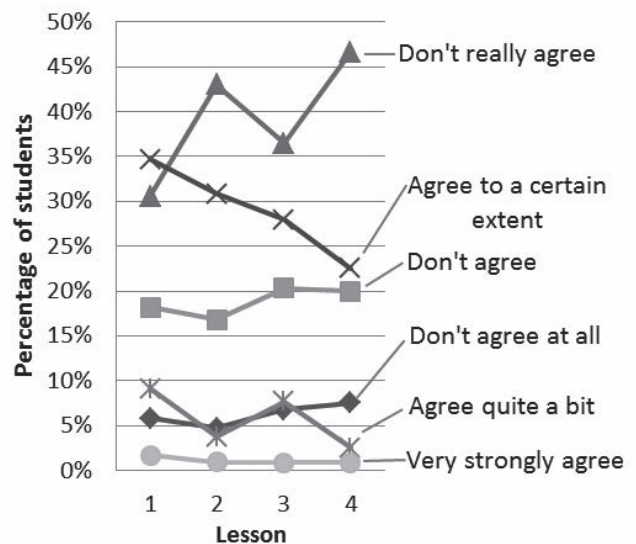

Fig. 1. Student responses to Statement 1: I had difficulty following the lesson because the English was too difficult
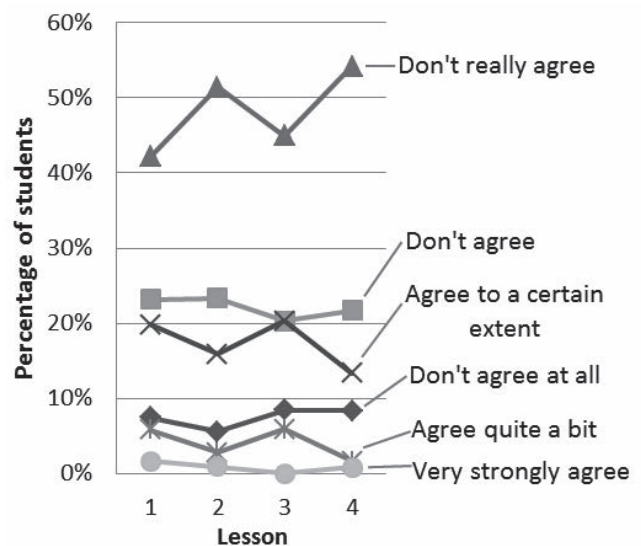

Fig. 2. Student responses to Statement 2: I had difficulty following the lesson because the medical content was too difficult
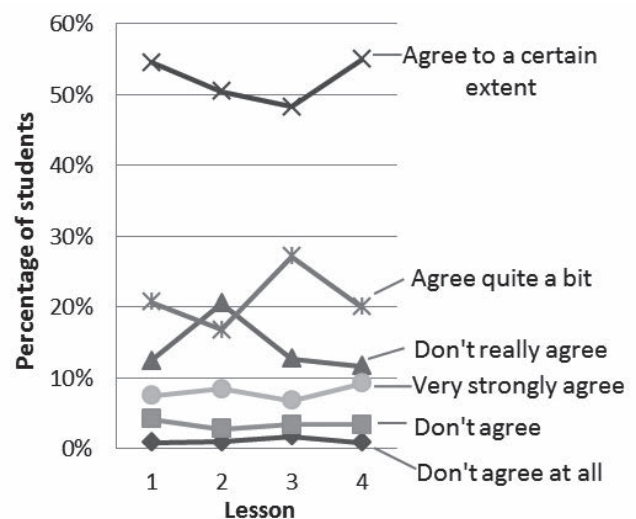

Fig. 3. Student responses to Statement 3: Was beneficial as a medical English lesson

The percentage of students who responded "agree to a certain extent" decreased steadily from 34.7% to 22.5% over the four lessons while those selecting "don't really agree" decreased from 30.6% for Lesson 1 to 46.7% for Lesson 4. Also notable was the decline in those selecting "agree quite a bit," which started at 9.1% and ended at 2.5%.

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

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

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

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

3.1.4. Student comments

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

Most of the 14 comments on the overall impression were positive and included responses such as: "It was good we got

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

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

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

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

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

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

3.2. Instructors' feedback

Written feedback in English was received from two instructors. The two instructors (henceforth Instructor A and B) expressed contrasting views of their experience using the trial materials. Instructor A was, on the whole, positive, commenting that it was good to let the students know about case presentations and that the students seemed to like them more than the instructor had expected. Specifically, the

instructor noted that the terminology list was "helpful" and the inclusion of the structure of the case report in Worksheet 1 was "very helpful." The instructor pointed out, however, that having multiple worksheets (i.e. a terminology sheet and the trial worksheets in addition to the regular teaching material) was troublesome and sometimes confusing.

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

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

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

skeptical about the appropriateness of the worksheets strongly agreed that the lesson was beneficial as a medical English session.

4. Discussion

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

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

It is noteworthy that 40% of these students had previously responded in a 3rd-year questionnaire that case reports would be suitable as material in their 5th–6th year.[7] This is a reminder that students' perception of what might be appropriate as EMP material, and when to tackle it, may change as they accumulate knowledge and progress through their time at college.

While the responses were on the whole favorable, it is also important to take note of the negative comments. The Likert scale responses of the student who wrote, "The material is not really worth doing in class. It can be done on one's own" was consistent across all four lessons. The student responded "agree to a certain extent" to Statement 1 on the difficulty of English, "do not agree at all" to Statement 2 on the difficulty of the medical content, and "don't really agree" to State-

ment 3 on whether the lessons were beneficial as an EMP lesson. Taken together, the student's comment seems to have been based on a combination of the medical content being not challenging enough and the worksheets being too simple.

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

What can be learned from this feedback is that there is scope for improvement in communicating the purpose of the lessons for both teachers and students. One essential point that was not sufficiently conveyed was the fact that the worksheets were aimed not so much at reinforcing the students' grammatical knowledge, but at creating awareness of the linguistic and structural conventions used in case presentations to allow the students to become competent users of the language used in this particular genre. For example, the aim of the exercise in Worksheet 2, in which students had to change sentences from the passive to the active voice, was not to teach a grammatical point, but to draw attention to the convention of using passives[18] to avoid mentioning the agent of the action (e.g. "the round mass was removed" rather than

"we removed the round mass"). Similarly, the aim of the exercise in Worksheet 2, in which students had to match diagnostic procedures with findings (e.g. "Angiography revealed total occlusion of the artery"), was to focus on the use of technology as the subject in active sentences, another distinctive feature of this genre.[18] These points should perhaps have been emphasized in the pre-lesson meetings and incorporated into the worksheets.

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

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

1	admitted to the hospital with *(symptom/medical condition)*	*(症状/疾患)*で入院する
2	oral glucocorticoids	経口グルココルチコイド
3	progressive	進行性の
4	associated *(symptom)*	関連する、併発する*(症状)*
5	post-tussive emesis	咳嗽後嘔吐

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

Today's Case

Warm-up activity: Terminology

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

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

whooping	**bacterial**	**pertussis**	**vaccine**
diphtheria	**adolescents**	**tetanus**	

Activity 1: Focus on the images

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

Activity 2: Focus on the content

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

    a. How old is the patient?

    b. What were his presenting symptoms?

    c. What did the medical team notice after his admission?

---

* The answers to the fill-in-the-blanks activity are shown in cursive font. The layout has been altered for publication.

aspiring medical professionals. How well instructors can utilize the students' medical knowledge as a resource might be the key to the success of EMP lessons with heavy medical content. Although collaboration with subject specialists will be essential for offering full-fledged content and language integrated learning, this study offers encouraging insights into the possibilities of using material with heavy medical content by the language instructor alone.

Instructor B also raised a pedagogical recommendation which was further brought up by some students—that the activities should be done orally rather than in writing. Such oral practice may be beneficial, especially considering the emphasis placed on acquiring well-balanced English language competencies.[6] To serve as a model for oral practice, instead of having just one recording, two recordings can be made—one delivered naturalistically and the other delivered clearly at a consistent and slower speed.

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

---

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

Activity: Focus on the Language

| Part I – Adjectives |

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

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

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

[questions c to e have been omitted]

| Part II – Adverbials of Time |

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

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

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

[questions h and i have been omitted]

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

The layout has been altered for publication.

Appendix 4: Student feedback sheet

Student Feedback Sheet

ID:＿＿＿＿＿＿　氏名:＿＿＿＿＿＿＿＿＿＿＿

医学英語の授業内容の改善のために、アンケートにご協力ください。

画像と症例報告を使用した教材について伺います。該当する欄に✓を入れてください。

なお、記入されたコメントは評価の対象にはなりません。

Worksheet 1						
	全くそう思わない	そう思わない	あまりそう思わない	ある程度そう思う	かなりそう思う	とても強くそう思う
1) 英語が難しすぎて授業についていけなかった						
2) 医学的に難しすぎて授業についていけなかった						
3) 医学英語の授業として有益だった						
その他、WorksheetやActivityについてよかった点、改善点などをご記入ください。						

コメントは日本語・英語どちらでも結構です。

ご協力ありがとうございます。

Thank you for responding to this questionnaire.

* The layout of the questionnaire has been altered for publication

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

5. Conclusion

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

References

1. Richards JC. 2001. *Curriculum Development in Language Teaching.* Cambridge: Cambridge University Press.
2. Shi L. 2009. English for Medical Purposes. In: *English for Specific Purposes in Theory and Practice.* (Belcher D, ed) University of Michigan. p. 205–228.
3. Belcher D. 2009. What ESP is and can be: an introduction. In: *English for Specific Purposes in Theory and Practice.* (Belcher D, ed) University of Michigan. p. 1–20.
4. Tsou W and Chen F. 2014. ESP program evaluation framework: Description and application to a Taiwanese university ESP program. *Eng Spec Purp* **33**:39–53.
5. Tudor I. 1997. LSP or Language Education? In: *Teacher Education for Languages for Specific Purposes.* (Howard R. and Brown G, eds) Multilingual Matters. p. 90–102.
6. Japan Society for Medical English Education. 2015. *Medical English education guidelines Corresponding to the Global Standards for Medical Education.* <http://www.medicalview.co.jp/JASMEE/Guidelines_Eng_rev.pdf>.
7. Noda C and Watanabe A. 2014. Future directions for curriculum development in English for medical purposes: a closer look at student needs. *J Med Eng Educ* **13**(3):65–74. [In Japanese]
8. Noda C and Watanabe A. 2012. A survey of English usage during the 2012 pre-graduation overseas clinical clerkship program [v1; not peer reviewed]. *F1000Research* 2016, **5**:122. Poster presented at the 170th Tokyo Medical University *Igakukai Sokai* in November 2012. [In Japanese. doi: 10.7490/f1000research.1111283.1]
9. Noda C. 2013. A report on an English workshop and orientation for the 2013 pre-graduation overseas clinical clerkship program [v1, not peer reviewed]. *F1000Research* 2016, **5**:123. Poster presented at the 171st Tokyo Medical University *Igakukai Sokai* in June 2013. [In Japanese. doi: 10.7490/f1000research.1111284.1.]
10. Martinez MSG and Cilveti LD. 1998. Using case reports in teaching medical English. In: *Language Policy and Language Education in Emerging Nations: Focus on Slovenia and Croatia and with Contributions from Britain, Austria, Spain, and Italy.* (De Beaugrande R, Grosman M and Seidlhofer B, eds) Ablex. p. 263–272.
11. Janjua N. 2014. Using case studies to develop effective medical English teaching materials and methods for Japanese undergraduate programs. *J Med Eng Educ* **13**(1):7–14.
12. Doty JR and Doty DB. 2002. Floating Left Atrial Thrombus. *N Engl J Med* **347**(19):e5.
13. Rutledge RK and Keen EC. 2012. Whooping Cough in an Adult. *N Engl J Med* **366**(25):e39.
14. Omar AMA. 2015. Improving reading comprehension by using computer-based concept maps: a case study of ESP students at Ummalqura Univeristy. *Br J Educ* **3**(4):1–20.
15. Rotzoll D, Wienhold R, Weigel A and Wolf R. 2014. Present situation of and future outlook for undergraduate English for medical purposes education in Germany. *J Med Eng Educ* **13**(3):47–54.
16. Krosnick JA, Judd CM and Wittenbrink B. 2005. The measurement of attitudes. In: *The Handbook of Attitudes.* (Albarracin D, Johnson BT and Zanna MP, eds) Mahwah, NJ: Lawrence Erlbaum Associates. p. 21–76.
17. Dörnyei Z and Taguchi T. 2010. *Questionnaires in Second Language Research: Construction, Administration, and Processing.* New York; London: Routledge.
18. Anspach RR. 1988. Notes on the sociology of medical discourse: the language of case presentations. *J Health Soc Behav* **29**(4):357–375.

Learning about legal issues in healthcare through an extracurricular activity

Najma Janjua

Department of Liberal Arts and Sciences and Graduate School of Research
Kagawa Prefectural University of Health Sciences

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

J Med Eng Educ (2016) 15(1): 37–40

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

1. Introduction

Extracurricular activities are generally school-based or school-sponsored activities that are not part of the regular curriculum. Their purpose is to enrich and extend classroom education.[1] Typical examples of extracurricular activities that support curricular achievements are those held through academic-related student clubs such as history club, forensic club, science club or foreign languages club.[2] In addition, a variety of educational lectures, symposia, seminars, and so on, held on campus but separate from regular lectures organized and administered by the school, can also be a significant source of extracurricular learning. However, not much has been written about such extracurricular events as compared to those organized and managed by students. This paper describes a school-organized extracurricular educa-

● **Corresponding author:**

Najma Janjua, Ph.D.

Professor

Department of Liberal Arts and Sciences and Graduate School of Research, Kagawa Prefectural University of Health Sciences

281-1 Hara, Mure-cho, Takamatsu, Kagawa 761-0123, Japan

Phone: 81-87-870-1212 (Ext. 1115)

Fax: 81-87-870-1202

Email: janjua@chs.pref.kagawa.jp

tional lecture in English held at a Japanese health sciences university that provided a unique opportunity for students to learn about legal issues in healthcare, and related language.

2. The extracurricular educational lecture

2.1. Background

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

students of other majors and to the faculty at large, and in some instances to the general public. Before the lecture described here, these lectures had always been given in Japanese by Japanese speakers.

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

2.2. The present lecture

The lecture described in the present paper was given by a visiting US state court judge and was delivered in English. The lecture was made possible through collaboration with a sister-city friendship association between the Japanese town where the university is located and a US city.[3] The title of the lecture was "Healthcare and legal issues in the United States". This title was chosen to suit the academic and professional qualifications of the speaker and to match the needs of the target class of health sciences majors.

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

2.3. The students

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

2.4. Pre-lecture briefing

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

2.5. Post-lecture survey

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

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

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

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

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

Table 1. Ten typical questions (unedited) written in English by the students prior to the lecture

1. I would like to know how to deal with brain death in USA.
2. How is legal issues about death with dignity in the USA?
3. In the trial of the case where the patient died of the operation though the doctor used every trick of the trade, is the doctor side still disadvantageous?
4. I heard that in U.S., there are "nurse practitioner" like semi doctor. So, I would like to know how many legal troubles of it your country have.
5. How is it thought about surrogate mother birth in the United States?
6. We have "Universal Health Insurance Coverage". Is it possible to be realized "Universal Health Insurance Coverage" in USA?
7. I would like to know about issues of citizen jude system.
8. I would like to know about the difference between healthcare and legal issues in the USA and it in the Japan.
9. I would like to know about brain death, organ transplants, insurance, euthanasia, a human killing and artificial insemination in the USA.
10. I would like to know about the actual condition of malpractice in USA.

questions.

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

3. Discussion

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

Japanese university freshmen are generally known to have minimal oral communication competency in English.[4] However, the questions written by the students (**Table 1**) show that they did indeed have the ability to formulate ideas and put them down in writing, even though their listening and speaking abilities may have been limited. Moreover, this suggests that such extracurricular activities can help students to build on their basic knowledge of English through increasing their vocabulary and giving them an opportunity to put their ideas in writing. This would be in agreement with research which shows that extracurricular activities can have a positive influence on students' academic accomplishments.[5]

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

Table 2. Ten typical impressions (unedited) written in Japanese by the students after the lecture (with English translation in parentheses)

1. 医療と法律の問題を考えることはしばしばあるが，海外との比較をしたりするということはなかなかない。新たな見聞の幅を広げるには良い試みだと思います。
(Although we often think about healthcare and legal issues in Japan, comparing the Japanese situation with that abroad is an opportunity not readily available. I think that it was a new and good attempt to broaden our experience.)

2. 「アメリカにおける医療と法律問題」について真剣にお話をしてくれました。分からない単語がたくさん出てきたけれど，先生の熱意が伝わってきて，法律問題にも興味を持つことができ，良い経験になりました。
(The lecturer talked earnestly about "Healthcare and legal issues in the United States". Although there were many words that I did not understand, the presenter's zeal was conveyed and I could get interested in legal issues as well. It became a good experience.)

3. 話を聞いて，アメリカの医療や法律について学ぶことができました。また，日本との違いについても知ることができ，とても勉強になりました。
(By listening to the talk, I was able to learn about healthcare and law in the United States. Moreover, I could know about differences between the Unites States and Japan. I learned a lot from the lecture.)

4. 日本とアメリカにおける医療と法律は異なる部分もあった。いくつかの法律問題の事例を挙げて，私たちに考える場面を与えて下さったり，いろいろな考え方を紹介して下さったり，分かりやすい講義内容だった。
(There are differences between Japan and the United States in healthcare and legal issues. The lecturer presented us with situations to think about and introduced various ways of thinking by giving several examples of legal issues. It was an easy to understand lecture.)

5. アメリカは，数多くの面で日本よりも優れた医療技術をもっているので，そのような国の医療の講義は興味深かったです。
(Because medical technology in the United States is superior to Japan in a lot of respects, listening to a lecture on healthcare of such a country was very interesting.)

6. アメリカにおける医療と法律問題についての講義を聞いて，これはアメリカだけでなく，日本にも深く関わることなので，しっかりと考える必要がある内容だと思いました。
(I thought that the content of the lecture required serious thinking because it was related deeply not only with the United States but also Japan.)

7. アメリカの医療について知らなかったので今回話を聞いてとても勉強になりました。アメリカの医療について興味が持てたので自分でも調べたり勉強したいと思いました。
(Because I did not know about healthcare in the United States, I learned a lot from this lecture. Also I became interested in American healthcare and felt like studying about it on my own too.)

8. とても興味深い内容だったので話を聞くことができてよかった。このような機会はなかなかないのでよかった。
(Because its content was very interesting, it is good that we could hear the lecture. It was good also because we usually do not have such a chance readily available.)

9. アメリカにおける医療と法律問題について話を聞いて日本とどんな違いがあるかよく分かった。制度が違うと状況もかなり変わるということが分かった。他の国のいい所を日本も見習って日本の医療も良くなればいいと思った。
(After hearing the lecture on American healthcare and legal issues, I understood well the differences between Japan and America in this area. I understood that when the systems are different, the conditions are considerably different too. I felt that Japanese medicine could improve by following the good aspects of other countries.)

10. 看護師を目指す私たちにとってとてもためになる講義だったと思う。もっと法律について学び，世界の医療についてもっと知りたいと思った。
(I think that it was a very good lecture for us who aim at being nurses. It made me want to learn more about law and global healthcare.)

to face in the future. This is especially reflected by comment 10 in **Table 2** where the student states (as translated into English) the following: "It was a very good lecture for us who aim at being nurses. It made me want to learn more about law and global healthcare."

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

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

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

4. Conclusion

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

References

1. Maine School Administration District No. 40 (MSAD40) Files. Cocurricular Activities, 2007. <http://www.msad40.org/files/JJ-COCURRICULAR_ACTIVITIES.pdf> [Accessed 2015 Oct 1].
2. Cordts D. 2006. Promoting Student Activities. Education News-redOrbit. <http://www.redorbit.com/news/education/396425/promoting_student_activities/index.html> [Accessed 2015 Oct 1]
3. Mure Elberton Friendship Committee. <http://www.cityofelberton.net/sistercity/history.htm> [Accessed 2015 Oct 1]
4. Hughes R. 2005. The MEXT English Education Reform Objectives and Student Motivation. *Journal of Regional Development Studies* 353-359. <http://rdarc.itakura.toyo.ac.jp/webdav/frds/public/kiyou/rdvol8/rd-v8-353.pdf> [Accessed 2015 Oct 1]
5. Fujita K. 2006. The effects of extracurricular activities on the academic performance of junior high students. *Undergraduate Research Journal for the Human Sciences* 5: 1-15. <http://www.kon.org/urc/v5/fujita.html> [Accessed 2015 Oct 1]
6. Zhao C, Kuh GD, Carini RM. 2009. A comparison of international student and American student engagement in effective educational practices. National Survey of Student Engagement. Indiana University Bloomington, Center for Postsecondary Research and Planning. <http://www.nsse.iub.edu/pdf/research_papers/international.pdf> [Accessed 2015 Oct 1]
7. Wong JJ. 2009. Extracurricular Education: Improving education outcome by supporting experiential learning. Harvard College. <http://www.scribd.com/doc/15538845/Extracurricular-Education> [Accessed 2015 Oct 1]

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

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

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

J Med Eng Educ (2016) 15(1): 42–46

1. はじめに

　放射線医学は，レントゲン博士がX線を開発された1895年に産声を上げました。私どもの日本医学放射線学会は1940年にアジア他国に先駆けて創設され，現在は会員数約9000名であり，世界最大規模の放射線医学会の一つです。

　私たち日本医学放射線学会には3つのミッションがあります。第一に国民に対し安全で質の高い放射線医療を提供すること，第二に全国の放射線科医に対し研究や教育の場を提供し優秀な放射線科医を育成すること，第三に国や世界の放射線医療体制づくりと維持に貢献することです。残念ながら，第三のミッションを遂行するための「国際化」については活動が長らく停滞していました。しかし，2010年前後より学会理事会を中心に「国際化」に対するさまざまな具体的試みを開始しました。

2. 国際化に取り組みだした背景

　最大の背景は，国際放射線医学界における我が国の存在感の相対的低下に対する大きな危機感です。

　かつては，日本の放射線科医の海外に対する姿勢は大変積極的で，欧米の一流の国際雑誌における我が国発の論文掲載はアジアでも群を抜いており，海外留学を希望する者も多数いました。しかしながら近年，国際雑誌における我が国の論文掲載は伸び悩みあるいは減少の一途をたどっており，一方，韓国，中国等のアジア諸国からの論文掲載が目立って多くなってきました（**図1**）。また，欧米学会でア

ジア諸国の参加者が激増しているのに対して，我が国の若い放射線科医の参加は減ってきており，海外留学希望者も少なくなっています。我が国では，多くの諸外国と異なり放射線医学に関する自国語の優れた教科書や雑誌があること，現状の学習・職場環境が比較的良く，あえて海外にそれを学ぶ必要がないと感じること，インターネットを通じて海外の情報が容易に入手できること，海外生活における日常的リスクが増してきていることなどがこれら最近の動向の裏事情としてあると思われますが，統計等で明らかにされているわけではありません。我が国全般で問題になっているいわゆる「ガラパゴス化」が我々放射線医学の分野でもみられているということだと思います。

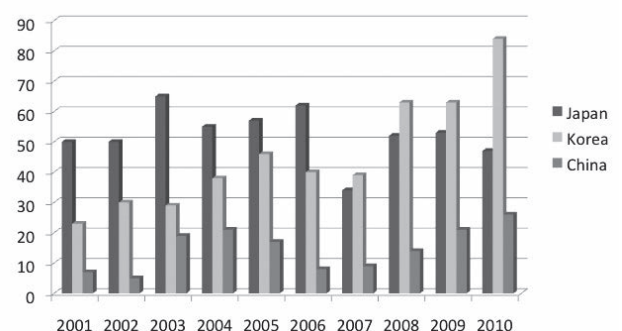　このような我が国の最近の傾向と比べると，アジア諸国は積極的に国際化を進めているように思います。特に国際意識に優れた韓国放射線医学会はさまざまな戦略的視点を

図1　Radiology・AJRの掲載論文数—中国，韓国との比較
(Lim KJ: *Radiology* 264: 796–802, 2012)

Radiology: RSNAの学術雑誌，AJR: 米国放射線学会 (ARRS) の学術雑誌

もって国際化を推進してきました。具体的には，学術誌である Korean Journal of Radiology が1を超える impact factor を常時獲得してその国際的存在感を増してきたこと，アジア諸国を対象に韓国でさまざまな国際会議を開催して自国の放射線医学の優位性を示すこと，アジア諸国の若い放射線科医を対象にさまざまな教育セミナーを行い放射線科医育成に国際貢献すること，ホームページや電子メールを用いてさまざまな情宣活動を英語で行うなどです。彼らの年次学術集会である Korean Congress of Radiology では約70％の発表は英語で成されており，外国からの参加者も増加していると報告されています。

また，前述の Korean Journal of Radiology は2000年から出版されていますが，オープン化された peer review journal であり，放射線医学のアジア圏での国際英語雑誌の先駆け的存在となりました。また，impact factor を上げるためのさまざまな戦略的努力を重ねてきています。それは，総説を多く掲載して引用されやすくする，Korean Journal of Radiology に掲載された論文をほかの国際雑誌でお互いに引用するようにする，引用されにくいとされる症例報告は掲載しないなどのようです。

また，学会事務局活動そのものも，国際学会を取り扱う学会運営会社に委託して，海外との通信や交流を容易にさせています。もちろんホームページは完全に英語化されており，私のところにもしばしば韓国放射線医学会から英語で学会参加募集のお知らせが来ます。韓国では，医科大学での教科書はほとんど英語であったりするので，基礎部分が違うといえばそれまでですが，学会で会う若い韓国の放射線科医が非常に流暢な英語で話すので，米国のどこの大学に留学したのかと尋ねると，米国留学歴はないといわれてびっくりすることもあります。また，彼らの国際化の背景の中には，昇進していくためには学会活動や論文執筆において国際的活動を当たり前のようにしくてならないという事情もあるようです。

いずれにせよ，気が付くと，いつの間にかアジアの学術的トップであった私たち日本医学放射線学会は，隣国の国際化のはるか後塵を拝する状況にあり，今何とかしないと取り返しがつかない状況にあることを認識したわけです。また，ヨーロッパでは，ヨーロッパ連合 (EU) の設立後にヨーロッパ各国の放射線医学会が集合して2005年にヨーロッパ放射線医学会 (European Society of Radiology; ESR) が結成されました。そして，毎年春にウイーンで European Congress of Radiology (ECR) が開催されており，その共通言語はもちろん英語です。アジアで，そしてヨーロッパで世界的に国際化（英語化）が拍車されていたわけです。

3. 国際化のための活動
　—その１：学術雑誌の国際化

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

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

　投稿論文数が多くなると査読が大変になるのはもちろんですが，多くの学会員査読者は快く査読を引き受けてくれて，出版に遅滞影響が出るようなことはありません。現在，年間最も多く査読してくれた会員には学会より最優秀査読者賞を差し上げています。また，投稿も最近は近隣アジア諸国だけでなく，イタリア，トルコなどからも多数投稿されています（**図3**）。これは，後述のそれらの国との学会同士の交流により，各ホームページにお互いの学術誌が掲載され，お互いがそれを自由に読むことができることが大きく影響しているようです。ちなみに2014年の全投稿数は541編であり，そのうち海外からの投稿数は400編（73.9％）に上りました。論文の採択率は19.1％ です。採択から掲載までの平均日数は2011年に184日であったのが，2014年には100日に短縮されています。また，impact factor もつくようになり，2013年は0.742であったのが，2014年には

0.837となり，徐々にではありますが，上昇傾向です。さらに，雑誌の評価を上げるため，症例報告は掲載しないことが最近の理事会で決定しました。もちろん，症例報告も大事ですので，別雑誌での掲載等の方法を考慮しているところです。

て各大学の放射線科教授にこの2点についてぜひご協力いただきたいとのお願いのお手紙を送りました。特に若い先生にはぜひ英語での口述発表をするように励ましていただきたいとお願いしました。また，発表に際しては英語，日本語，どちらでもよい，という選択肢をつくり，どちらで

4. 国際化のための活動
　　—その2：学術集会の
　　国際化

　続いて行ったのは学術集会の国際化です。私どもの学会は4月に開催地を横浜に固定して医学放射線学会総会を，秋には開催地を固定せず秋季学術大会を開催します。秋季学術大会はどちらかというと教育的内容が多く，参加者も2000名程度ですが，4月の総会は学術発表中心の内容であり，5000名以上の学会員が参加します。また，この時には，Japan Radiology Congress (JRC) として，日本放射線技術学会総会学術大会，日本医学物理学会学術大会，さらに日本ラジオロジー工業会による国際医用画像総合展によるCTやMRIなどの画像機器展示が同時開催されるため，会場のパシフィコ横浜には2万人以上の関係者が集まります。大変規模の大きな学術集会ということになります。この4月の総会を，私たちは2012年から2014年にかけての三か年計画で国際化することを理事会で決めました。以下のように計画を立て，それを遂行したのです。

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

　私自身はこの三か年計画の最終年である2014年の大会長をさせていただきましたが，2012年，2013年と計画通りに来ましたので，2014年も何とか目標を達成したいと思いました。なかでも懸念されたのが，抄録の完全英語化，英語での口述発表30%ということで，これにより応募演題が減少するのではないかと心配でした。その対策として，演題応募を開始するにあたっ

表1. 月別投稿数

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Jan.	7	3	5	13	8	5	12	11	13	29	23	30	37	50
Feb.	4	3	4	10	12	9	12	13	11	20	27	37	33	42
Mar.	8	6	4	9	13	7	17	7	10	21	22	32	32	49
Apr.	6	3	7	10	8	9	6	20	12	26	31	29	49	46
May	6	4	5	13	10	14	13	8	22	22	22	41	35	45
June	4	4	6	7	4	5	14	7	25	21	28	23	42	42
July	5	4	9	9	8	9	10	15	22	28	29	45	36	41
Aug.	7	9	11	8	9	5	12	15	15	18	29	42	39	41
Sep.	3	6	16	9	12	12	13	13	16	26	24	43	30	41
Oct.	4	1	10	9	11	12	10	10	26	23	21	24	49	44
Nov.	7	3	10	9	9	8	7	9	19	22	26	28	53	53
Dec.	2	2	7	1	7	11	11	7	29	20	27	30	44	47
Total	63	48	94	106	111	106	137	135	220	276	309	404	479	541

2007年6月より電子投稿・査読システム（Editorial Manager®）導入
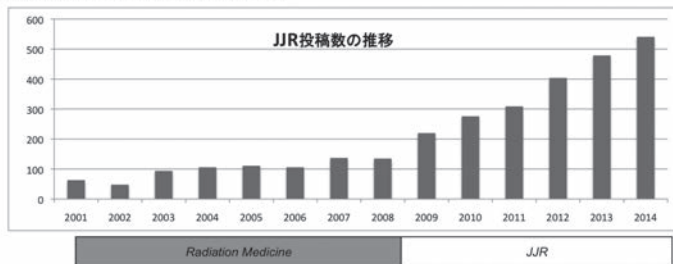
図2　学術雑誌の完全英語化・オープン化の効果

1 Editorial Development　　　　　　4　⌂ Springer
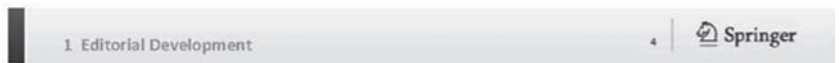
1.4 New Submissions by Location

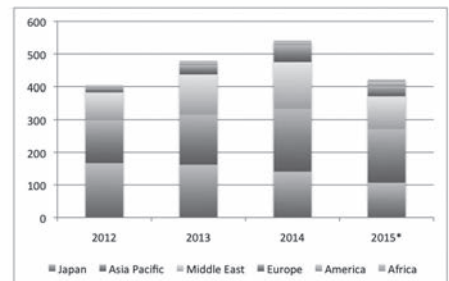| Location	2012	2013	2014	2015*
Japan	167	162	141	107
Asia Pacific	132	154	193	165
Middle East	85	121	141	100
Europe	11	29	53	29
America	6	9	8	13
Africa	3	4	5	8
Total	**404**	**479**	**541**	**422**

*as of Sep 16

図3　地域別投稿数の推移

一般演題（口演）
Oral Session Programs
No special English sessions

1,English presentation
2,Japanese presentation
3,Enlish presentation
4,Enlish presentation
5,Japanese presentation

Moderator can use both of English and Japanese.

The audience can ask a question in English and/or Japanese.

図4　学術集会の国際化

図5　How to improve your English
"From data to English presentation and publication" by Professor Date

図6　JRS 2014
学会場の案内はすべて日英併記。

もよいと選択してくださった応募者には，当日は可能なら英語で発表してくださるように事務局より事前に直接お願いいたしました。

　結果として，一般応募された400演題中140題が英語で発表され，これは35%にあたりますので，目標を上回りました。ちなみに，演題応募時は，28%が英語での発表を希望されており，どちらでもよいと選択してくださった応募者の中には，私たちのお願いを受け入れてくださった発表者が少なからずいたということで，大変うれしく思いました。参考までに，2015年には40%が英語発表とさらに増加しており，私どもの意図を理解してくださる方々が増えたことを示していると思われます。

　発表においては，特に英語セッションといったプログラムは設けず，日本語，英語混合で自由に発表していただきました。座長にもどちらでも結構です，とお願いしました。これは，英語に対する抵抗をなくし，英語のみのセッションへの参加者を減らさないための方策でしたが，会員には特に問題なく受け入れられました（図4）。また，海外から講演に来てくださった先生には，その講演のテーマに沿った一般演題の間でキーノート・レクチャーをしていただくことをベースにプログラムを組みました。これにより，参

加者は海外からの先生の英語講演を一般口演から引き続き拝聴できる状況ができ，会場に多くの参加者を引き留めることができました。How to improve your Englishというシンポジウムでは，日本医学放射線学会理事長の本田 浩 教授自ら座長を務められ，岡山大学脳神経外科学の伊達 勲 教授などから英語上達のヒントとなる教育講演をしていただきましたが，会場外に人があふれる盛況でした（図5）。

　学会のプログラム・抄録集も完全英語化しました。ただし，利便性を図るために会場の案内などは裏側に日本語版も添付しました。また，このプログラム・抄録集の表紙もこの会からオリジナルな表紙に変更して，従来との差別化を図りました。学会場の案内はすべて日英併記として，英語で対応ができるコンシェルジェを配備しました（図6）。海外からの参加者にはこれらの努力は大変好評で，参加して海外の知人から何の不自由も感じないというお褒めの言葉をいただきました。

　これらの学術集会の国際化は，まず，我が国の放射線科医，特に若い放射線科医が国内にいながらにして国際化に親しむことが第一の目標ですが，もちろん，その次のステップとしては，RSNAやECRと同様に諸外国からの参加者を増やしていくことが目標です（図7）。徐々にではありますが，その成果が上がりつつあり，2015年には50名を超える海外からの一般参加者がありました。

5. 国際化のための活動　　　―その3：海外の学会との定期的交流

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

　会議では，お互いの現状を毎回紹介した後に，さまざまなexchange programについて審議され，覚書（MOU）が交

わされています。内容としては，お互いの学術雑誌のホームページにおける紹介，教育講演の交換，学術ポスターの交換などです。教育講演の交換では，お互いに1〜2名の講演者を毎年相互に派遣して，滞在費・参加費は招待側が受け持ち，旅費は派遣側が受け持つという相互平等の原則を貫いています。これにより，日本医学放射線学会総会時には必ず十数名の海外講演者が確保されることとなり，会の潤滑な運営に役立っています。交換フェローシッププログラムについても検討議題に上がりますが，スポンサーの確保が現状では困難であり，あまり話は進みません。しかし，これらの定期的交流は海外の現状を知る上だけでなく，我が国の現状を知ってもらうことでも有効であり，さらに優秀な若手放射線科医を我々側から派遣して講演してもらうことにより，我が国の放射線医学の高いレベルを知ってもらうことにもなります。そのほかに，ECRでは，会場内に日本医学放射線学会のブースを設けて，私たちの学会活動の紹介を行っています。

これらの定期的交流を継続推進するためには，それを担当する人材が必要で，現在日本医学放射線学会では，国際担当理事をアジア，ヨーロッパ，アメリカの各々1名ずつ計3名決めており，これらの理事はその優れた英語力を生かして精力的に活動してくれています。また，代議員会などでも国際交流活動について代議員に報告するようにして，国際活動を会員に周知するようにしています。

図7　世界の放射線医学会とJRS

With ESR board members

With FSR board members

With TSR board members

Exhibition of JRS2016

図8　ECR 2014, 2015 at Vienna

6. 最後に

私たちの国際化の取り組みはやむに已まれぬ状況で始まりました。しかしながら，3つの活動にそれぞれ目標を置きながら活動することにより，ある程度の成果を上げることができました。もちろん，途上であることに変わりなく，今後とも努力を重ねるつもりです。

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

第18回日本医学英語教育学会
教育講演 (Educational lecture)
グローバル化の中のミャンマー医療支援
Medical support to Myanmar in the age of globalization
（岡山コンベンションセンター，2015年7月19日）

木股 敬裕　Yoshihiro Kimata

岡山大学大学院医歯薬学総合研究科形成再建外科
Okayama University Medical School

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

J Med Eng Educ (2016) 15(1): 47–50

1. はじめに

　1988年8月8日は，ミャンマーでアンラッキーナンバーである8が4つも連なる国民的民主化運動勃発の日である。その後，それを鎮圧した軍事政権の支配はさらに強まり，大学の閉鎖，国際的教育・研究面での孤立などが長期間続き，その結果教育水準の低下，研究の劣化とともに，保健医療を含めた劣悪な医療環境が改善されることもなく今も続いている。岡山大学は，各国が支援を取りやめる状況で，共同研究や医療支援を継続して行い，現在までに100名近いミャンマー人を短期長期研修や訪問などで受け入れてきた。実臨床に関しては，形成外科，脳外科，整形外科，麻酔科，消化器内科，乳腺外科など多数の科が，現地での医療の実践とともに医療人の指導を行ってきている。

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

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

2. ミャンマーの医療状況

　Health in Myanmar 2013によれば，死亡疾患の上位は感染症であり，特にAIDSはここ数年上昇傾向で大きな問題になっている。一方，生活環境における安全対策の不備や，急激な経済発展に伴う車を中心とした交通状況の悪化などにより外傷は先進国と比較し圧倒的に多く罹患疾患のトップである。乳児・妊産婦死亡率もアジアで最も悪い状況にある。これはいまだに単胎の自然出産に伴う周産期の合併症，乳児の感染症や劣悪な栄養管理に伴うものである（**図1**）。2013年度の医療費は，日本が38.5兆円と一人当たり30万円を超えるのに対し，ミャンマーは1400億円で一人当たりが2300円である。総GDPは福井県に相当する程度であり，経済成長が見込めるミャンマーではあるが，保健医療という観点からみると非常に大きな課題が山積みである。

罹患疾患、死亡疾患

罹患疾患順位(2011)	死亡順位(2011)
1. 外傷	1. AIDS
2. 妊娠出産の合併症	2. 敗血症
3. 単胎の自然出産	3. 呼吸器疾患
4. 下痢・胃腸炎	4. 肺結核
5. マラリア	5. 肝疾患
6. 妊娠中絶	6. 胎児の障害
7. ウイルス感染	7. 脳卒中
8. 胃炎・十二指腸炎	8. 心不全
9. 白内障	9. マラリア
10. 上気道感染	10. その他心疾患

乳児・妊産婦死亡率

項目		2010	世界子供白書2011
乳児死亡率（出生1000対）	都市	25.6	54
	地方	27.8	
5歳未満死亡率（出生1000対）	都市	34.43	71
	地方	35.11	
妊産婦死亡率（出生1000対）	都市	1.12	24
	地方	1.54	
平均寿命	都市 男	65.8	62
	都市 女	70.8	
	地方 男	64.3	
	地方 女	67.8	

※アジアでも最も悪い状況

図1　ミャンマーの医療状況
(Health in Myanmar 2013より)

3. 岡山大学を中心とした ミャンマー医療支援

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

この点に重きをおいて岡山大学ではミャンマーに対する医療支援を25年以上にわたって行ってきた。その一つに，演者らが中心となっている形成外科領域の人材育成と手術支援がある。ミャンマーの人口は約5000万人に及ぶが，形成外科医師は8人しかいない。外傷による顔面四肢の変形や先天異常などのほとんどが未治療の状態である。このような患者さんを救済するために，ミャンマーの形成外科の若手医師を短期に当科に留学させ，現地で一緒に手術治療を展開している。過去6年間の現地ミッションで300人以上の手術治療を行い，5人の形成外科医を育ててきた。
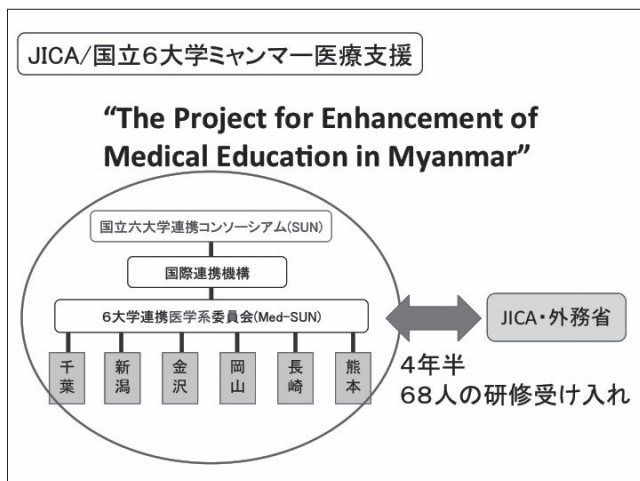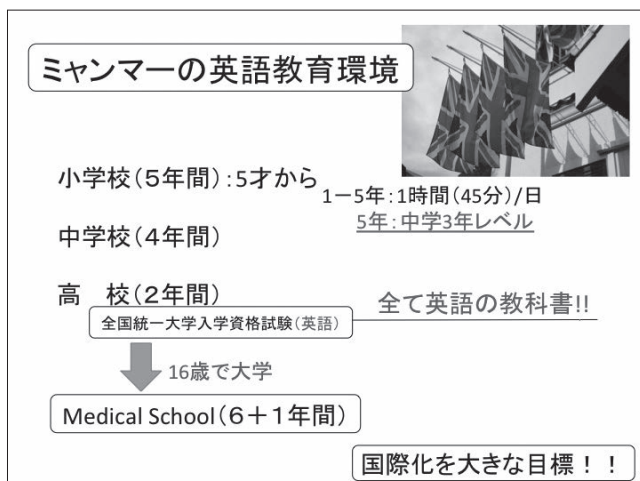
一方，さらなる大きな展開は，JICAと6大学（千葉大学，新潟大学，金沢大学，岡山大学，長崎大学，熊本大学）との連携による大型の医療人材育成プロジェクトである。基礎医学と臨床医学の領域で，4年半にわたり60人の医師と8人の放射線技師を日本で研修させる内容で，2015年の4月から開始された（**図2**）。

4. 国際支援における英語の必要性

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

したがって，ミャンマーの保健省や医科大学，医療系施設での協定や会議，講演なども当然英語が共通言語となる。

図2　JICA/国立6大学ミャンマー医療支援

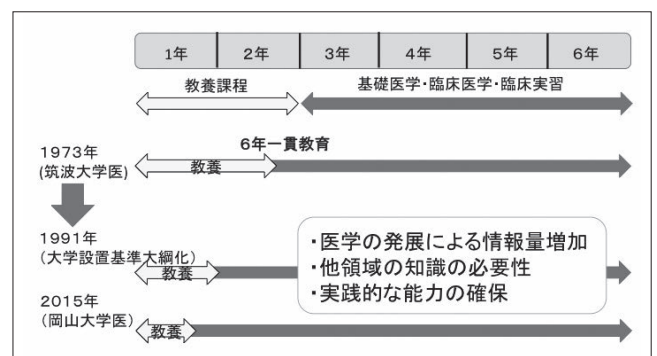**図3　ミャンマーの英語教育環境**

図4　英語能力向上のための教育の改善は必要？

図5　日本の医学部教育

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

5. 日本の医学教育における英語教育

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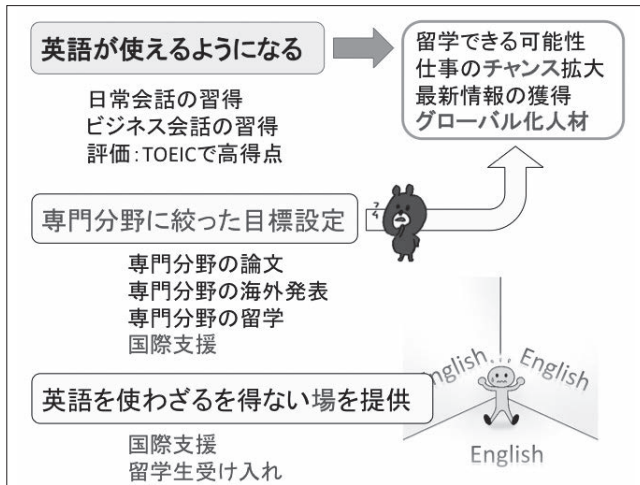
医制度，医療安全，医療倫理など非常に多くの卒後教育システムに晒され，余裕がなくなる状況になってきている（**図5**）。これらの状況は留学希望者をさらに減少させることになり，かつ英語を積極的に学ぶ姿勢や環境整備もできにくいことにつながってくる。

6. 効果的な英語教育の一案

では，国際支援も含めて英語能力を強化するために効果的な方法はないだろうか。一般社会における英語能力の向上の目的は，ビジネスチャンスの獲得にある。しかしそのためには，かなりの努力と時間を必要とする。ただし，医学部学生や卒業生に関して言えば，専門領域の論文作成，専門分野の発表や留学，そして専門領域の国際支援であれば，すべての領域において英語能力の向上が必要というわけでなくなり，効率良く能力が向上するのではと考える。すなわち，専門分野に絞った目標設定を行い，それを実践する方法がよいのではと思われる。さらに，英語を使わざるをえない場を，学生や医師に提供することも一案である。そこに国際支援や本邦への留学生受け入れなどが大きな力を発することになる（**図6**）。個人的な意見にはなるが，正しい文法を身につけるとか，綺麗な発音をするとか，他人を気にして上手に話そうとするとか，というより専門分野

図6　英語を使わざるをえない場を提供

図7　専門分野に限れば会話可能
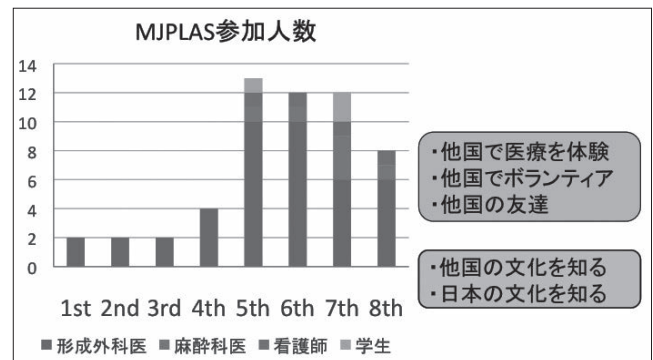

図8　見学・研修生が来たら担当を決める

図9　MJPLAS参加人数

に関する表現力と理解力を向上させることや，またその場に飛び込ませる（**図7**）ということが良いきっかけになると考えている。研修生，留学生を受け入れる際にも担当を決めて接遇させることも，強制的な場を与えることになる（**図8**）。

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

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

7. グローバル化の危機感を与える

ミャンマーは，アウンサンスーチーの選挙勝利とともに急激な民主化と経済成長が期待されている。最大都市ヤンゴンではすでに巨大なショッピングセンターの出現，ホテル建設のラッシュ，若い女性のファッションの変化，携帯電話やパソコンの普及など，まさに先進国の文化が急激に入り込む状況である（**図10**）。すなわち，ミャンマーでさえも知識人や裕福な人は，世界中の最新知識や情報を容易に瞬時に得られるようになってきた。まさに，グローバル化の時代の突入で，優秀な人は最新知識を常に収集し，最新技術を開発し，職種に関係なく国境のない時代の到来を意味していると考えられる。しかもこれらのすべてが英語ベースで動いているということを認識せざるをえない（**図11**）。

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

8. 最後に

ミャンマー医療支援の経験から，英語の必要性ならびに次世代の医療人にとってのグローバル化とは何かという点について話をしてきた。まとめると，英語はあくまでも道具であり，目的ではないということ，そして効果的な能力向上には専門領域から始めることや，国際医療支援や留学生受け入れなどの英語の場を提供することなどの案を提唱した。グローバル化の危機感を与えることなども重要であると思われる。そして，その根本には日本語を基本とした日本文化の再認識と，考える力や議論する力の向上が重要であると考えている（**図12**）。
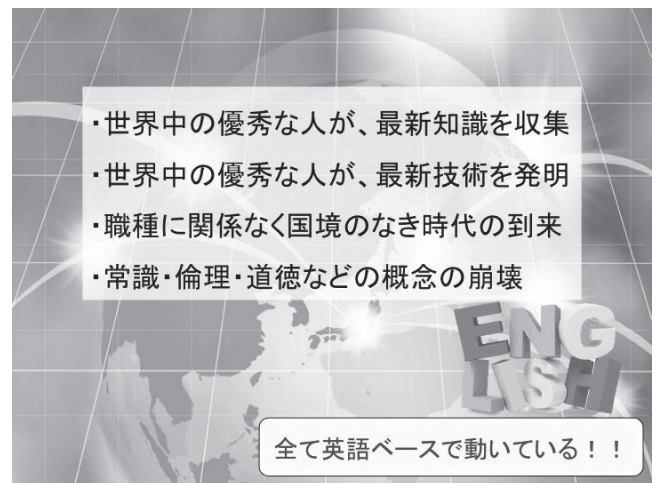
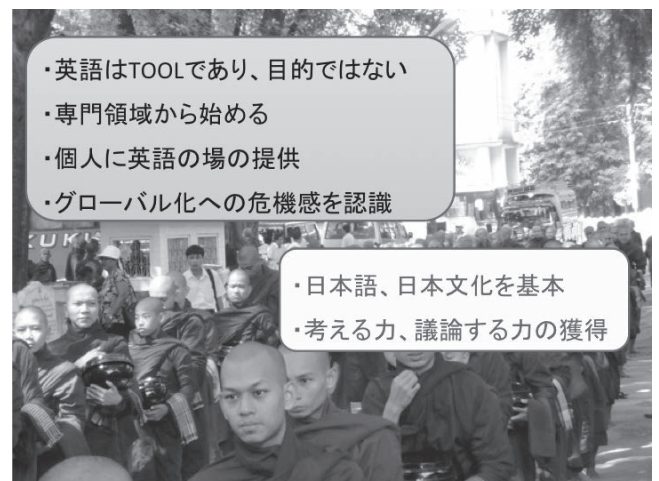**図11　すべてが英語ベースで動いている！**

図10　先進国の文化が急激に入り込むミャンマー

図12　日本文化の再認識と考える力や議論する力の向上が重要

第18回日本医学英語教育学会
シンポジウム：病院に外国人患者を受け入れるために
Symposium: How can we prepare ourselves to accept growing numbers of international patients at our hospitals?

外国人患者に優しい病院：りんくう総合医療センター（大阪府）の現状

A foreign patient-friendly medical center: Rinku General Medical Center (RGMC), Osaka, Japan

（岡山コンベンションセンター，2015年7月18日）

入交重雄　IRIMAJIRI Shigeo, M.D.
りんくう総合医療センター国際診療科，総合内科・感染症内科，膠原病内科　Rinku General Medical Center

　りんくう総合医療センターは大阪府南部にあり三次救急医療にも対応する地域の基幹病院である。また西日本唯一の特定感染症指定医療機関であり輸入感染症にも対応可能である。関西国際空港の対岸に位置する当院には訪日・在日の外国人患者受診が多い。当院では有償ボランティア登録通訳士（約60名）および国際医療コーディネーターによりスペイン語，英語，ポルトガル語，中国語，タガログ（フィリピン）語の通訳サービスを無償で提供している。また米国，ブラジル，中国の医師免許を有する日本人医師達が必要に応じ外国人患者の対応にあたる。外国人患者受入れ医療機関認証制度 (Japan Medical Service Accreditation for International Patients; JMIP) が2012年に厚労省の支援事業として開始となり，当院は2013年に国内初のJMIP 認証病院の一つとなった。以前から必要に応じて翻訳した同意書や説明書等があったが，翻訳書類の整備や追加，院内表示英語併記の追加のみならず，病院食英語メニューや災害発生時用多言語誘導ボード作成など新たに取り組むべき事項も多かった。新たに作成した外国人患者対応マニュアル・フローチャートが役に立ち，その後外国人患者対応がスムーズに運ぶようになった。

J Med Eng Educ (2016) 15(1): 51–54

1. りんくう総合医療センターの医療通訳サービス

　りんくう総合医療センターは大阪府南部にあり，3次救急医療にも対応する地域の基幹病院である。また西日本唯一の特定感染症指定医療機関であり，輸入感染症にも対応可能である。関西国際空港の対岸に位置する当院は関西国際空港の搬送先指定病院でもある。病院のすぐそばには外国人も数多く利用するホテルが2つあることもあり，訪日・在日の外国人患者受診が多い。

　当院では2006年に「国際外来」を設け（2012年より「国際診療科」），主に通訳サービスを提供してきた。現在，有償ボランティア登録通訳者（約60名）および国際医療コーディネーターによりスペイン語，英語，ポルトガル語，中国語，タガログ（フィリピン）語の通訳サービスを無償で提供している。

　病院に入ると，正面に総合受付カウンターがあり，カウンターの上に通訳サービス案内表示をそれぞれの言語で記

している（**図1**）。ボランティア通訳者は英語28名，スペイン語15名，ポルトガル語7名，中国語16名である。対応言語を曜日ごとに設定し，午前10時から午後3時まで通訳者を配置している。海外旅行会社や航空会社，大使館，海外保険会社，本国の家族との連絡や未払い医療費等の業務，外国人からの問合せやトラブルなどさまざまな事項を国際診療科のスタッフが対応する。外国人患者の対応内容は疾患，言語，健康保険の有無・種類により状況が異なるためマニュアル作成は困難であり，スタッフが個別対応す

図1　総合案内 General information counter

る。救急搬送され緊急手術後ICU管理となった外国人患者の通訳，突然の海外からの問い合わせの電話対応，院内からの退院予定外国人患者の紹介状の翻訳依頼などの対応が日常業務に加わるためスタッフはしばしば突発的にとても忙しくなる。米国，ブラジル，中国の医師免許を有する当院の常勤の3人の日本人医師が必要に応じ外国人患者の対応/診察を行う場合もある。

　1年間の延べ通訳件数は862件であり，スペイン語254件が最多で以下，英語226件，ポルトガル語140件，中国語140件，タガログ（フィリピン）語92件の順である（**表1**）。外国人患者の内訳は訪日19%に対して在日76%である。当院受診外国人は旅行者・航空会社クルー・出張ビジネスマンらの訪日外国人よりも，駐在ビジネスマン・留学生・労働者らとその家族らの在日外国人の割合が多い。国籍別通訳件数では，日系人が多いペルー205件，ブラジル142件が上位にあり，以下中国，フィリピン，アメリカ，コロンビアと続く（**表2**）。

　日本語でコミュニケーション可能な外国人や知人を通訳者として同伴する場合や医師が通訳者を介さずに外国語で診察する場合は，通訳件数に含まれない。よって，前述通訳件数より実際の外国人患者の受診数は多い。彼らの受診理由は外傷や疾患など日本人と同様にさまざまである。内科医である筆者の外来を定期受診する在日外国人患者には，バングラデシュ出身留学生，オセアニア出身パイロット，北米出身英語教師たちが含まれる。航空会社クルーのなかには，当院で受診すれば航空会社提供の医療保険を使い自己負担ゼロで，速やかに自国よりも質の高い医療と検査が英語で受けられるからとの理由で，同僚数人とともに緊急性の乏しい慢性症状や軽度感冒症状で受診する外国人患者もいた。

表1　言語別通訳件数 Number of interpreting cases by language

スペイン語 Spanish	254
英語 English	226
ポルトガル語 Portuguese	140
中国語 Chinese	140
タガログ語 Tagalog	92
その他 Others	10
合計 Total	862

表2　国籍別通訳件数 Number of interpreting cases by nationality

ペルー Peru	205
ブラジル Brazil	142
中国 China	130
フィリピン Philippines	116
アメリカ合衆国 United States of America	57
コロンビア Columbia	46
バングラデシュ Bangladesh	22
オーストラリア Australia	12
タイ Thailand	12
フランス France	11

2. 外国人患者受入れ医療機関認証制度 (JMIP) 取得

　国際化に伴い，日本の医療機関を受診する訪日・在日外国人患者が急増し医療機関の体制整備が求められるようになった。外国人患者受入れ医療機関認証制度 (Japan Medical Service Accreditation for International Patients: JMIP) は外国人が安心・安全に国際的に高い評価を得ている日本の医療サービスを享受することができる体制を構築することを目的とするものである（**図2**）。JMIPは2012年に厚労省の支援事業として開始となり，当院は2013年に国内初のJMIP認証病院の一つとなった。JMIP認証を維持するには3年毎に更新のための受審が必要である。

　JMIP認証のため，外国人患者検討委員会および国際診療科が中心となり準備を進めた。JMIP受審の準備には病院全体で取り組む必要があった。複数の診療科，検査科，放射線科，栄養科，地域医療課，薬剤科，総務課，医事課を含めての定期的に開催した外国人患者検討委員会のみならず，各部署と国際診療科との打合せを繰り返した。

　以前から必要に応じて翻訳した同意書や説明書等が数多くあったため（**図3**），それほど準備は大変ではないであろうと当初考えていたが，準備期間が2カ月間と短かったこともあり，実際には予想以上に大変であった。評価項目は詳細かつ非常に多岐にわたるものであった（**表3**）。

　翻訳書類の整備や追加，院内表示英語併記の追加のみならず，病院食英語メニューや災害発生時用多言語誘導ボー

本制度の目的:

外国人が安心・安全に国際的に高い評価を得ている日本の医療サービスを享受することができる体制を構築すること。
JMIP has been established as a part of a national project to promote smooth acceptance of international patients in Japanese medical settings.

一般財団法人 日本医療教育財団
外国人患者受入れ医療機関認証制度
Japan Medical Service Accreditation for International Patients

図2　外国人患者受入れ医療機関認証制度 Japan Medical Service Accreditation for International Patients (JMIP)

図3　日本語とスペイン語の同意書 Informed consent form

表3　JMIPの評価項目 Rating categories of JMIP

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

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

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

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

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

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

　申し込みからJMIP認証の流れは以下の通りであった（**図4**）。申し込み〜契約，書面調査，訪問調査，中間報告，最終判定，審査結果通知。訪問調査は書類調査，合同面接での150分の質疑応答，院内ラウンド調査など2日間にわたる。JMIP認証を取得することができたが，未整備だった夜間休日の通訳体制の構築を指摘され今後の課題となった。これまで国際診療科のみが外国人患者対応をしていたが，JMIP受審準備を通じて病院の各部署が以前よりも外国人患者に対して積極的に対応するようになった。

3. 米国退役軍人メディカルチェック

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

　皆保険制度をもつ日本と異なり，米国では最近オバマケアとよばれる公的医療保険が義務づけられるようになるまでは，公的医療保険は高齢者のためのMedicareと低所得者および身体障害者のためのMedicaidのみであったが，米国において，軍人および退役軍人への医療保険制度は非常に手厚い優れた制度である。米国内では退役軍人は退役
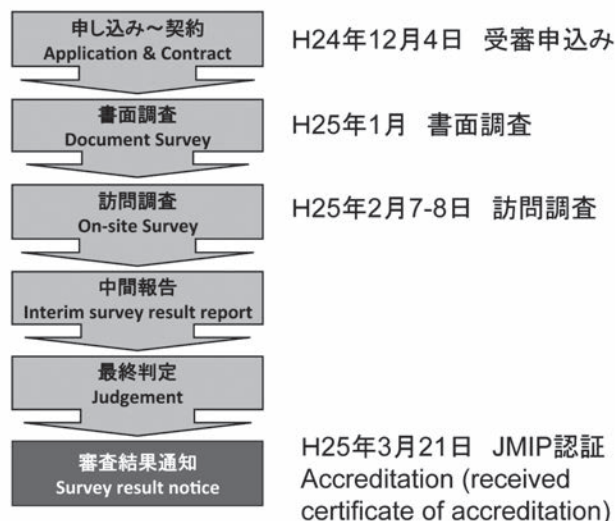

図4　申し込みから認証までの流れ Accreditation process of JMIP

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

軍人病院を訪れるが，米国外に在住する退役軍人が障害補償を国の機関である退役軍人局へ申請した場合には，在住地域近くの当院のような指定医療機関を訪れ問診や診察，検査を受ける。

処方を含めた治療は行わないし，次回診察予約もしない。保険診療ではなく，自費診療である。当院設定の検査費用に加えて問診・診察項目数により一定額が後ほど米国から病院に支払われる。問診，診察，検査項目は，あらかじめ通知される指定項目のみである。退役軍人局は指定病院からの情報などを基に障害補償につき決定を行う。日本国内の指定医療施設は関東，九州，沖縄などにあり，りんくう総合医療センターを含めて5カ所ほどある。

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

テキサスにある会社，Veterans Evaluation Services (VES) が退役軍人局，在日退役軍人，当院と連絡をとり，スケジュールを調節する。心エコー，呼吸機能検査，単純X線，心電図などVESを通じて指定される検査を当院で施行する。CT・MRI検査はこれまでに一度も依頼がなかった。こちらの判断で検査を追加することもない。

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

診断名，これまでの画像・血液検査結果，疾患の経過，手術・処方を含む治療内容，診察所見など実に詳細にDBQシートへの記載を要求されるが，本人に詳細に質問しても，退役軍人が正確な診断名，検査結果，治療内容を覚えていることはまれであり，記載は不十分とならざるをえない。過去の医療情報として300ページものスキャンされたPDF書類をオンライン上で見ることが可能である。

しかし，「捻挫して基地内の診療所でX線撮影されたが骨折を認めず鎮痛剤処方のうえ経過観察となった」，「胸部違和感で夜間に救急外来受診時心電図に異常を認めず経過観察となった」などの判読困難な手書きのカルテのコピーや，X線検査の読影結果，医療とは直接関係のない判読不能手書きカーボンコピーされた米軍の書類などがランダムに含まれており，膨大な資料のなかから必要な情報を得るのは至難の業である。書類は診療科別でも時系列でもなく，上下逆さまだったり斜めにスキャンされていたりする。入退院サマリーなどの診断名，病歴，検査結果，処方内容等がまとまっている書類はない。やっとの思いで記載し提出した後も，しばしば詳細記述を求められたり，軍での職務と症状や疾患との関連を尋ねられる。狭心症が職務のために発生したのか，軍での職務のために民間業務の場合よりも狭心症が悪化したのか，狭心症と軍での職務との関連性は50%以上か50%未満かと問われても，科学的に回答することは困難である。本人に所属部署と職務内容を尋ねるが，そもそも軍の職務に詳しくない筆者が多少質問した程度ではそれぞれの職務における疾患に対する影響の理解が十分とは言いがたい。

退役軍人の訴えや診断名に基づき，問診と診察を行いDBQシートに記載後，オンラインで提出する。内容は人それぞれ異なるが，毎回複数のDBQがあらかじめVESを通じ指定されている。例えば一人の退役軍人に①高血圧，②糖尿病，③胸痛，④呼吸器系，⑤膝，⑥脊椎，⑦足首，⑧頸部，⑨膝の問題がある。それぞれのDBQシートは約12ページで構成される。筆者による問診・診察に2時間，リハビリスタッフによる関節可動域測定や筋力テストなどに1時間，オンライン入力に2時間程度かかる。数十キロの装備をつけての一日中の行軍や激しい身体訓練時に生じた外傷既往をもつ人が多い。また，戦闘機の整備士の騒音性難聴，軍用車排気系欠陥による一酸化炭素中毒後遺症高次脳機能障害，戦争体験によるPTSD，枯葉剤などの有毒物質曝露による症状の例もあった。

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

第18回日本医学英語教育学会
シンポジウム：病院に外国人患者を受け入れるために
Symposium: How can we prepare ourselves to accept growing numbers of international patients at our hospitals?

Useful expressions for communicating with English-speaking patients

（Okayama Convention Center, July 18, 2015）

James Thomas
Medical Education Center, Keio University School of Medicine

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

J Med Eng Educ (2016) 15(1): 55–57

1. Introduction

The number of non-Japanese-speakers visiting Japan is increasing and is expected to rise even more rapidly over the coming years. Many such individuals speak English as a first or second language. As a consequence, it is important that Japanese hospitals and health-care institutions can adapt to accommodate a possible rise in the number of English-speaking patients. The Japanese National Tourism Organization highlighted this projected increase through the statistics shown in **Figure 1**.

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

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

National importance

"According to the JNTO, the estimated number of international visitors to Japan in May 2015 reached over **1.64 million** (49.6% increase from the previous year), being the highest figure for May."

www.tourism.jp

Figure 1. National importance

2. Preparation and considerations

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

Figures 2 and 3 highlight a few of the possible considerations that may be relevant to your institutions. The list is by no means exhaustive. Session content is often one of the first considerations, and this can vary greatly depending upon the institution, instructors, participants, and their needs. The content will also vary with the participants' roles within the institution, including, but not limited to, whether they are doctors, nurses, medical students, interpreters, allied health-care professionals, or administrative staff. As an example, doctors may benefit from medical interview and physical examination training, whereas administrative staff may have very different needs. I believe that almost all participants, regardless of their role, can benefit from practising basic techniques such as those outlined in **Figure 4**. This may be a

good starting point for many institutions wishing to increase the medical English proficiency of their staff. Consequently, I have dedicated the next part of this presentation to introducing a number of expressions and ideas that could prove useful in improving these fundamental components of medical English communication.

3. Examples and suggestions

As shown in **Figure 4**, there are a number of fundamental topics which most Japanese health-care providers will need to be able to cover when meeting non-Japanese-speaking patients and will most likely benefit from practising. Teaching formal and polite greetings, such as those shown in **Figure 5**, may at first seem elementary, but it is often a good starting point. I often begin by having participants practise role-plays with basic phrases provided to increase their confidence before progressing to more advanced conversations and phrases. Of course, many of these phrases will also require some explanation. For example, the phrase "Nice to meet you" is perfectly acceptable for use with a patient who is comfortable, pain-free, and smiling. However, a patient who is angry, upset, anxious, or in obvious pain may become
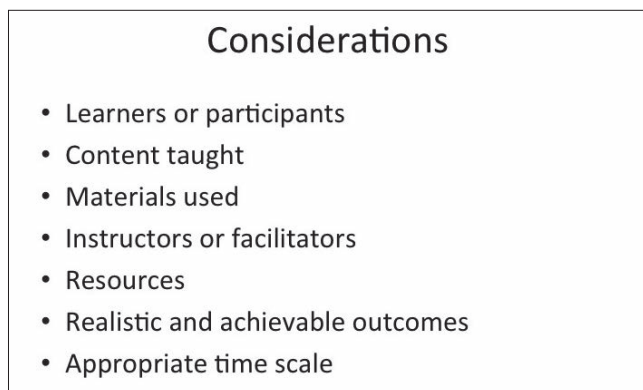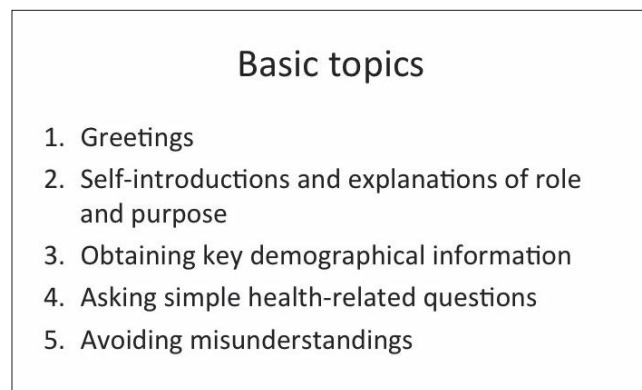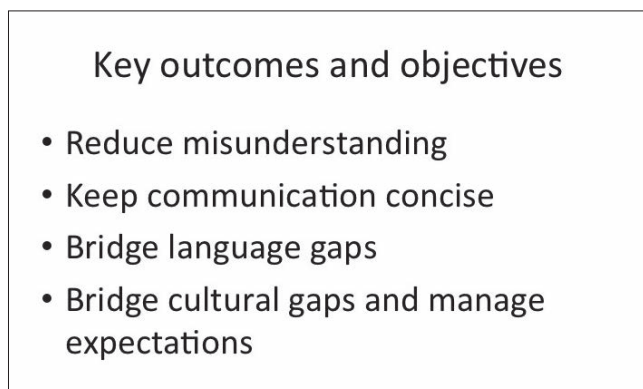
Figure 2. Considerations

Figure 4. Basic topics

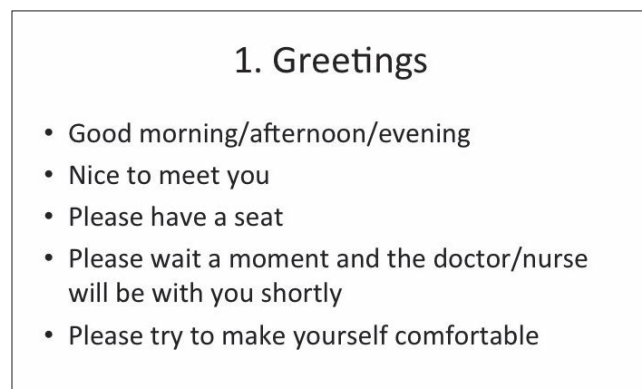Figure 3. Key outcomes and objectives

Figure 5. Basic topics 1. Greetings

annoyed if a doctor or nurse uses that same phrase.

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

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

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

freely about their concerns and symptoms.

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

4. Final remarks

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

2. Self-introductions

- My name is Dr/Mr/Ms *Smith*
- I am one of the nurses/medical students/ cardiologists working in this department
- I will be taking care of you today
- I need to ask you some questions
- I will be taking a blood sample/x-ray etc.
- Is that o.k?

Figure 6. Basic topics 2. Self-introductions

3. Obtaining demographics

- Please can I confirm your full name?
- What is your date of birth?
- Which country are you from?
- Are you married, single, or divorced?
- How long have you been in Japan?
- Do you speak any Japanese?
- Do you have any form of health insurance?

Figure 7. Basic topics 3. Obtaining demographics

4. Simple health-related questions

- How can I help you today?
- What can I do for you today?
- How are you feeling today?
- Can you tell me more details about your symptom/problem/concerns?

Figure 8. Basic topics 4. Simple health-related questions

5. Avoiding misunderstanding

- What do you mean by (*unknown word or phrase*)?
- Do you mean *(paraphrase)*?
- Please could you repeat that?
- How do you spell that?
- Please could you write that down?
- Please could you speak more slowly?
- Could you explain what you mean in more detail?

Figure 9. Basic topics 5. Avoiding misunderstanding

Nell L. Kennedy 先生を偲んで

日本医学英語教育学会の発足時から，長年にわたり理事および学会誌編集長として多大な貢献をされ植村研一賞の第1回受賞者でもあったケネディ先生は，昨年（2015年）10月15日に76歳で天に召された。

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

出会い

ケネディ先生との出会いは，メジカルビュー社の『アクセプトされる医学英語論文を書こう！』の翻訳を依頼されたことであった。この書のFORE-WORDにも記したが，ケネディ先生は長年多くの日本人医師，科学者の英語論文の添削をしてきた経験から，日本人の陥りやすい間違い，またよくわからないまま習慣的におかしてきた間違いなどに対し，的確な説明と共に正しい表現・記述方法を大変わかりやすく説明された。学会の理事会でもしっかりとした意見を言い，厚い信頼を得ていた方からの仕事の依頼で，おおいに感謝してお引き受けしたものの，未経験の私にとっては思いも掛けない経験であり，試練であった。

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

とも含めて的確なアドバイスや表現のチェックをされた。「いいかげんなことはできない！」が彼女の信条で，日常生活はほとんどの時間を論文読みに費やしていたそうである。

学会誌編集長と日本語の副編集長として

ケネディ先生は本学会の第2代学会誌編集長であり，私は副編集長として主に日本語の面でサポートする立場であった。彼女が編集長であった期間に学会誌に投稿した方は，詳細なチェック，アドバイス，多様な表現の提案など，驚くほど丁寧な添削が戻って来たことに，驚き，恐縮した経験をお持ちの方が多くいらっしゃることと思う。編集長として，本学会の学会誌のレベルを上げたい。学会誌掲載にふさわしい論文を載せたい，そのためには曖昧な表現ではなくきちんと科学的にスッキリ書いてほしいと願う気持ちが，一つ一つの投稿原稿に真摯に向き合い，長い時間をかけて添削する作業につながっていた。そんな彼女にも弱い？点があり，疑問を持つ論文，あるいは掲載するにあたっては，ある条件を要求しなければならないような場合，なかなかストレートに言えない。そんな時，彼女から私に，貴女の柔らかい日本語で伝えてほしいと依頼があった。

共著者あるいは訳者として

通常，書き終えてからの校正は4,5回ではないかと思うが，ケネディ先生の場合，そろそろこれで最終原稿？と思ってからも幾度となく繰り返される校正，書き終えてからの何十回ものチェック（本人曰く20回のチェックは必要）には本当に驚いた。彼女はとにかく妥協を許さない！よりよい表現，誰が読んでも誤解する余地を与えない表現を追求して何度も何度も推敲を重ねる。そして，表現，漢字はもちろんのこと，スペース，パンクチュエーションにも厳しい。ダッシュの長さ（mダッシュとnダッシュの使い分け）も正確だ。また日本語らしい表現にもこだわった。英語で"Mr. XX"と書かれていたのを「××氏」と訳したところ，日本語では「××さん」とは言わない。「○○さん」と言

いませんか？ また "black and white" を「黒白」と訳したら，日本語では「黒白」より「白黒」と言うのが自然でしょう？ と。

どんな本も完璧にはできないのはわかっているが少しでも完璧に近づけたい，と言うのがいつも彼女の姿勢であった。編集者，出版側としては，時間的な制約もあり，出来上がった原稿から順に送ってほしいと要望するが，彼女は「まだ見直したいし，全体が出来上がってから構成を変えるかもしれないから未だ完成だと思わないで！」と，ある意味では出版社泣かせの著者であった。あまりに改訂版の原稿が多いので，受け取る側もきちんと整理していないと改訂版の順序を間違えたりしてしまう。前回の訂正部分が直っていない！ とのお叱りを受けたりすることも多々あるのだが，その都度のメールの長さが尋常ではない。1ヵ所の訂正の説明が長い長い英文で毎日山のように届くのである。本のレイアウト，右のページに来るべきもの，左のページに来るべきものに関しても全てチェックされる。そんなこんなで，あの本が出来上がってからでも何十ヵ所も？間違いを見つけて残念だったとおっしゃっていたが，それでもあの本が出来上がるまでにやり取りした原稿の量は半端ない量であった。

その他にも，ケネディ先生と協働した本は数冊あり，その一つ，平野美津子先生がメインで書き始めた菱田との共著の本にケネディ先生のアドバイスをお願いしたところ，大変貴重な意見を多くいただいてレベルの高い著書が出来上がったものの，主張を曲げない彼女との話し合いは時には凍り付いたり，雪解けでホッとしたり…

そんな折，彼女が体調を崩して入院したことがあった。仕事の都合で一緒には行けなかった平野先生と私は，それぞれ札幌の病院まで飛んだ。入院して以来本当に元気をなくして伏せっていたケネディ氏が私たちの顔を見るなり，いっぺんに病人を止め，いきいきと仕事の話に夢中になり，お世話をしていた河田さんを驚かせた。

癌の再発がみつかって以来，徐々に体力も衰えて理事を辞任され，学会の出席もままならなくなっても仕事への情熱は全く衰えることなく，『アクセプトされる…』の改訂版を書きたい，まだ私から伝えたいことがあるから新しく本を書きたい，と言い続けていた。

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

<div align="right">

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

</div>

略歴

1939年	米国テキサス州生まれ
1964年	米国テキサス州立大学教育学部卒業，同大学院ジャーナリズム科専攻
1968年	来日，神奈川県 座間の米軍キャンプの学校の教師として赴任
1970〜73年	毎日新聞記者
1970〜80年	クリスチアニティトウデイ誌（ワシントンDC）アジア，ミクロネシア地域記者
1972〜85年	北里大学医学部非常勤講師，相模女子大学非常勤講師
〜93年	北里医学ジャーナルおよび国外投稿英語医学論文校閲
1986年	米国コロンビアパシフィック大学教育学博士号取得
1986〜2008年	酪農学園大学獣医学部教授 バイオメディカルイングリシュ研究室

所属学会	日本医学英語教育学会（1998.7〜） 　理事（2001〜2009） 　学会誌編集長（2004〜2008） 全国語学教育学会 国際英語教育学会 国際聖書学会

Nell L. Kennedy 1939–2015

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

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

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

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

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

During her time as Editor, Nell converted the publication into a respectable international scientific journal. When she started, the journal had two titles, and no criteria for accepting submissions. Nell removed one of the titles, established its present title, and wrote the first set of Instructions to Authors. She also created a reviewing process that ensured that all accepted papers would be published at, or above a certain standard. Nell personally read over each submission and sent the authors detailed comments that led to substantial improvements. When Professor Yoshioka and I visited her in 2008, she was already in poor health, yet she spent a number of hours with us, explaining in detail the minutiae involved in editing the journal. She also endowed me with a thick file of notes, comments and partially edited papers. Although she used her com-

puter extensively and mailed her friends and colleagues regularly, Nell was of the pre-computer age. Back home I went through a great many documents in which, immaculately inscribed in red ink, were her notes. Both instructive and helpful, they were never over-critical or insulting.

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

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

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

Reuben M. Gerling
Former Editor-in-chief
Journal of Medical English Education
(2008–14)

投稿申請書
Submission Form

　　下記の論文を日本医学英語教育学会会誌 *Journal of Medical English Education* に投稿します。なお，他誌への類似論文の投稿はいたしません。また，採用された場合，本論文の著作権が日本医学英語教育学会に帰属することに同意いたします。

　　The undersigned authors submit the manuscript detailed below to the Editorial Board of the *Journal of Medical English Education* and request that it be considered for publication. If the manuscript is accepted, we agree to transfer copyright ownership to the Japan Society for Medical English Education.

Date 申請日 _____

Title 論文題名

_____

_____

Manuscript classification 分類（please circle 該当するものに○印）：

1. Original article (research)　　　　**2. Original article (teaching methods)**

3. Short communication (research)　　**4. Short communication (teaching methods)**

5. Letter

Author(s) 著者
Name 氏名・Affiliation 所属　　　　　　　　**Signature 署名**

_____　　_____

_____　　_____

_____　　_____

Corresponding Author 通信著者

_____

Name 氏名

_____

Contact Address 連絡先 / 校正紙送付先

_____　_____　_____

TEL　　　　　　　　　　**FAX**　　　　　　　　　　**E-MAIL**

日本医学英語教育学会
Japan Society for Medical English Education
入会のご案内

---

1. 下記のホームページで入会申し込みが可能です。
   〈**http://www.medicalview.co.jp/JASMEE/ nyukai.shtml**〉

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

   [平成 27 年度年会費]
   - 個人会員　￥9,000
   - 学生会員　￥1,000
   - 賛助会員　￥35,000

   [ゆうちょ銀行 振替口座]
   - 口座番号　00120 - 7 - 417619
   - 口座名称　日本医学英語教育学会

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

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

3. ご不明な点がございましたら，下記の事務局までお問い合わせください。

[問合せ先]

〒 162 - 0845
新宿区市谷本村町 2 - 30　メジカルビュー社内
日本医学英語教育学会　事務局（担当：江口）

- TEL　　03 - 5228 - 2274
- FAX　　03 - 5228 - 2062
- E-MAIL　jasmee@medicalview.co.jp
- URL　　http://www.medicalview.co.jp/ JASMEE/index.shtml

---

1. Prospective members can fill the forms and submit them online at:
   <**http://www.medicalview.co.jp/JASMEE/ nyukai_e.shtml**>

2. Please transfer the Membership fee through the Japan Post Bank (post office).
   Annual fees are ¥9,000 for individual membersihp, ¥1,000 for student membership and ¥35,000 for supporting membership.

   Japan Post Bank
   Account No. 00120-7-417619,
   Account Name "日本医学英語教育学会".

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

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

   The JASMEE Secretariat (Attn: Mr. Junji Eguchi)
   c/o Medical View
   　2-30 Ichigaya-hommuracho, Shinjuku-ku, Tokyo 162-0845, Japan
   - TEL　　　+81-3-5228-2274
   - FAX　　　+81-3-5228-2062
   - E-MAIL　jasmee@medicalview.co.jp
   - URL:　　http://www.medicalview.co.jp/ JASMEE/index.shtml